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County Offices
Newland
Lincoln
LN1 1YL

1 September 2015

Adults Scrutiny Committee

A meeting of the Adults Scrutiny Committee will be held on **Wednesday, 9 September 2015 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL** for the transaction of business set out on the attached Agenda.

Yours sincerely

Tony McArdle
Chief Executive

Membership of the Adults Scrutiny Committee
(11 Members of the Council)

Councillors C E H Marfleet (Chairman), R C Kirk (Vice-Chairman), W J Aron, S R Dodds, B W Keimach, J R Marriott, Mrs H N J Powell, Mrs A E Reynolds, Mrs N J Smith, Mark Whittington and Mrs S M Wray

ADULTS SCRUTINY COMMITTEE AGENDA
WEDNESDAY, 9 SEPTEMBER 2015

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Minutes of the previous meeting of the Adults Scrutiny Committee held on 8 July 2015**	5 - 8
4	**Care Quality Commission Adult Social Care Inspection Update** *(A report by Deanna Westwood, Inspection Manager Lincolnshire, which provides the Committee with a position statement on the progress and themes coming out of the Care Quality Commission's (CQC) inspections of Adult Social Care services in Lincolnshire)*	9 - 12
5	**Better Care Fund - Update** *(A report by Glen Garrod, Director of Adult Care, which details both national and local developments since March, and the second quarter performance report (April to June 2015), which was submitted to NHS England on 28 August following sign off by the Health and Wellbeing Board Chairman, Councillor Sue Woolley)*	13 - 26
6	**Deprivation of Liberty Safeguards (DoLS) Status Report** *(A report by Mandy Cooke, Head of Safeguarding, in connection with the effects of the Cheshire West Judgement in March 2014, which has had a significant impact for the Deprivation of Liberty Safeguards both nationally and locally)*	27 - 40
7	**Council Business Plan 2015 - 2016 Performance Report, Quarter One** *(A report by Jasmine Sodhi, Council's Performance Manager, which presents Quarter 1 data in a new style performance report against the Council Business Plan)*	41 - 90
8	**Sensory Impairment Services Re-Procurement** *(A report by Clare McNally, Project Manager, Adult Frailty and Long Term Conditions, Commissioning Team and Marie Kaempfe-Rice, Programme Manager, Adult Frailty and Long Term Conditions, Commissioning Team Adult Care, which invites the Committee to consider a report due to be considered by the Executive Councillor for Adult Care and Health Services, Children's Services on 14 September 2015)*	91 - 136

9 **Adult Care Market Position Statement 2015-2016** 137 - 180
(A report by Clare McNally, Project Manager, Adult Frailty and Long Term Conditions, Commissioning Team and Rebecca Walukiewicz, Programme Manager, Adult Frailty and Long Term Conditions, Commissioning Team Adult Care, which invites the Committee to note the attached Adult Care Market Position Statement 2015-2016. The document is intended to be public facing and aims to encourage dialogue with the care and support sector)

10 **Lincolnshire Safeguarding Boards Scrutiny Sub Committee - Update** 181 - 188
(A report by Catherine Wilman, Democratic Services Officer, which enables the Committee to have an overview of the activities of the Lincolnshire Safeguarding Boards Scrutiny Sub-Group. The draft minutes of the last meeting of the Scrutiny Sub-Group held on 15 July 2015 are attached)

11 **Adults Scrutiny Committee Work Programme** 189 - 196
(A report by Simon Evans, Scrutiny Officer, which provides the latest update of the Work programme)

Democratic Services Officer Contact Details

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Please note: for more information about any of the following please contact the Democratic Services Officer responsible for servicing this meeting

- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details set out above.

All papers for council meetings are available on:
www.lincolnshire.gov.uk/committeerecords

ADULTS SCRUTINY COMMITTEE
8 JULY 2015

PRESENT: COUNCILLOR C E H MARFLEET (CHAIRMAN)

Councillors R C Kirk (Vice-Chairman), W J Aron, S R Dodds, B W Keimach, J R Marriott, Mrs H N J Powell, Mrs A E Reynolds, Mrs N J Smith and Mrs S M Wray

Councillors: R G Fairman, C R Oxby and Mrs J M Renshaw attended the meeting as observers;

Officers in attendance:- Simon Evans (Scrutiny Officer), Nigel Gooding (Head of Portfolio & Programme Management Office, LHAC), John Griffin (Adult Workforce Quality & Development (Practitioner), Emma Scarth (County Manager Performance, Quality & Development), Pete Sidgwick (Frail, Elderly and Long Term Conditions), Gary Thompson (Chief Officer, South Lincolnshire CCG & LHAC Transformation Director), Catherine Wilman (Democratic Services Officer).

11 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

No apologies were received.

12 DECLARATION OF COUNCILLORS' INTERESTS

Councillor S R Dodds declared an interest in item 15 – Neighbourhood Teams as she was the County Organiser for Lincolnshire Neurological Alliance.

13 MINUTES OF THE MEETING HELD ON 27 MAY 2015

RESOLVED

That the minutes of the meeting held on 27 May 2015 be approved and signed by the Chairman as an accurate record.

14 RESEARCH IN PRACTICE FOR ADULTS - DEMONSTRATION

The Committee received a demonstration from John Griffin, Adult Workforce Quality and Development (Practitioner), of the Research in Practice for Adults website – www.ripfa.org.uk.

The website was available, at a cost, to those who subscribed. Through the site, users could access to a range of resources which could be downloaded for free, or hard copies could be paid for.

The site operated on a subscription basis, which the Council paid for and members of the Committee would be provided with their own login details.

The Council had had a subscription since April 2014, which would be up for renewal in April 2016. There were currently 118 user accounts across the authority under the Council's subscription. Membership cost £30,000 for two years.

Within the site, there were opportunities to discuss issues with other users and also view the work of other councils and the subscription entitled the Council to two days of tailored support each year.

Members of the Committee were asked to have a look at the website, using their login, and report back their views at the next Committee.

RESOLVED

That the report be noted.

15 NEIGHBOURHOOD TEAMS

Consideration was given to a report which informed and updated the Committee on the implementation of Neighbourhood Teams across the county. Gary Thompson and Nigel Gooding, both from Lincolnshire Health and Care (LHAC) were present to address the Committee.

Neighbourhood Teams were a key component of the Proactive Care Programme and were absolutely fundamental to the delivery of the Lincolnshire Health and Care vision. LHAC aspired to a population-based model of health where wellbeing was maximised through communities, voluntary and statutory services working together.

Lincolnshire's health care faced a number of challenges and the current system of health and social care in the county was not sustainable.

A Communications Plan was currently being developed in collaboration with all partners would be going to formal public consultation in December 2015.

The Neighbourhood Team approach would move care wherever possible closer to home through the creation of neighbourhood teams. The aim of which was to reduce the number of situations where a journey to an acute hospital was required.

An early group of implementer Neighbourhood Teams were set up in 2014 in the County in Skegness, East Lindsey Coastal, Sleaford, Grantham Town/Grantham Rural, Stamford, Long Sutton/Sutton Bridge, Lincoln City South and Lincoln City North. Current proposals were for an additional four teams in the County by September 2015. Each team will have a number of Multi-Disciplinary Teams within them.

The benefits of the system for the patient, are a single integrated system where only on assessment will be required. This will create one record and one plan for the patient. The system will also help to stop weekend admissions to hospital as the team will ensure the patient is receiving care closer to home, 24 hours a day, 7 days a week.

Officers were currently identifying buildings in each area which could be used as a hub, where all agencies within the team could come together. In Long Sutton, for example, a disused doctors' surgery was being used.

The impact of the neighbourhood team in Long Sutton had already seen a reduction in repeat admissions to hospital. However, the pressure test omn admissions would be in the winter months.

In response to questions from Members, the following was confirmed:

- Currently, staff time was not used effectively and Neighbourhood Teams sought to utilise their time better and maximise their knowledge and skills through better organisation;
- Each team will include a care coordinator who would devise and lead a care timetable;
- The reduction in beds at acute hospitals would not impact on Neighbourhood Teams as people would be cured more and more in their own homes. Dermatology was a good example of a treatment that did not need to be undertaken in hospital;
- The Scrutiny Officer, along with Nigel Gooding would organise a visit for Committee members to see frontline workers within a Neighbourhood Team;
- Any member of the Committee wishing to see a good example of neighbourhood teams already set up and in action, were directed to look at Torbay Council.

The next steps were for the Executive to sign off the consultation at its meeting in October 2015. The CCGs would sign off the consultation individually.

The proposals for Neighbourhood Teams would also be considered at the Health Scrutiny Committee for Lincolnshire at forthcoming meetings and by the Overview and Scrutiny Management Committee at its meeting on 30 July 2015.

The Adults Scrutiny Committee would continue to receive updates on the proposals either as a specific item or as part of an update on work within LHAC.

RESOLVED

1. That the report be noted;

2. That comments made by the Committee be noted and the frequency of further udpates on Neighbourhood Teams be determined.

16 QUARTER 4 PERFORMANCE REPORT

Consideration was given to a report which provided a summary of the Adult Care performance measures in the local performance framework including three Council Business Plan indicators.

Within the framework, three measures had been indentified as a priority for the authority and therefore included in the Council Business Plan. They were:

- % of people received reablement where the outcome was no ongoing support;
- Delayed transfers of care attributable to social care or jointly to social care and the NHS per 100,000 population;
- % of clients in receipt of long term support and carers who receive a direct payment.

In relation to these measures, in quarter 4 of 2014/2015;

- 57% of people reported that they required no further help from Adult Care following the receipt of reablement;
- There had been a slight dip in performance in relation to delayed transfers of care (1.66 per 100,000 population) however Lincolnshire still remained one of the best performing authorities for delayed transfers of care;
- The percentage of clients in receipt of long term support did not quite hit its target this quarter, however it had seen significant improvements in performance since the previous quarter.

The local performance framework included a total of 29 measures. In summary, 16 out of the 25 measures that could be compared to 2013/2014 had performed better than the previous year.

Overall, the customer experience was good. Of the 146 complaints received in 2014/2015, 83 were substantiated and owing to system changes and the move to Serco, further information breakdown on complaints was not available.

RESOLVED

That the report be noted.

17 ADULTS SCRUTINY COMMITTEE WORK PROGRAMME

The Committee gave consideration to a report which provided details of its work programme for the coming months.

During discussion, the following items were suggested for the work programme:

- Depravation of Liberty Safeguards;
- Care Farming
- Better Care Fund update.

RESOLVED

That the work programme and changes made therein be noted.

The meeting closed at 1.25 pm

Lincolnshire
COUNTY COUNCIL
Working for a better future

Open Report on behalf of the Care Quality Commission

Report to:	**Adults Scrutiny Committee**
Date:	**9 September 2015**
Subject:	**Care Quality Commission Adult Social Care Inspection Update**

Summary:

This is a short report to provide the Adults Scrutiny Committee for Lincolnshire with a position statement on the progress and themes coming out of the Care Quality Commission's (CQC) inspections of Adult Social Care services in Lincolnshire.

When considering this report it is important for the Committee to bear in mind that the CQC is not subject to Local Authority Scrutiny, and the relationship is an informal one based on an understanding, trust and joint aspiration to improve services by sharing insight and complementing each other's roles. The Committee is asked to bear in mind that the CQC is neither a commissioner nor a provider of services. The role of the Care Quality Commission is to monitor, inspect and regulate all health and social care services in England to ensure that they meet fundamental standards of quality and safety within the framework of the Health and Social Care Act 2008.

Actions Required:

(1) To consider the information presented on the themes arising from CQC's inspections of ASC services in Lincolnshire to date.

(2) To determine whether the Committee would wish to receive further updates and at what frequency

1. Background

The Care Quality Commission (CQC) began inspecting with the new approach in Lincolnshire in October 2014. There are 375 locations registered in Lincolnshire for the provision of adult social care, of which 93 are registered to provide nursing care.

<u>Inspection Arrangements</u>

Inspections are carried in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which have replaced earlier regulations (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). For each inspection, five main questions are asked about a service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

Safe, *Effective*, *Caring*, *Response* and *Well-led* are referred to as the five domains.

All CQC inspection teams gather and use information and feedback from people using services, their carers and families, and their representatives. This includes national data such as information from Skills for Care, as well as people's stories sent to CQC.

CQC also asks local partners, including Local Authorities, Health and Wellbeing Boards and Clinical Commissioning Groups (CCGs), to share information about the quality of services before our inspections. We are not responsible for monitoring commissioners of services but we work closely with them to share information about risks and the quality of local services.

During the inspections, our inspection teams check on different aspects of care, the environment, the staff and how the service is run. They observe care, talk to people using the services and their families, and to staff, and check policies, records and care plans to decide on the quality of the care.

As well as an overall rating for each service against the five key questions above, each key question is rated against these domains. The following ratings are made:

- Outstanding
- Good
- Requires improvement
- Inadequate

<u>Inspection Findings</u>

Since October 2014, the CQC has inspected and published ratings of 103 Adult Social Care Services in Lincolnshire and the table below is a summary of our findings. Where providers are failing to meet the fundamental standards of care we will take enforcement action such as the issue of requirement notices, warning notices, cancellation of registration, placing a service into special measures or, if appropriate, prosecution.

Rating	Safe	Effective	Caring	Responsive	Well Led	Overall
Outstanding				1	1	
Good	65	74	83	68	65	63
Requires improvement	31	24	19	30	34	36
Inadequate	7	3		2	3	4

Display of CQC Rating

Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires service providers to display at their premises the most recent overall rating from the CQC, including ratings for each of the services provided. There are also requirements on each service provider to include a link on their website to the CQC's website where the most recent CQC report may be found.

2. Conclusion

The Committee may wish to note that the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were introduced in November 2014, with amendment regulations effective from 1 April 2015. These regulations address the specific recommendations for the CQC in the Francis Report. Details can be found on CQC web site.

We are committed to inspecting and rating all adult social care services by the end of September 2016.

3. Consultation

a) Policy Proofing Actions Required

N/A

4. Background Papers

The following background papers as defined in the Local Government Act 1972 were relied upon in the writing of this report.

Document Title	Where the document can be viewed
CQC local area profile	Care Quality Commission

This report was written by Deanna Westwood, Inspection Manager Lincolnshire, who can be contacted via deanna.westwood@cqc.org.uk or 03000 616161.

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Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Glen Garrod, Director of Adult Social Services

Report to:	**Adults Scrutiny Committee**
Date:	**09 September 2015**
Subject:	**Better Care Fund update**

Summary:

Further to the Lincolnshire BCF submission on 9 January and the required financial 'envelope' submitted on 31 March 2015, this report details both national and local developments since March, and the second quarter performance report (April to June 2015), which was submitted to NHS England on 28 August following sign off by the Health and Wellbeing Board Chair Cllr Sue Woolley.

Actions Required:

Note and comment on this report and the attached quarterly performance report.

1. Background

The Adults Scrutiny Committee will recall that the BCF submission was made to the Government on 9 January 2015. In February we were notified that the submission had been approved. The "delivery vehicle" for transfer of the national funding to Lincolnshire is a Section 75 Agreement. This was signed off by the County Council, the four CCGs and the Chair of Health and Wellbeing Board.

The minimum value of the BCF in 2015/16 is £53.2m (£48.4m revenue and £4.8m capital) though Members will note that the level of pooling is actually £197m. This fact alone determines the nature of the agreement, in this case a framework agreement, and the number of separate elements that make up the whole. This means the BCF in Lincolnshire is made up of five Section 75 agreements and two aligned budgets.

It is important to recall that the BCF is for 2015/16 only and does not represent new money. A most pressing area of concern in securing agreement has, and continues to be, the level of financial risk that pertains to the BCF and the savings expected in an already stretched health and social care economy.

Integration between health and care has a high national profile and it would seem this is set to continue with the BCF funding mechanism, although the precise details surrounding the future of the BCF are yet to be determined.

Financial Risk

The BCF pooling itself represents a financial risk because the amount available in 2015/16 is less than that spent in 2014/15. As such, service developments and commissioning activity alongside the programme overseen by LHAC is a combined attempt to reduce this financial risk.

The overall financial risk was mitigated by a 'reserve' for 2015/16 only of £5.35m held within the 'Corporate' Section 75. Members will recall that the majority of this - £3.75m - was to mitigate the risk of underperformance against the 'pay for performance' element in the BCF (non-elective activity) as required nationally.

In addition and as a part of the negotiations between the partners (four CCGs and the County Council (LCC)) to secure an agreed pooled budget the CCGs commissioned Mills and Reeve to advise them. One outcome of this work was that an additional financial risk was introduced related to the £20m agreed for the 'protection' of adult social care.

The net effect is that LCC agreed to a 'pay for performance' arrangement covering £1m out of the £20m. This provided the CCGs with a more 'balanced' level of financial risk across the health and social care community. The details of what performance is required to secure the £1m are included in Appendix A.

In summary, there are three levels of financial risk, notwithstanding the overall financial position for health and social care in Lincolnshire:

a. The consequences on NHS partners as a direct result of the national requirements in the BCF and the £20m allocated to protect Adult Care.
b. The failure to achieve a 3.5% reduction in non-elective admissions in any or all of the four quarters and,
c. The £1m financial risk to Adult Care of not achieving the pay for performance element agreed with the CCGs.

Performance

The performance report attached as Appendix A provides the second quarter analysis for both the BCF Metrics (national requirement) AND the £1m pay for performance requirement on Adult Care (local requirement) which monitors the impact of social care activity on reducing pressures on the NHS.

BCF metrics (national) commentary

a) For the three out of the six national measures reportable in this period, one is ahead of target, and two are below. Three measures cannot be calculated until later in the year when the data is available.

b) Despite achieving an encouraging 4.1% reduction in non-elective admissions last quarter (compared to the same quarter from the previous year), the data provided by the NHS for this quarter shows a slight increase in admissions compared to the same period in the previous year. Unfortunately this means that the 3.5% reduction per quarter has not been achieved. However, since the estimate of the adult population has increased this year, the level of admissions in the quarter represents fewer admissions per 100,000 population, which is arguably a better result. The financial penalty attributable to non-delivery in this quarter is approximately £930k. This sum is of course fully provided for as part of the £5.35m reserve, and we need to be clear on the picture for the entire calendar year before fully understanding the financial position.

c) This trend is consistent with the increase in the number of reported bed days patients have been delayed in a hospital bed. This increase can be attributed to a general increase in hospital activity, in particular in non-acute care, and delays caused by arranging clinical and social care assessments and care packages. The proportion of delayed discharges attributable to social care has increased from 14% in 2014/15 to 17% from April to June 2015.

d) The number of older adults admitted permanently to residential and nursing care is ahead of target, with 83 placements fewer than the target.

Performance Matrix: Pay for Performance (local) commentary

a. In relation to the ten measures agreed with the CCGs, five are ahead of target and five are below the target.

b. Each of the ten measures has an allocation of £100,000 and stretch targets have been agreed with the CCGs, and financial penalties are incurred on a sliding scale depending on the deviation from the target. At the end of the first quarter of monitoring, overall performance translates to an estimated protection of £520,000 out of £1m.

c. For the measures below the target, the issues relate to the reablement and home support market, which are both going through transitional phases following recent commissioning activity to award contracts to new providers. The current pressures should lessen as the year progresses, and towards the end of the year, capacity should be fully utilised with good outcomes experienced by all. Just to give some reassurance, there is still time and work already in play that will ensure that more of the £1m will be secured by the end of the year.

It is not possible to draw any positive conclusions about the effect of service developments in LHAC and the BCF projects that generated the results. Continued effort is being made to more clearly attribute improvement.

2. Conclusion

The BCF represents a major experiment across the health and social care community in developing a shared agenda, integration at a greater level than seen hitherto and, is a reflection of national policy. The second quarter's results for the calendar year 2015 have not mirrored the first quarter's successes, most notably in the single pay for performance element. The Joint Commissioning Board will be working hard to find solutions to address areas of underperformance.

An updated version of this report will also be presented to the Health and Wellbeing Board on 29 September 2015 in order that it can 'sign-off' the quarterly performance submission required by the Government.

3. Consultation

a) Policy Proofing Actions Required

n/a

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Better Care Fund Performance Report - April to June 2015

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Glen Garrod, who can be contacted on 01522 550808 or Glen.Garrod@lincolnshire.gov.uk.

Lincolnshire
COUNTY COUNCIL

Better Care Fund
Performance Report

2015/2016

Activity for the second monitoring period (April to June 2015)

Produced by Lincolnshire County Council, Adult Care Performance Team

ASC_Performance@lincolnshire.gov.uk

BCF National Metrics only

Performance Alert		Count	
Performance is on or ahead of target	☺	1	33%
Performance is behind target	☹	2	67%
Performance can not be determined owing to missing figures	?	3	
Total measures		6	

Chart Symbols Key:

Actual

Target

National Measures

Polarity	Indicator Description	Responsibility / Lead Officer	Previous Year 2014/15 Actual	Previous Year 2014/15 Target	2015/2016 Q1 Actual	2015/2016 Q1 Target	2015/2016 Y/E target	2015/2016 Alert	2016/17 Y/E Target
Effectiveness of Care									
Smaller is Better	Total non-elective admissions in to hospital : General and Acute (per 100,000 population)	NHS	2,408	2,409	2,453	2,366	2,436	☹	?
Smaller is Better	Permanent admissions to residential and nursing care homes - aged 65+ (per 100,000 popn) **ASCOF 2A part ii**	LCC	938 (586.4)	1,030 (643.9)	163 (101.9)	246 (153.5)	982 (613.9)	☺	?
Bigger is Better	% people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part i**	LCC	78.8%	76.0%	-	-	80.0%	?	?
Patient Experience									
Smaller is Better	Delayed transfers of care (delayed days) from hospital, aged 18+ (per 100,000 population)	NHS / LCC	447.6	656.9	1,176.0	648.3	618.8	☹	?
Bigger is Better	Do care and support services help you to have a better quality of life (ASC Survey) (%)	LCC	94.3%	91.0%	-	-	92.0%	?	?
Bigger is Better	Proportion of people feeling supported to manage their (long term) condition (local indicator) (%)	NHS	tbc	64%	-	-	64.0%	?	?

Local Performance Matrix (detailed reporting to be developed)

Associated BCF Projects	Measure	Responsibility / Lead Officer	Baseline	2015/16 Activity Current Actual	2015/16 Activity Year End Projection	2015/16 Activity Y/E Target	2015/16 Activity Alert	2015/16 Finance Penalty (Est)	2015/16 Finance Allocated
Provider of last resort Agency staffing Demographic Growth	1. Average number of hours of home care purchased per 4 week period	LCC	139,871	132,325	132,325	143,507	☹	£ 100,000	£ 100,000
Provider of last resort Agency staffing Demographic Growth	2. Current number of service users provided with homecare	LCC	3,696	4,208	4,208	3,791	☺	£ -	£ 100,000
Reablement Demographic growth	3. Average number of hours of reablement provided per calendar month	LCC	9,588	6,214	6,214	12,500	☹	£ 100,000	£ 100,000
Reablement Demographic growth	4. Total number of completed service user episodes of reablement	LCC	2,836	1,313	5,252	3,200	☺	£ -	£ 100,000
Reablement	5. % of people receiving reablement where the outcome (sequel) was hospital admission	LCC	18.2%	20.2%	20.2%	16.0%	☹	£ 100,000	£ 100,000
Seven day working Provider of last resort	6. Percentage of home support brokered within 7 days	LCC	86.7%	86%	86%	90.0%	☹	£ 100,000	£ 100,000
Agency staffing Demographic growth	7. Percentage of current social care clients who have received an annual review in the period	LCC	77.3%	22.9%	91.6%	85.0%	☺	£ -	£ 100,000
Agency staffing Demographic growth	8. Number of social care clients supported to live at home at any point during the year	LCC	7,600	6,094	7,603	7,800	☹	£ 80,000	£ 100,000
Agency staffing Demographic growth	9. Percentage of assessments for new clients completed within 28 days	LCC	87.6%	94.3%	94.3%	90.0%	☺	£ -	£ 100,000
Carers Breaks - Older people Demographic growth	10. Number of carers caring for adults receiving direct care during the year	LCC	6,107	7,124	7,124	6,266	☺	£ -	£ 100,000
								£ 480,000	**£ 1,000,000**
							LCC Retained (Est)	**£**	**520,000**

Effectiveness of Care

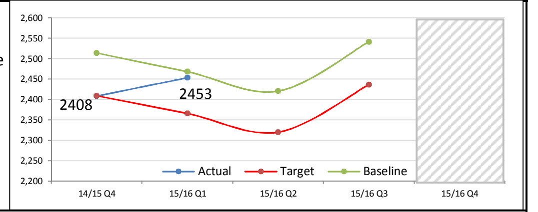
1: Total non-elective admissions in to hospital (general and acute) (per 100,000 population) - IN QUARTER FIGURES
Baseline figures have been included below to show how the targets for Jan 15 to Dec-15 have been derived (i.e 3.5% reduction on activity from the same quarter in the previous year)

	BCF Baselines										2014/15 Q4 monitoring period		
	2013/14 Q4	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Numerator	18,307	-	-	17,973	-	-	17,626	-	-	18,507	-	-	17,658
Denominator	728,288	-	-	728,288	-	-	728,288	-	-	728,288	-	-	733,220
Actual	**2,514**	-	-	**2,468**	-	-	**2,420**	-	-	**2,541**	-	-	**2,408**

	c/f	2015/16 Q1 monitoring period			2015/16 Q2 monitoring period			2015/16 Q3 monitoring period			2015/16 Q4 monitoring period		
	2014/15 Q4	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Numerator	17,658	5,947	12,126	17,984							2016/17 BCF monitoring starts in this quarter - yet to be confirmed		
Denominator	733,220	733,220	733,220	733,220			733,220			733,220			
Per 100,000	**2,408**	**811**	**1,654**	**2,453**									
Target (adm)	17,663			17,345			17,008			17,862			
Target (per 100k)	2,409			2,366			2,320			2,436			
Performance	☺			☹									

Comments

The BCF target on non elective emergency admissions requires a reduction of 3.5% compared to the same quarter from the previous year. The target reduction for Q1 for this indicator has not been achieved as 639 more admissions than the target were made. Despite this, since the population has increased, this translates as a lower rate per 100,000 which may be considered a better measure of performance. As with the previous quarter, the East CCG has the highest rate of non elective admissions and the South West CCG has the lowest rate per 100,000.



By CCG

Numerator	2014/15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
East	6,144	2,071	4,169	6,270									
West	5,305	1,762	3,665	5,440									
South	3,329	1,198	2,432	3,340									
South West	2,392	916	1,860	2,581									
Out of Area	337	0	0	353									
Unknown	151	0	0	0									
Total	**17,658**	**5,947**	**12,126**	**17,984**									

Denominator	2014/15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
East	230,978	230,978	230,978	230,978									
West	231,179	231,179	231,179	231,179									
South	143,528	143,528	143,528	143,528									
South West	123,674	123,674	123,674	123,674									
Out of Area	3,861	3,861	3,861	3,861									
Total	**733,220**	**733,220**	**733,220**	**733,220**									

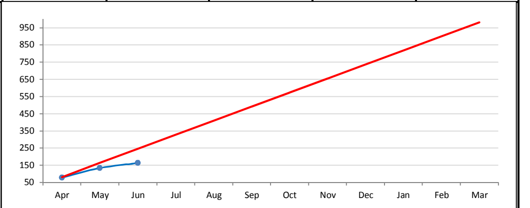
Actual	2014/15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
East	2,660	897	1,805	2,715									
West	2,295	762	1,585	2,353									
South	2,319	835	1,694	2,327									
South West	1,934	741	1,504	2,087									
Out of Area	8,728	0	0	9,143									
Total	**2,408**	**811**	**1,654**	**2,453**									

2: Permanent admissions to residential and nursing care homes - aged 65+, per 100,000 popn (ASCOF 2A part ii)

	2014/15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Numerator	938	78	134	163									
Denominator	159,953	159,953	159,953	159,953	159,953	159,953	159,953	159,953	159,953	159,953	159,953	159,953	159,953
Per 100,000	**586.4**	**48.8**	**83.8**	**101.9**									
Target (adm)	1,030	82	164	246	327	409	491	573	655	737	818	900	982
Target (per 100k)	643.9	51.2	102.3	153.5	204.6	255.8	307.0	358.1	409.3	460.4	511.6	562.8	613.9
Performance	☺			☺									

Comments

The target for Q1 for this indicator has been achieved with a the rate per 100,000 population of 101.9 against a target of 153.5. This relates to 163 admissions to permanent residential and nursing care made in the quarter; 83 admissions fewer than target. The highest rate of admission per 100,000 is in the South West CCG with a rate of 109.3 per 100,000 with the lowest the South with a rate of 87.9 per 100,000



By CCG

Numerator	2014/15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
East	321	33	50	56									
West	336	23	36	44									
South	131	7	21	28									
South West	121	11	21	28									
Not Recorded	29	4	6	7									
Total	**938**	**78**	**134**	**163**									

Denominator	2014/15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
East	58,286	58,286	58,286	58,286									
West	44,185	44,185	44,185	44,185									
South	31,865	31,865	31,865	31,865									
South West	25,617	25,617	25,617	25,617									
Not Recorded	0	0	0	0									
Total	**159,953**	**159,953**	**159,953**	**159,953**									

Actual	2014/15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
East	550.7	56.6	85.8	96.1									
West	760.4	52.1	81.5	99.6									
South	411.1	22.0	65.9	87.9									
South West	472.3	42.9	82.0	109.3									
Not Recorded	-	-	-	-									
Total	**586.4**	**48.8**	**83.8**	**101.9**									

3: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation (ASCOF 2B part i)

	2014/15						Sep-15						Mar-16
Numerator	652												
Denominator	827												
Actual	**78.8%**												
Target	76.0%						80.0%						80.0%
Performance	☺												

Comments

The percentage of people aged 65 or over still at home 91 days after discharge from hospital into Reablement/ Rehabilitation services is not reported in Q1. This is an annual measure, however, the intention is to undertake a mid-year positon at the end of Quarter 2.

By CCG

Numerator	2014/15						Sep-14						Mar-15
East	261												
West	143												
South	143												
South West	97												
Not Recorded	8												
Total	**652**												

Denominator	2014/15						Sep-14						Mar-15
East	327												
West	196												
South	171												
South West	124												
Not Recorded	9												
Total	**827**												

Actual	2014/15						Sep-14						Mar-15
East	79.8%												
West	73.0%												
South	83.6%												
South West	78.2%												
Not Recorded	88.9%												
Total	**78.8%**												

Patient Experience

1: Delayed transfers of care (delayed days) from hospital (aged 18+) (per 100,000 population)
Baseline figures have been included below to show how the targets for Jan 15 to Dec-15 have been derived (i.e 3.5% reduction on activity from the same quarter in the previous year)

	BCF Baselines										2014/15 Q4 monitoring period		
	2013/14 Q4	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**
Numerator	4,310	-	-	4,045	-	-	3,992	-	-	3,837	-	-	3,888
Denominator	587,562	-	-	587,562	-	-	587,562	-	-	587,562	-	-	591,829
Actual	**733.5**	**-**	**-**	**688.4**	**-**	**-**	**679.4**	**-**	**-**	**653.0**	**-**	**-**	**656.9**

	c/f	2015/16 Q1 monitoring period			2015/16 Q2 monitoring period			2015/16 Q3 monitoring period			2015/16 Q4 monitoring period		
	2014/15	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
Numerator	2,630	2,283	4,490	6,910							2016/17 BCF monitoring starts in this quarter - yet to be confirmed		
Denominator	587,562	587,562	587,562	587,562									
Actual	**447.6**	**388.6**	**764.2**	**1,176.0**									
Target	656.9			648.3			639.9			631.4			
Performance	☺			☹									

Comments

The target for this indicator has not been met for Q1, as the number of delayed days throughout the period has been unusually high. A higher proportion of delayed days are attrributable to social care, and there appears to be more non-acute delays than normal. Overall the main reasons for patient delays is awaiting an assessment, awaiting further non-acute care, and awaiting a care package at home.

Type of Care													
	2014/15	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
Acute	2,062	1,825	3,424	5,090									
Non Acute	568	458	1,066	1,820									
Total	**2,630**	**2,283**	**4,490**	**6,910**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Responsible Organisation													
	2014/15	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
NHS	2,185	2,005	3,855	5,755									
Social Care	285	164	424	750									
Both	160	114	211	405									
Total	**2,630**	**2,283**	**4,490**	**6,910**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Reason													
	2014/15	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
A - Completion of Assessment	509	639	1,262	1,859									
B - Public Funding	15	34	73	101									
C - Waiting Further NHS Non-Acute	719	439	967	1,455									
Di - Awaiting Residential Care	21	109	273	397									
Dii - Awaiting Nursing Care	72	46	152	229									
E - Awaiting Care Package at home	695	498	909	1,566									
F - Awaiting Equipment	173	109	209	294									
G - Patient or Family Choice	317	272	439	663									
H - Disputes	31	73	104	155									
I - Housing - Not covered by NHS and CC Act	78	64	102	191									
Total	**2,630**	**2,283**	**4,490**	**6,910**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

2: Do care and support services help you to have a better quality of life (ASC survey) (%)

	2014/15	2015/16
Numerator	346	
Denominator	367	
Actual	**94.3%**	
Target	91.0%	92.0%
Performance	☺	

Comments
This indicator is not reported in Q1 as it is taken from an annual adult care survey

By CCG

Numerator	2014/15	2015/16
East	132	
West	89	
South	57	
South West	57	
Not Recorded	11	
Total	346	

Denominator	2014/15	2015/16
East	139	
West	97	
South	59	
South West	61	
Not Recorded	11	
Total	367	

Actual	2014/15	2015/16
East	95.0%	
West	91.8%	
South	96.6%	
South West	93.4%	
Not Recorded	100.0%	
Total	94.3%	

3: Proportion of people feeling supported to manage their (long term) condition (local indicator) (%)

	2014/15	2015/16
Numerator	not available	
Denominator	not available	
Actual	not available	
Target	63.5%	64.0%
Performance		

The figures for this measure come from the GP survey, which is published twice a year. Figures will next be available in July 2015.

By CCG

Numerator	2014/15	2015/16
East	not available	
West	not available	
South	not available	
South West	not available	
Total	not available	

Denominator	2014/15	2015/16
East	not available	
West	not available	
South	not available	
South West	not available	
Total	not available	

Actual	2014/15	2015/16
East	not available	
West	not available	
South	not available	
South West	not available	
Total	not available	

Effectiveness of Care

Total non-elective admissions in to hospital (general & acute) (per 100,000 population)	
Rationale	This indicator measures the number of emergency admissions to hospital in England for acute conditions such as ear/nose/throat infections, kidney/urinary tract infections and heart failure, among others, that could potentially have been avoided if the patient had been better managed in primary care. Therefore, measuring the progress in helping people recover as effectively as possible. This indicator has been indirectly age and sex standardised.
Numerator	Total number of emergency admissions episodes for people of all ages where an acute condition that should not usually require hospital admission was the primary diagnosis. The data include emergency admissions for patients of all ages.
Denominator	Size of adult population in Lincolnshire, per 100,000 population
Frequency & Reporting Basis	This measure is reported cumulatively within each distinct quarter, with quarterly BCF targets based on the corresponding quarter from the previous year
Responsibility for Reporting	NHS

Permanent admissions to residential and nursing care homes - aged 65+, per 100,000 popn (ASCOF 2A part ii)	
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency and evidences Local Health and Adult Care working together to reduce avoidable admissions.
Numerator	The number of local authority funded/part funded permanent admissions of older people, aged 65+, to residential and nursing care during the year.
Denominator	Size of older people population (aged 65+) in Lincolnshire based on the Office of National Statistics mid year population 2013 estimates.
Frequency & Reporting Basis	Reported on monthly This measure is reported cumulatively (adding the current months totals to the previous months totals)
Responsibility for Reporting	LCC

% people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation (ASCOF 2B part i)	
Rationale	Reablement is a key service to helping people regain their independence. By determining whether an individual remains living at home 91 days following discharge from ILT services is an indicator of the success of reablement services.
Numerator	Number of older people (within a 3 month period) discharged from acute or community hospitals to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital.
Denominator	Number of older people (within a 3 month period) discharged from acute or community hospitals to their own home/residential or nursing care home/ extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home.
Frequency & Reporting Basis	Reported on 6 monthly This measure is reported cumulatively (adding the current months totals to the previous months totals)
Responsibility for Reporting	LCC

Patient Experience

Delayed transfers of care (delayed days) from hospital (aged 18+) (per 100,000 population)	
Rationale	This measures the impact of hospital services; acute, mental health and non-acute; and community based care in facilitating timely and appropriate transfer from all health settings for all adults. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of health and social care.
Numerator	The average number of delayed transfers of care (days) that are attributable to Adult Care or jointly to Adult Care and the NHS. This is the average of the 12 monthly snapshots collected in the monthly Situation Report (SitRep)
Denominator	Size of adult population in Lincolnshire, per 100,000 population
Frequency & Reporting Basis	This measure is reported cumulatively within each distinct quarter, with quarterly BCF targets based on the corresponding quarter from the previous year
Responsibility for Reporting	NHS / LCC

Do care and support services help you to have a better quality of life (ASC survey) (%)	
Rationale	This measure is based on responses to the care and support quality of life question in the Adult Social Care survey, serving as a overarching measure of the impact of care and support services on the quality of life of users of social care. Enhancing quality of life for people with care and support needs is one of the desired outcomes of health and social care.
Numerator	The number of people who responded 'Yes' to the question 'Do care and support services help you to have a better quality of life?'
Denominator	The number of people who responded to the question 'Do care and support services help you to have a better quality of life?'
Frequency & Reporting Basis	Responses to the question are collected annually in the ASC Survey
Responsibility for Reporting	LCC

Proportion of people feeling supported to manage their (long term) condition (local indicator) (%)	
Rationale	This indicator measures the degree to which people with health conditions that are expected to last for a significant period of time feel they have had sufficient support from relevant services and organisations to manage their condition. Patients are encouraged to consider all services and organisations, which support them in managing their condition, and not just health services. Ensuring people feel supported to manage their condition is one of the desired outcomes of health care.
Numerator	The number of people who responded 'Yes, definitely' or 'Yes, to some extent'. Respondents who answer 'Yes, to some extent' are deemed to feel half as supported as respondents who answer 'Yes, definitely'. Therefore, this group of responses is weighted by 0.5 when calculating the numerator (Number responding 'Yes, definitely' + (Number responding 'Yes, to some extent' x 0.5)).
Denominator	The first filter is the number of people who responded 'Yes' to the question 'Do you have a long-standing health condition?' or who selected any of the conditions in 'Which, if any, of the following medical conditions do you have?'. Of the number of people identifying a long-term condition in the previous questions, the number who responded to the question 'In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term health condition(s)?'
Frequency & Reporting Basis	Responses to the question are collected annually in the GP Survey
Responsibility for Reporting	NHS

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Lincolnshire
COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open report on behalf of Glen Garrod, Director of Adult Social Services

Report to:	**Adults Scrutiny Committee**
Date:	**9 September 2015**
Subject:	**Deprivation of Liberty Safeguards (DoLS) Status Report**

Summary:

The Cheshire West Judgement in March 2014 has had a significant impact for the Deprivation of Liberty Safeguards both nationally and locally. As the safeguards are now considered unsustainable, the Law Commission have been asked to review the safeguards but they have indicated that it will take at least three years for the legislation to change. Appendices A and B provide further detail on how the current scheme works and, what is in the consultation proposals.

The number of applications to the council to authorise deprivation has risen dramatically since the judgement was passed. As far as the author of this report is concerned, the safeguards are being managed as well as can be expected given the circumstances through a system which prioritises cases so the most important are dealt with first.

Recommendations

Members of the Adults Scrutiny Committee are asked to note and comment on the report as detailed.

1. Background

The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of vulnerable adults who lack the mental capacity to do so for themselves. The Act itself was derived from two particular elements of law - Human Rights legislation and the Mental Health Act.

The Act came into force in October 2007 and the government has subsequently added new provisions to the Act in 2010; these provisions are known as the Deprivation of Liberty Safeguards (DoLS).

The legislation has decreed that the deprivation of a person's liberty is a very serious matter and should not happen unless it is absolutely necessary and in the best interests of the person concerned. It should never be an arbitrary decision.

The purpose of the DoLS is to ensure that any decision to deprive someone of their liberty is made following very defined legal processes and in consultation with the relevant authorities.

The adults most likely to require protection from the safeguards are those that have significant learning difficulties, those with dementia or brain injury.

When a care home or hospital form the view that they may be depriving an individual of their liberty the home or hospital have to, by law, apply to the local authority to be able to lawfully deprive someone of their liberty. The local authority will then commission a prescribed six assessments, three from a Mental Health Doctor and three from a Best Interests Assessor to fulfil the process. If the deprivation is occurring, we will authorise the deprivation and manage the process whereby the deprivation is reviewed as required according the best interests assessment.

In the first year of the standards being enforced LCC authorised 53 deprivations, in 2012 we authorised 159 applications.

In March 2014, a Supreme Court Judgement triggered an unprecedented rise in applications to authorise DoLS in England and Wales. From April 2014 the LCC DoLS team have been receiving on average, 163 applications *per month*. This has had consequences on the Judicial System, the Coronial Service and on all upper tier local authorities.

The Judgement also extended the deprivation to those individuals who are residents in community supported living and shared lives type accommodation, therefore extending the amount of people who could be subject to the DoLS.

The impact for the Authority is mainly financial with reputational risk as well. Although we are not complacent about the reputational risk, in the cases where we have appeared in court, the judges have been sympathetic about the fact that we are working in very difficult circumstances. The pertinent issue to the Council is the increased financial cost because of the extraordinary increase of DoLS applications.

To risk manage the safeguards we have tabled the Judgement at the Lincolnshire Safeguarding Adults Board, so that all partners have been made aware of the likely impact of this court ruling in their organisations. We have devised a risk management tool that we use to screen all new applications, so that the highest priority ones can be fast tracked. We have also shared this screening tool with all relevant partners. We have taken the DoLS cases to the Court of Protection that are the highest priority and will continue to do this on a priority needs basis.

The law commission has subsequently been asked to review this piece of legislation and it has started this process by publishing a consultation in July 2014. This consultation document proposes to radically change the existing scheme of authorisation because post Cheshire West, the scheme is considered unsustainable.

The Commission have reinforced a view that this consultation will not produce a 'quick win' envisaging the timescale before implementation of a new system to be at least three years.

2. Conclusion

The DoLS team are working closely with legal services to ensure we are risk managing the situation as well as we can. We are also closely managing our service provider who provides the Best Interests Assessors so we know that we have enough Mental Health professionals to achieve this role.

The Law Commission proposals to amend the mental capacity legislation are currently out for consultation and contain a number of significant changes – many appear designed to address the consequences of the Cheshire West judgement and make the protection of safeguards around liberty for people who lack capacity more proportionate and, sustainable.

3. Consultation

a) Policy Proofing Actions Required

Not applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Deprivation of Liberty Safeguards under the Mental Health Capacity Act 2005
Appendix B	Briefing – Law Commission Proposals (for members)

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Mandy Cooke, who can be contacted on 01522 554067 or Mandy.Cooke@lincolnshire.gov.uk.

DEPRIVATION OF LIBERTY SAFEGUARDS UNDER THE MENTAL CAPACITY ACT 2005

Short Fact sheet

What are the Deprivation of Liberty Safeguards?

The Deprivation of liberty Safeguards are a framework under the Mental Capacity act 2005 which provide legal protection for people who are, or may become deprived of their liberty within the meaning of Article 5 of the European Convention of Human Rights (ECHR) within a care home or hospital **and** who lack capacity to consent to such arrangements. The safeguards were introduced as a result of the decision in HL v United Kingdom[1] (commonly referred to as the "Bournewood" judgment) which had highlighted breaches of Article 5 in that the deprivation had not been in accordance with a "procedure prescribed by law" and the individual had no means of quickly applying to the court to establish whether his detention had been lawful.

What amounts to a Deprivation of Liberty?

There is no simple definition of what amounts to a deprivation of liberty. Practitioners have had to be guided by the Deprivation of Liberty Safeguards Code of Practice [2] and case law including European jurisprudence.

On 19 March 2014 however the Supreme Court delivered its long awaited judgment in the case of P (by his litigation friend the Official Solicitor) v Cheshire West and Cheshire Council and Anor [2014] UKSC 19 (19 March 2014). This case has provided a new "acid test" for when arrangements made for the care or treatment of an individual lacking capacity to consent to those arrangements amounts to a deprivation of liberty. This test replaces the multifactorial test which had been in operation pre Cheshire. The court has clarified that there **is** a deprivation of liberty for the purposes of Article 5 when:-

1. The person is under continuous supervision and control AND
2. The person is not free to leave.
   Both components must be satisfied

Whilst the court has not provided any further guidance on these terms it has clarified that the following factors are NOT relevant for the purposes of deciding whether someone is being deprived of their liberty:-

1. The person's compliance or lack of objection
2. The relative normality of the placement
3. The reason or purpose behind the placement

Where there is doubt as to whether the arrangements amount to a deprivation of liberty the court in the above case (due to the vulnerability of the individuals concerned) stated that "we should err on the side of caution".

The authorisation of arrangements which amount to a deprivation of liberty

A person can be deprived of their liberty in a variety of different settings – hospitals, care homes, supported living placements, foster placements (including children over the age of 16), adult supporting

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[1] HL V United Kingdom (2005) 40 EHRR 32
[2] 2008 ISBN 978 0 11 3228157

adults and even within their own home. **ALL** deprivations of liberty which are attributable to the State **must** be authorised. How they are authorised depends on where the deprivation occurs. Where the deprivation occurs in a setting other than a care home or hospital an application to the court will need to be made prior to any deprivation taking place. Where the deprivation occurs in a hospital or care home the deprivation of Liberty Safeguards referred to above will come into play. The rest of this fact sheet is devoted to the latter.

Application of the Deprivation of Liberty Safeguards Sched A1 MCA 2005

Where a "managing authority" (a hospital or care home) forms the view that the arrangements that they are making or are planning to be making for an individual's care or treatment amounts to a deprivation of liberty and the individual cannot consent to those arrangement they have responsibility to apply for an authorisation to the "supervisory body". The supervisory body for Lincolnshire for both care homes and hospitals (and for residents who are placed outside of Lincolnshire but remain ordinarily resident in Lincolnshire) is Lincolnshire County Council. The supervisory body is responsible for considering any requests for authorisation, commissioning the required assessments and authorising any deprivation of liberty.

The Department of Health has produced forms developed for use by managing authorities and supervisory bodies. Whilst these forms do not have statutory basis - they are used because if completed it ensures that all the necessary information required by law is provided.

Two different types of authorisation

There are two different types of authorisation – **an urgent authorisation** and a **standard authorisation.**

An urgent authorisation is given by a managing authority to itself for a maximum of seven days, which may subsequently be extended by the supervisory body by a maximum of a further seven days. The authorisation gives the managing authority lawful authority to deprive the individual of their liberty while the standard authorisation process is undertaken. As the name suggests this is used in urgent circumstances when the by its nature there is no time to seek the standard authorisation. When the urgent authorisation has been given by the managing authority they must at the same time submit a request for a standard authorisation.

A standard authorisation is an authorisation given by the supervisory body after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in a hospital or care home.

What is the process when a request for a standard authorisation has been submitted?

When the application form has been received by the supervisory body it will assess whether the request is appropriate and seek any further information it requires from the managing authority to help it with the decision. The supervisory body will consider whether the person requires a s.39 Independent Mental Capacity Advocate (IMCA) if the person has no one that can support them in this capacity. The supervisory body will then go on to appoint appropriate assessors to carry out the necessary assessments to find out whether the six qualifying requirements are met.

What are the qualifying requirements – the necessary assessments?

Part 2 of Schedule A1 sets out the qualifying requirements which have to be met before a standard authorisation can be given to provide legal authority to deprive an individual of their liberty. There are six different assessments. The six different assessments do not have to be completed by different assessors.

However there must be a minimum of two assessors and the mental health and best interests assessors must be different.

1. **Age assessment**

This is simply to confirm whether the person is over 18 as the safeguards only apply to individuals over 18. This assessment can be undertaken by anybody whom the supervisory body is satisfied is eligible to be a best interests assessor.

2. **No refusals Assessment**

An assessment to establish whether there is any other existing authority for the decision making for the relevant person that would prevent the giving of a standard authorisation. This might include any valid advance decision, or a valid decision by a deputy or donee appointed under a Lasting Power of Attorney. This assessment can be undertaken by anybody whom the supervisory body is satisfied is eligible to be a best interests assessor.

3. **The Mental Capacity Assessment**

The purpose of the mental capacity assessment is to establish whether the relevant person lacks capacity to decide whether or not they should be accommodated in the relevant hospital or care home to be given care or treatment. It is capacity to make this specific decision at the time it needs to be made. Supervisory bodies may wish to consider using an eligible assessor who may know this individual if they think it would be of benefit.

4. **The Mental Health Assessment**

This assessment is to establish whether the relevant person has a mental disorder within the meaning of the Mental Health Act 1983. This therefore means any disorder or disability of the mind. Dependence of alcohol or drugs is not considered to be a mental disorder for the purposes of the 1983 Act. It will however include a person with a learning disability whether or not the disability is associated with abnormally aggressive or seriously irresponsible conduct. The mental health assessment must be carried out by a doctor and the assessing doctor has to either be approved under s. 12 of the Mental Health Act 1983 or be a registered medical practitioner with at least three years post registration experience in the diagnosis or treatment of mental disorder such as GP with a special interest. The mental health and best interests assessments cannot be carried out by the same person.

5. **Eligibility Assessment**

This is an assessment to establish whether or not a person is rendered ineligible (circumstances set out in Sch 1A (para 17) for a standard deprivation of liberty authorisation because the authorisation would conflict with the requirements that are, or could be, placed on the person under the Mental Health Act 1983. In order to carry out an eligibility assessment the person must be a mental health assessor who is also a section 12 doctor or a best interests assessor who is also an approved mental health professional (AMHP).

6. **Best interests Assessment**

The purpose of this assessment is to establish firstly, whether the person is being or about to deprived of their liberty and if they are they must then consider whether:

a) It is in the best interests of the person to be deprived of their liberty
b) It is necessary for them to be deprived in order to prevent harm to themselves

c) The deprivation of liberty is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm.

The best interests assessment must be undertaken by an AMHP, social worker, nurse, occupational therapist or chartered psychologist with the skills and experience specified in the regulations. [3] The best interests assessor can make recommendations as to whether or not there should be any conditions attached to the authorisation and must specify what the maximum authorisation period should be. This must not exceed 12 months.

What happens once all the assessments have been completed?

The supervisory body will consider all the assessments and if the assessments conclude that the relevant person meets all the qualifying requirements it will grant the authorisation. If any of the assessments are negative then the assessment process should stop and the authorisation will not be given. If all the qualifying requirements are met the supervisory body will set the period (which must not be longer than that recommended by the BIA). It will also consider whether any conditions should be added to the authorisation after considering any recommendations made by the BIA. The supervisory body will also provide copies of the authorisation to certain specified individuals and the managing authority and appoint a representative for the relevant person.

[3] The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008.

BRIEFING NOTE

LAW COMMISSIONS PROPOSALS FOR MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

INTRODUCTION

On 7th July 2015 the Law commission published its consultation document on proposals to change the existing scheme of authorisation and regulation in respect of those incapacitated individuals who are, or who may be, deprived of their liberty. The consultation proposals arise out of heavy criticism that they are not fit for purpose, are unduly complex and, in the light of Cheshire West, unsustainable. Appendix A attached provides a snapshot of the current DoLS regime.

The new scheme proposed which will replace the Deprivation of Liberty Safeguards will be entitled "protective care" which will establish different approaches dependent on the different care settings to which it has application. One size has been found not to fit all. The new scheme however will be much wider than its predecessor and will encompass much more than just deprivations of liberty.

The proposal is that "Protective Care" will apply to hospitals (for physical disorders) and care homes although the nature of the actual safeguards will differ according to the setting. The scheme will also apply to those in supported living, extra care and shared lives accommodation and will extend to family and other domestic settings. In these latter cases the proposal will mean that the need for court authorisation in these areas will, (unless there are additional complications which do require court intervention), fall away.

The new scheme will comprise two elements known as "**supportive care**" and "**restrictive care and treatment**". Supportive care will focus on those vulnerable individuals who lack capacity to be able to decide on their accommodation but who are not yet subject to more restrictive forms of care or deprivations of liberty. The intention is to create a preventative set of safeguards for these individuals that reduce the need for intrusive interventions in the longer term. If their care needs do however increase it may mean that they will then fall into the safeguards provided by the restrictive care and treatment component. Restrictive care and treatment will provide the direct replacement for the Deprivation of Liberty Safeguards. Its application however will be wider than its predecessor in that it will include cases where the individual's care is becoming more restrictive even though the care delivered may actually fall short of being classed as a deprivation.

The nature of both components to protective care will be further explored below.

TIMESCALES

The consultation runs until 2 November 2015. During the course of 2016 the Law Commission will consider the responses it receives to its proposals. The next stage will then be for the Commission to produce and submit a response to the Lord Chancellor by the end of 2016. It is anticipated that this report will contain their final recommendations with their reasons and a draft bill.

HEALTH WARNING – this paper contains proposals upon which the Commission are inviting significant stakeholder consultation and input. The proposals contain widescale revision of the current system and it is highly likely that this proposed scheme will undergo change (which could be significant) before the final version is produced. So, as with any consultation, these proposals should not be seen, nor relied on, as being the definitive version. The Law Commission advised at a consultation meeting on

11 August 2015 that they would not anticipate anything coming on to the statute books before 2018 **at the earliest**. An added complication to the timescales is the need to rewrite a new Code of Practice to support the new scheme and an update to the existing Mental Capacity code. Pending a change to the law the existing system

as set out in the Schedule A1 to the MCA 2005 will remain in force supported by the evolving case law in this field.

SUPPORTIVE CARE

This element of the scheme will apply to those individuals who are living, or are about to move into, a care home, supported living or shared lives accommodation where they lack the capacity to make the decision about their accommodation for the purpose of being given care or treatment. The lack of capacity must result from an impairment of, or a disturbance of the mind or brain, closely aligning it to, and creating consistency with, the diagnostic test of Mental Capacity Act rather than the definition of mental disorder contained within the Mental Health Act. This represents a change as currently the DOLS applies to those individuals who suffer from a mental disorder within the meaning of the Mental Health Act.

It will have **no** application to those living in family settings or in other domestic settings. It is also important to understand that supportive care will **not** provide legal authority **to move** someone into that accommodation where there is objection from the individual themselves or where there is a dispute as to what is in the best interests of the individual concerned. In those cases legal advice will need to be sought about the need to make an application to the Court of Protection under s.16 MCA 2005.

Where it appears that an individual may fall within the ambit of supportive care it will be the responsibility of the local authority to ensure that an assessment is carried out. It is not however the intention of these proposals that work is duplicated or that fresh legislation is required. In most cases an assessment of an adult's needs for care and support under s.9 Care Act 2014 may already have been carried out. In most cases it would also be expected that local authorities will have already assessed their capacity to make decisions as to their accommodation. Only where an appropriate capacity assessment is lacking would it be expected that a capacity assessment will need to be initiated.

SUPPORTIVE CARE - THE SAFEGUARDS

Where an individual falls within the supportive care component the individual will be entitled to a number of safeguards.

The safeguards under this component will comprise the following:

(1) The local authority would be required to keep under review the person's health and care arrangements and whether a referral to the restrictive care and treatment part of protective care is needed;

(2) Care plans must include a record of capacity and best interests assessments and any restrictions imposed (including confirmation that the restrictions are in the person's best interests);

(3) The local authority would have discretion to appoint an "Approved Mental Capacity Professional" to oversee the case. This new role is to replace the role of the Best Interests Assessor (see below);

(4) An advocate or appropriate person must be appointed (if not already appointed); and

(5) The advocate and appropriate person would be responsible for ensuring that the person has access to the relevant review or appeals process.

The Law Commission see that the key to these proposals is the requirement on the local authority to keep the individual's situation under review. Again it would normally be expected that reviewing would in any event be in place under the Care Act or other existing legislation. It may simply be the case that the local authority needs to ensure that review of their supportive care component should be automatically linked to the existing review process.

The Law Commission also sees as an additional safeguard the need to protect an individual's article 8 rights when proposing a move into accommodation and sees the role of greater access to advocacy as being essential. Within

the consultation document they are also inviting comments on the draft Disabled People (Community Inclusion) Bill 2015 which has a number of proposals of relevance to individuals and moving to other care environments.

Finally the proposals recommend that all registered care providers should be required to refer individuals for assessments under the relevant components of the protective care scheme. The paper also asks for comments as to whether this requirement should find its way into the regulatory requirements enforced by CQC.

RESTRICTIVE CARE AND TREATMENT

This is the direct replacement for the DoLS. However its application is wider in that as well as catering for those individuals who are without doubt deprived of their liberty - it will also cover cases where the care plan includes restrictive care which may fall short of a deprivation of liberty. The idea is that it will provide safeguards for individuals whose arrangements for their care and treatment are becoming sufficiently intrusive and restrictive to warrant having some safeguards and oversight in place.

In order qualify the individual would need to:

a) Lack capacity to consent to the relevant care and treatment. [it should be noted that this differs from the relevant supportive care criterion which is based on a lack of capacity to consent to their accommodation]
b) Lack capacity as a result of an impairment of, or a disturbance in the functioning of the mind or brain. [Consistent with the LCC's proposals for supportive care but NOT consistent with the current DoLS scheme which is based on mental disorder]
c) Receive care which would fall within the ambit of restrictive care and treatment. This is going to be determined in accordance with the law commission's non exhaustive list.

Proposals that restrictive care and treatment should include but should not be limited to, any one of the following:

- continuous or complete supervision and control;
- the person is not free to leave;
- the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;
- barriers are used to limit the person to particular areas of the premises;
- the person’s actions are controlled, whether or not within the premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication– other than in emergency situations;
- any care and treatment that the person objects to (verbally or physically);
- significant restrictions over the person’s diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).

RESTRICTIVE CARE AND TREATMENT - THE SAFEGUARDS

1. The use of an Approved Mental Capacity Professional (AMCP) – this will replace the Best Interests Assessor (BIA) and they will be in the same position legally as an AMHP. They will be acting as independent decision makers on behalf of the local authority. The local authority will have a role in ensuring that applications for

protective care are "duly made" and founded on the necessary assessments. The AMCPs will have an enhanced role from their predecessor the BIA. All restrictive care and treatment assessments would be referred to an AMCP. As the RCT component is much wider the workload of the AMCP will be increased. The AMCP whilst having the responsibility to ensure an assessment is actually done - how that is achieved will be down to their discretion. Dependent on the circumstances of the case it may mean the AMCP will do it themselves or they may decide that a professional already known to the individual may be best placed to undertake the assessment. It is proposed that the standards for education, training and experience of AMCP's will be set by the Health and Care Professions Council.

2. AMCP's will be able to set conditions directly and monitor performance against those conditions although the AMCP could choose to delegate this to an appropriate health and social care professional.

3. AMCP's will be able to make recommendations to the local authority as to the suitability of the care plan.

4. The AMCP allocated to the case will be required to ensure that the arrangements are in accordance with the law.

5. The AMCP will also be required to review any restrictive care and treatment that had been authorised.

6. The AMCP will have the discretion to discharge the person from restrictive care and treatment as would the local authority.

7. Reviews would need to be timely and could occur at the request of the person or a family member, representative, care provider, advocate or appropriate person.

8. Where the restrictive care and treatment amounts to a deprivation of liberty – it must be expressly authorised in the care plan and the AMCP would be responsible for ensuring and certifying that the DoL is in the best interests of the person concerned and that objective medical expertise had been provided.

OTHER SETTINGS – DOMESTIC SETTINGS

Where care or treatment is proposed in a domestic setting and such care amounts to a deprivation an AMCP will be required to authorise the deprivation or discuss with the local authority or NHS trust how, and if, alternative care packages could be put in place which would end any deprivation. In some instances the case may need to be put before the court.

DOMESTIC SETTINGS SAFEGUARDS

The safeguards of the restrictive care and treatment component will apply.

URGENT AUTHORISATIONS

Self authorisation by care providers in cases of emergency is absent from the Law Commission's proposals. In cases of emergency the AMCP would be able to provide temporary authorisation for a period of seven days. If need be this could be extended for a further seven days pending full assessment.

OTHER SETTINGS – MENTAL HEALTH PATIENTS (INCAPACITATED)

The above scheme of protective care would have no application to incapacitated mental health patients who require treatment for their mental disorder and whose care and treatment would amount to a deprivation of liberty. The proposal is that the Mental Health Act 1983 will be amended to cater for this cohort of individuals.

MENTAL HEALTH PATIENTS SAFEGUARDS

1. the right to a Mental Health Act Advocate;

2. a power to provide treatment if a donee of a lasting power of attorney, a deputy, or the Court of Protection consents to the treatment on the person's behalf;

3. a requirement that treatment cannot be given under this power if it is contrary to a valid advance decision or if force is needed to administer it;

4. a requirement that a second medical opinion is needed for certain treatments including medication;

5. rights for the patient and the nearest relative to seek a review of the treatment plan; and

6. rights to apply to the mental health tribunal for an order to discharge the patient.

OTHER SETTINGS – HOSPITAL SETTINGS (for physical disorders) AND PALLIATIVE CARE (hospices)

The Law Commission has proposed a bespoke system for these settings.

Qualifying conditions

(a) Lack of capacity to consent to the care and treatment
(b) Real risk that at some point within the next 28 days that the care required in best interests will amount to a deprivation of liberty or
(c) The patient requires care in best interests that amounts to a deprivation
(d) Deprivation of liberty is a proportionate response to likelihood and seriousness of harm

HOSPITAL SETTING AND HOSPICES SAFEGUARDS

1) Up to 28 days provided registered medical practitioner has examined patient and certified to hospital managers that the criteria are met.

2) Hospital managers required to appoint responsible clinician.

3) Responsible clinician required to prepare written care plan after having consulted specified individuals and provided copies of the plan following authorisation to named individuals.

4) Appointment of advocate or appropriate person.

5) Extension of authorisation beyond 28 days only if AMCP has also carried out an assessment and confirms that the conditions are met. Deprivation can then be authorised for up to 12 months.

SUPPORTED DECISION MAKING

The Commission feels that there is a good case for creating a new legal process in which a person (known as a "supporter") is appointed to assist with decision making where a person lacks capacity. The supporter must be willing and able suitable to perform this role. The AMCP would have the power to displace the supporter if deemed necessary although there will be a right of appeal.

OTHER MISCELLANEOUS PROPOSALS

Best interests – it is proposed that s.4 Mental Health Act is amended to ensure that decision makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interests decision.

Advance Decision Making – it is provisionally proposed that the ability to consent to a future deprivation of liberty should be given statutory recognition. This would only apply as long as the person has made an informed decision and the circumstances do not change materially.

Regulation and Monitoring – the proposal is for CQC to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme.

Age –Protective care would apply to 16 and 17 year olds whereas currently the DoLS only has application to those aged 18 and over.

Criminal Offence – The Law Commission are inviting thoughts on whether a criminal offence of unlawful deprivation should be introduced.

Coroner's inquests – it is proposed that the 2009 Criminal Justice Act should be amended to reflect that inquests are only necessary into deaths that are subject to the restrictive care and treatment where the coroner is satisfied that the individual was deprived at the time of their death and that there is a duty under Article 2 to investigate the circumstances of that individual death. They are also considering whether the coroner should have the power to release the body prior to the conclusion of an inquest or investigation.

Charging for accommodation – The Law Commission invites responses on whether or not an individual should be charged for their accommodation when they are being deprived of their liberty in their best interests. They also wonder whether there is any "realistic way of dealing with the resource consequences if they are not charged".

RIGHT TO APPEAL

Individuals who are subject to the proposed restrictive care and treatment regime would have the right to appeal. The issue for the Law Commission is whether that remains with the Court of Protection or whether a First Tier Tribunal should be set up along similar lines to the successful tribunals in mental health cases. On balance the Law Commission favour setting up a Tribunal to deal with these cases. Thereafter a further appeal will lie either to the Upper Chamber or to the Court of Protection. It is noted that the Commission proposes that local authorities would be required to refer individuals to the First Tier Tribunal if there has been no application made to the Tribunal within a specified period of time.

Helen Glover
Local Authority Solicitor
12.8.2015

Lincolnshire COUNTY COUNCIL
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Policy and Scrutiny

Open Report on behalf of Pete Moore, Executive Director of Finance and Public Protection	
Report to:	**Adults Scrutiny Committee**
Date:	**9 September 2015**
Subject:	**Council Business Plan 2015 - 2016 Performance Report, Quarter One**

Summary:
To present Q1 data in a new style performance report against the Council Business Plan.

Actions Required:

The Committee is invited to review, scrutinise and comment on Quarter 1 performance.

1. Background

Council Business Plan 2015/2016

In October 2014, Corporate Management Board supported a new Performance Management Framework for the Council which included a proposal to use infographics for performance reporting against the Council Business Plan. The Council Business Plan 2015/16 was approved by Council in February and has been organised around the 17 commissioning strategies. Appendix A lists the measures in the Council Business Plan that are within the remit of this scrutiny committee.

New style performance reporting

The Council Business Plan 2015/2016 was developed as a simple, easy to ready document with a view to using infographics to 'bring the plan to life' as part of a new style performance report. During July feedback was received on proposals for infographics from Corporate Management Board, Informal Executive and a workshop for Elected Members. This feedback has informed the infographics used to display Q1 performance. The infographics are designed to aid effective review and scrutiny of performance and inform decision making.

Feedback from Elected Members on a new style of performance reporting

Feedback has been positive. Members at the workshop specifically liked that:-

- The infographics show trends in performance;
- What is and is not being achieved is identified easily;
- The infographics provide a better balance with the big picture and detail between the commissioning strategies, targets and how we have performed.

Quarter One

The purpose of reporting Q1 data, where it is available, to scrutiny committee is to allow committee to review and scrutinise performance using infographics. The aim is for all of the information in the infographics to be self- explanatory so that whatever is presented to committee should not need explaining. This way of reporting is new and still in development so please do bear this in mind when reviewing and scrutinising Q1 performance.

Performance for Adults Scrutiny Committee

Performance is detailed in Appendix B and a presentation will be provided at the meeting to aid discussion of performance.

Four commissioning strategies sit within the remit of this committee:-

- Safeguarding Adults
- Adult Specialties
- Carers
- Adult frailty, long term conditions and physical disability

Further information to improve the infographics

Historical data

All of the measures in the Safeguarding Adults and Adult Specialties commissioning Strategies and the Percentage of carers supporting people not known to adult care are new in 2015/16 and therefore historic information is not available for these measures. The only exceptions are:-

- Adult safeguarding reviews where risk was reduced or removed;
- Recovery rates from psychological therapies (NHS Measure)
- Patient experience of community mental health services (NHS Measure).

Where historical data is available it will be provided by Adult Care in Q2.

Explanations of measure

Further explanation and definition will be provided in Q2 by Adult Care for the following measures:-

- Adult safeguarding reviews involving serious harm or death;
- All of the measures in the Carers and the Adult frailty, long term conditions and physical disability Commissioning Strategies.

All of the measures in the Adult Specialties Commissioning Strategy that are NHS measures are being developed and once developed an explanation and definition will be included in the infographics.

Calculations of measures

In Q2 Adult care will provide information about how measures that are reported as a percentage or rate per population are calculated and actual numbers will also be provided for these measures.

Reviewing targets

All the Adult Care targets will be reviewed after six months, and the service has identified that there is likely to be a disruption to reporting or oddities in the reported figures when Mosaic is implemented later in the year. This is because reporting routines will all have to change and the data will be in a different format following different business processes.

Web based reporting and paper reports

Although ideally we would want to reduce the amount of paper used to present performance information and encourage Elected Members to use technology to view the infographics we have produced paper based reports for Q1 as we develop web based technology to present performance information.

2. Conclusion

Q1 performance for the commissioning strategies within the remit of this Committee has been presented in a new style performance report with the aim to assist effective review and scrutiny of performance.

3. Consultation

a) Policy Proofing Actions Required

n/a

4. Appendices

These are listed below and attached at the back of the report.	
Appendix A	Business Plan measures within the remit of the Committee
Appendix B	Q1 Performance

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Jasmine Sodhi, who can be contacted on 01522 552124 or jasmine.sodhi@lincolnshire.co.uk.

Appendix A Council Business Plan 2015/2016 measures within the remit of the Adults Scrutiny Committee

Commissioning Strategy	Outcomes Outcomes are the results or benefits for individuals, families, groups, communities, organisations or systems. Outcomes reflect priorities and resources are allocated to achieve stated outcomes.	Measures Measures are how we will monitor and report progress in achieving the outcome.
Safeguarding adults The purpose of this commissioning strategy is that vulnerable adults' rights are protected so that everyone can live safely and free from abuse and neglect.	Safeguarding adults whose circumstances make them vulnerable, protecting them from avoidable harm and acting in their best interests where they lack capacity	People report they feel safe (Bigger is better)
		Proportion of concluded safeguarding enquiries where the person's desired outcomes were:- a) identified b) fully or partially met (Bigger is better)
		Proportion of cases where support was provided by an advocate, family or friend (for concluded safeguarding enquiries where the person at risk lacks capacity) (Bigger is better)
		Individuals involved in safeguarding adult reviews who suffered serious harm and died per 100,000 population
		Proportion of safeguarding referrals where the 'Source of Risk' is a 'service provider'
		Completed safeguarding referrals where a risk has been identified – proportion where the risk was reduced or removed (Smaller is better)
Adult Specialties[1]	Prevent people from dying prematurely	Excess under 75 mortality rate in adults with common mental illness
		Excess under 75 mortality rate in adults with serious mental illness
		Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services
		Excess under 60 mortality rate in adults with learning disability
		Levels of self-harm
	Enhanced quality of life and care for people with learning disability, autism and or mental illness	Proportion of adults with a learning disability or autism who live in their own home or with their family (Section 75 arrangement with Health)
		Proportion of adults in contact with secondary mental health services living independently, with or without support. (Section 75 arrangement with Health)
	Help people to recover from episodes of ill health	Recovery rates from psychological therapies (NHS Measure)
	People have a positive experience of care	Overall satisfaction of people who use services with their care and support (learning disability and autism sub-sets) (NHS Measure)
		Patient experience of community mental health services (NHS Measure)
Carers The purpose of this commissioning strategy is to help carers build resilience in their caring role and to prevent young carers from taking on inappropriate caring roles, protecting them from harm. Carers should have appropriate access to support which enables them to improve their quality of life and help prevent crisis.	Carers feel valued and respected and able to maintain their caring roles	Percentage of carers who receive a direct payment
		Carer reported quality of life (Survey every 2 years)
		The proportion of carers who report that they have been included or consulted in discussions about the person they care for (Annual Measure) (Survey every 2 years)
		Percentage of carers supporting people not known to adult care
		The proportion of carers who find it easy to find information about services (Survey every 2 years)
Adult frailty, long term conditions and physical disability	People are supported to remain independent and at home	Permanent admissions to residential and nursing care homes aged 65+ per 100,000 population
		Percentage of requests for support for new clients, where the outcome

[1] The outcomes and measures detailed above for the Adult Specialties commissioning strategy are based on the work completed so far in developing the commissioning strategy and have yet to be considered by the Specialist Services Delivery Board.

The purpose of this commissioning strategy is for the most vulnerable individuals to feel safe and live independently. We think this can be achieved by eligible individuals receiving appropriate care and support, with greater choice and control over their lives.		was universal services/ signposted to other services
	The quality of life for the most vulnerable people is improved	Proportion of people using the service who have control over their daily life (Annual survey)
		Percentage of clients in receipt of long term support and carers who receive a direct payment
	People have a positive experience of care and support	Delayed transfers of care from hospital and those that are attributable to adult social care or jointly to social care and the NHS per 100,000 population
		Percentage of people in receipt of long term support who have been reviewed

Communities are safe and protected from harm

Our communities are safe and protected from harm

Safeguarding adults

The purpose of this commissioning strategy is that vulnerable adults' rights are protected so that everyone can live safely and free from abuse and neglect.

Outcome

Safeguarding adults whose circumstances make them vulnerable, protecting them from avoidable harm and acting in their best interests where they lack capacity.

Measure

People report they feel safe

This measure reflects the extent to which users of care services feel that their care and support has contributed to making them feel safe and secure. As such, it goes some way to separate the role of care and support in helping people to feel safe from the influence of other factors such as crime levels and socio-economic factors.

Annual Measure from the statutory Adult Social Care Survey (ASCS) and will be reported in Quarter 4.

About the target

About the target range

About benchmarking

Further Details

This is a new measure in 2015/16 so no historical data is available.

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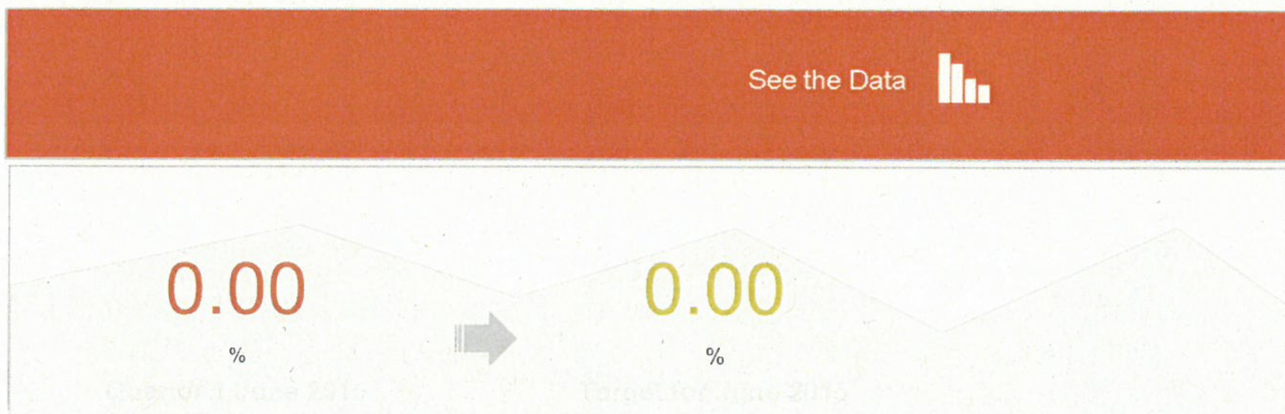
Measure

Safeguarding desired outcomes fully or partially met



There is a national consultation about this measure and data is unlikely to be available until 2016/2017

About the target
Targets are based on trends and CIPFA group averages

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking

Further Details
This is a new measure in 2015/16 so no historical data is available.

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Outcome

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Measure

Safeguarding cases supported by an advocate

This indicator identifies, of those individuals that have been assessed and lack mental capacity, how many had the support of an advocate (which can include an Independent Mental Health Advocate (IMHA), an Independent Mental Capacity Advocate (IMCA) or non-statutory advocate), family member or friends.

Performance has remained the same from the end of 2014/15 and at the end of Quarter 1, 100% had been supported.

About the target
Targets are based on trends and CIPFA group averages

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
CIPFA / ASCOF benchmarking available Autumn

Further Details
This is a new measure in 2015/16 so no historical data is available.

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Outcome

Safeguarding adults whose circumstances make them vulnerable, protecting them from avoidable harm and acting in their best interests where they lack capacity.

Measure

Adult safeguarding reviews involving serious harm or death

There have been no individuals involved in adult safeguarding reviews who have suffered serious harm and died this year.

About the target
Targets are based on trends and CIPFA group averages

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
Not yet known

Further Details
This is a new measure in 2015/16 so no historical data is available.

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Outcome

Safeguarding adults whose circumstances make them vulnerable, protecting them from avoidable harm and acting in their best interests where they lack capacity.

Measure

Safeguarding referrals where the source of risk is a service provider

This is the first year this indicator has been measured. At the end of quarter 1, 8.8% of safeguarding referrals had a 'source of risk' identified as a 'service provider'.

About the target
Targets are based on trends and CIPFA group averages

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
CIPFA / ASCOF benchmarking available Autumn

Further Details
This is a new measure in 2015/16 so no historical data is available.

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The purpose of this commissioning strategy is that vulnerable adults' rights are protected so that everyone can live safely and free from abuse and neglect.

Outcome

Safeguarding adults whose circumstances make them vulnerable, protecting them from avoidable harm and acting in their best interests where they lack capacity.

Measure

Adult safeguarding reviews where risk was reduced or removed

This is a local measure which attempts to establish the effectiveness of Safeguarding interventions, from the perspective that if the risk has been removed or reduced this is a more favourable outcome for the person, and help them to feel safe.

Performance has increased compared to the same period last year for the proportion of completed (and substantiated) safeguarding referrals where the risk was reduced or removed. There were 60.6% where the risk was reduced or removed compared to 40.0% in quarter 1 2014/15.

About the target
Targets are based on trends and CIPFA group averages

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
Not yet known

Further Details

Lincolnshire
COUNTY COUNCIL
Working for a better future

Health and Wellbeing is improved

The health and wellbeing of the population is improved

People remain independent for longer and feel responsible and in control of their own future.

Adult Specialties

Adult Specialties

Outcome

Prevent people from dying prematurely

Measure

Excess under 75 mortality rate in adults with common mental illness

This measure is being developed by NHS and as yet Lincolnshire County Council holds no data or how the frequency will be reported other than quarterly

See the Data

Not yet known Not yet known

This is an NHS measure and is in development.

About the target

About the target range

About benchmarking

Health and Wellbeing is improved

The health and wellbeing of the population is improved

People remain independent for longer and feel responsible and in control of their own future.

Adult Specialties

Adult Specialties

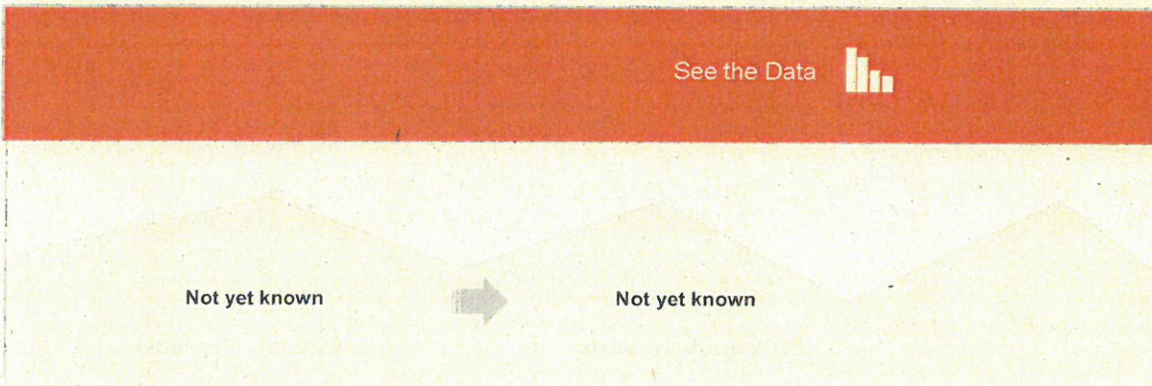
Outcome

Prevent people from dying prematurely

Measure

Excess under 75 mortality rate in adults with serious mental illness

This measure is being developed by NHS and as yet LCC hold no data or how the frequency will be reported other than quarterly



This is an NHS measure and is in development.

About the target
Not yet known

About the target range
Not yet known

About benchmarking
Not yet known

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COUNTY COUNCIL
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Adult Specialties

Adult Specialties

Outcome

Prevent people from dying prematurely

Measure

Death from injury of undetermined intent following recent contact with NHS

Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services

See the Data

Not yet known Not yet known

This is an NHS measure and is in development.

About the target
Not yet known

About the target range
Not yet known

About benchmarking
Not yet known

Health and Wellbeing is improved

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Adult Specialties

Adult Specialties

Outcome

Prevent people from dying prematurely

Measure

Excess under 60 mortality rate in adults with learning disability

Excess under 60 mortality rate in adults with learning disability

See the Data

Not yet known Not yet known

This is an NHS measure and is in development.

About the target
Not yet known

About the target range
Not yet known

About benchmarking
Not yet known

Health and Wellbeing is improved

The health and wellbeing of the population is improved

People remain independent for longer and feel responsible and in control of their own future.

Adult Specialties

Adult Specialties

Outcome

Prevent people from dying prematurely

Measure

Levels of self-harm

0

See the Data

Not yet known

Not yet known

This is an NHS measure and is in development.

About the target

Not yet known

About the target range

Not yet known

About benchmarking

Not yet known

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Adult Specialties

Adult Specialties

Outcome

Enhanced quality of life and care for people with learning disability, autism and or mental illness

Measure

Adults with learning disabilities who live in their own home or with family

Proportion of adults with a learning disability or autism who live in their own home or with their family (Section 75 arrangement with Health)

There has been a slight increase since the end of 2014/15 in the proportion of adults with a learning disability or autism who live in their own home or with their family, with a Q1 outturn of 72.3%. The measure is intended to improve outcomes for adults with a learning diability by demonstrating the proportion in stable and appropirate accommodation. The nature of accommodation for people with a learning disability has a strong impact on their safety and overall quality of life and the risk of social exclusion. The 2015/16 target was set before the year end target was known, so will need to be reviewed after 6 months.

About the target

Targets are based on trends and CIPFA group averages

About the target range

5% +/-. Based on tolerances used by Department of Health

About benchmarking

CIPFA / ASCOF benchmarking available Autumn

Lincolnshire
COUNTY COUNCIL
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Adult Specialties

Adult Specialties

Outcome

Enhanced quality of life and care for people with learning disability, autism and or mental illness

Measure

Adults in contact with community mental health teams living independently

Proportion of adults in contact with secondary mental health services living independently, with or without support. (Section 75 arrangement with Health)

See the Data

0

%

25.0

%

Target for June 2015

This measure is reported from the Mental Health Minimum Dataset (MH-MDS). The data for Q1 is not available and is published with a 1 quarter lag. The target was set before the year end outturn of 47% was known (only recently released in August 2015). The target will need to be reviewed in 6 months.

About the target
Not yet available

About the target range
Not yet available

About benchmarking
Not yet available

Health and Wellbeing is improved

The health and wellbeing of the population is improved

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Adult Specialties

Adult Specialties

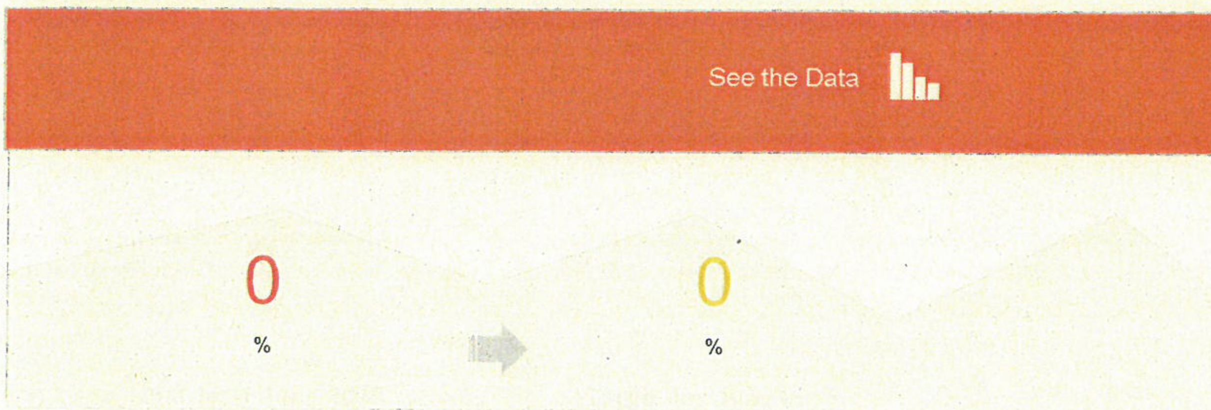
Outcome

Help people to recover from episodes of ill health

Measure

Recovery rates from psychological therapies

Recovery rates from psychological therapies (NHS Measure)



Data not yet available. Provisional target set by the NHS.

About the target
Not yet available

About the target range
Not yet available

About benchmarking
Not yet available

Health and Wellbeing is improved

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Adult Specialties

Adult Specialties

Outcome

People have a positive experience of care

Measure

Satisfaction with learning disability and autism care and support services

Overall satisfaction of people who use services with their care and support (learning disability and autism sub-sets) (NHS Measure)

Reported Annually

See the Data

0

%

0

%

Annual Measure from the statutory Adult Social Care Survey (ASCS).

About the target

Targets are based on trends and CIPFA group averages

About the target range

5% +/-. Based on tolerances used by Department of Health

About benchmarking

CIPFA / ASCOF benchmarking available Autumn

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Adult Specialties

Adult Specialties

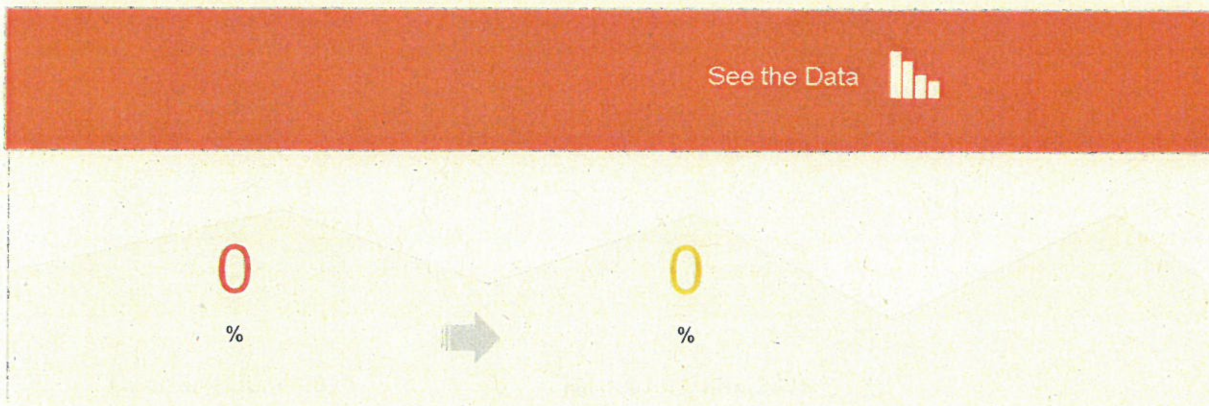
Outcome

People have a positive experience of care

Measure

Satisfaction with community mental health services

Patient experience of community mental health services (NHS Measure)



Data is not yet available. This measure is sourced from the NHS survey and the results are published every 6 months. Provisional targets set by the NHS.

About the target

About the target range

About benchmarking

Lincolnshire
COUNTY COUNCIL
Working for a better future

Health and Wellbeing is Improved

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Carers

The purpose of this commissioning strategy is to help carers build resilience in their caring role and to prevent young carers from taking on inappropriate caring roles, protecting them from harm. Carers should have appropriate access to support which enables them to improve their quality of life and help prevent crisis.

Outcome

Carers feel valued and respected and able to maintain their caring roles

Measure

Carers who receive a direct payment

Percentage of carers who receive a direct payment

See the Data

64.5 %		%
Quarter 1 June 2015		Target for June 2015

This indicator was previously combined with the percentage of clients receiving a direct payment. From 2015/16 the two indicators will be reported separately. At the end of Q1 64.5% of carers were in receipt of a direct payment.

About the target

Lincolnshire County Council provides performance reports to the Chartered Institute of Public Finance and Accountancy (CIPFA) which facilitates a benchmarking services to enable Adult Social Care performance to be monitored against other local authorities. Lincolnshire County Council is in a benchmarking group of 16 authorities. Targets are based on trends and CIPFA group Averages.

About the target range

5% +/-. Based on tolerances used by Department of Health

About benchmarking

Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

Lincolnshire
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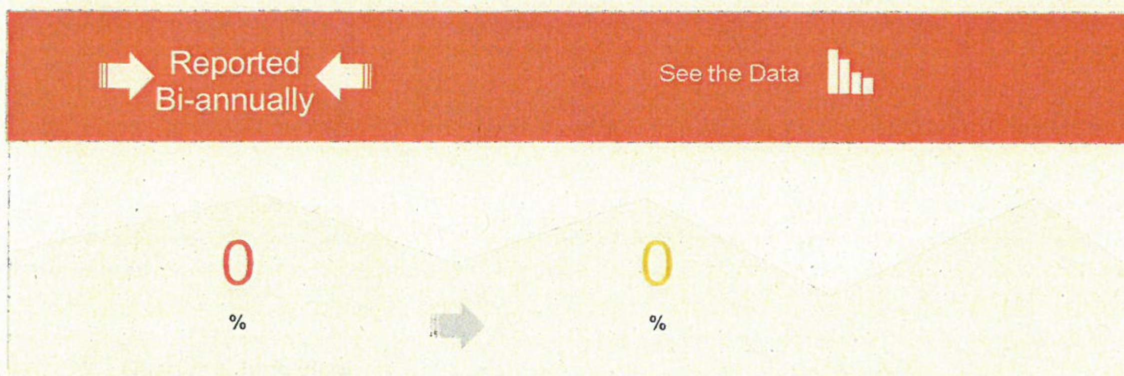
Outcome

Carers feel valued and respected and able to maintain their caring roles

Measure

Carer reported quality of life

Carer reported quality of life (Survey every 2 years)



This measure is reported bi-annually and is sourced from the statutory survey of Adult Carers in England (SACE) every 2 years.

About the target
Not yet available

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

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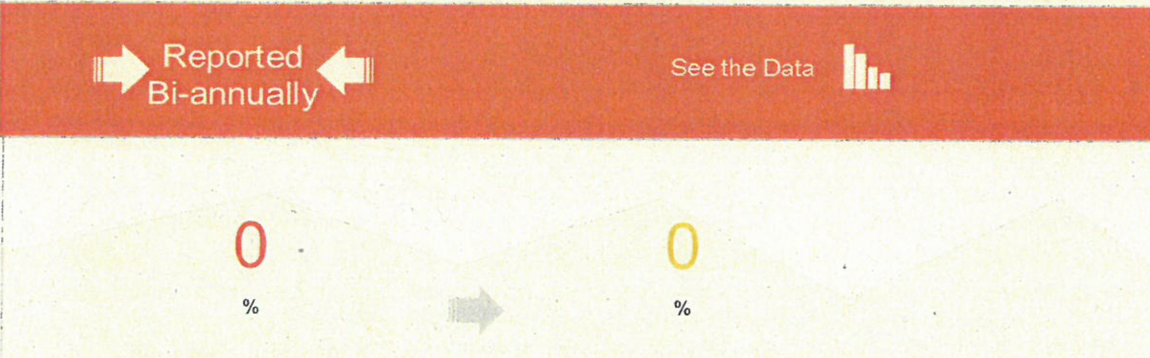
Outcome

Carers feel valued and respected and able to maintain their caring roles

Measure

Carers included or consulted in discussions about the person they care for

The proportion of carers who report that they have been included or consulted in discussions about the person they care for (Annual Measure) (Survey every 2 years)



This measure is reported bi-annually and is sourced from the statutory survey of Adult Carers in England (SACE) every 2 years.

About the target
Not yet available

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

Lincolnshire
COUNTY COUNCIL
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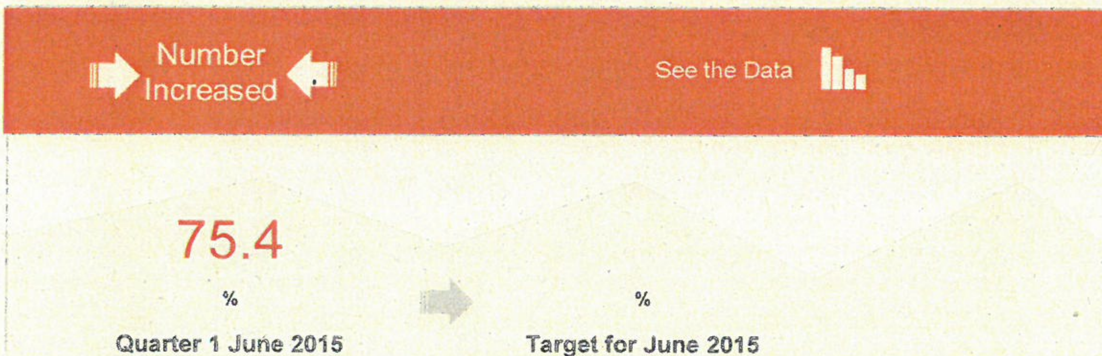
Outcome

Carers feel valued and respected and able to maintain their caring roles

Measure

Carers supporting people not known to adult care

Percentage of carers supporting people not known to adult care



At the end of Q1, the proportion of carers supported where the person they care for is not a client of Adult Care was 75.4%. This is a slight increase from the year end 2014/15 when the outturn was 74.7%. New Mosaic processes will likely increase the rate of referral from Adult Care Teams, who feel carer support provided along side Adult Care services will produce the best outcomes.

About the target

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About the target range

5% +/-. Based on tolerances used by Department of Health

About benchmarking

Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

Lincolnshire
COUNTY COUNCIL
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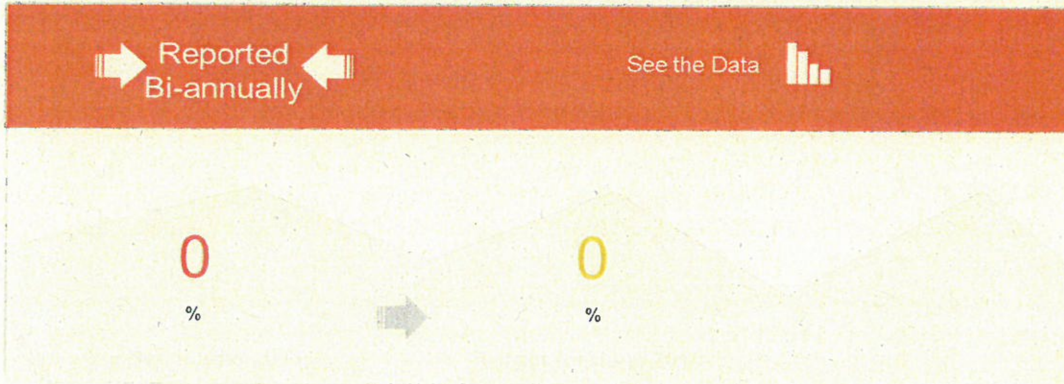
Outcome

Carers feel valued and respected and able to maintain their caring roles

Measure

Carers who find it easy to find information about services

The proportion of carers who find it easy to find information about services (Survey every 2 years)



This measure is reported bi-annually and is sourced from the statutory survey of Adult Carers in England (SACE) every 2 years.

About the target

Lincolnshire County Council provides performance reports to the Chartered Institute of Public Finance and Accountancy (CIPFA) which facilitates a benchmarking services to enable Adult Social Care performance to be monitored against other local authorities. Lincolnshire County Council is in a benchmarking group of 16 authorities. Targets are based on trends and CIPFA group Averages.

About the target range

5% +/-. Based on tolerances used by Department of Health

About benchmarking

Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

Lincolnshire
COUNTY COUNCIL
Working for a better future

Health and Wellbeing is improved

The health and wellbeing of the population is improved

People remain independent for longer and feel responsible and in control of their own future.

Adult frailty, long term conditions and physical disability

The purpose of this commissioning strategy is for the most vulnerable individuals to feel safe and live independently. We think this can be achieved by eligible individuals receiving appropriate care and support, with greater choice and control over their lives.

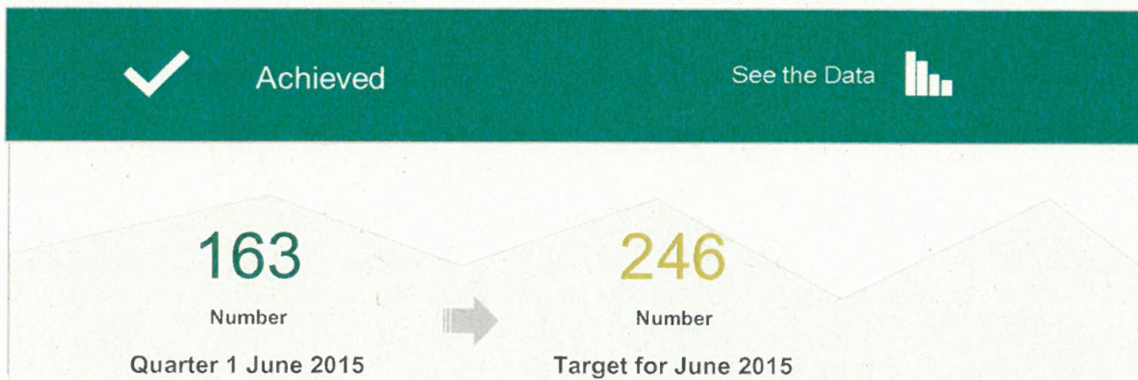
Outcome

People are supported to remain independent and at home

Measure

Permanent admissions to residential and nursing care homes aged 65+

Permanent admissions to residential and nursing care homes aged 65+ per 100,000 population



In Q1 there were 163 permanent admissions into residential and nursing care for adults aged over 65 years. This equates to 102 per 100,000 population (65+). At the end of the same quarter last year there had been 184 admissions so this is showing improved performance this years. This a Better Care Fund measure and goes a long way to demonstrating the effectiveness of Adult Care at preserving people's independence in a community setting.

About the target

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About the target range

5% +/-. Based on tolerances used by Department of Health

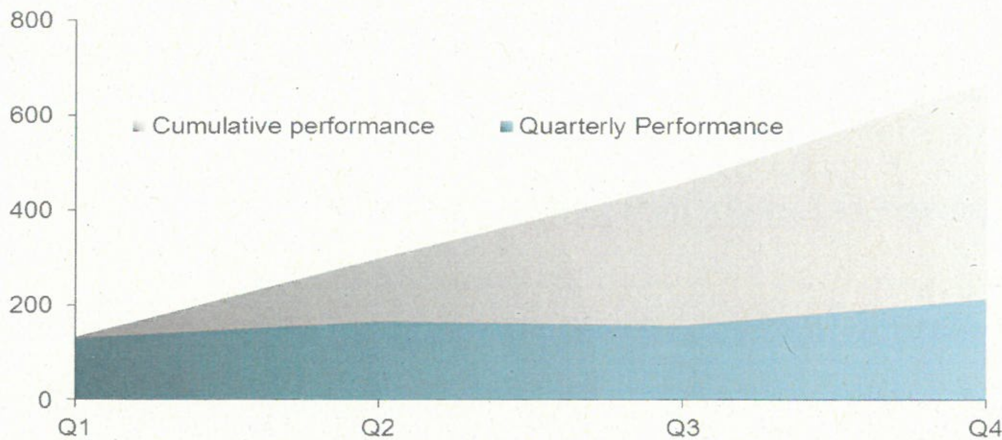
About benchmarking

Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

Further details

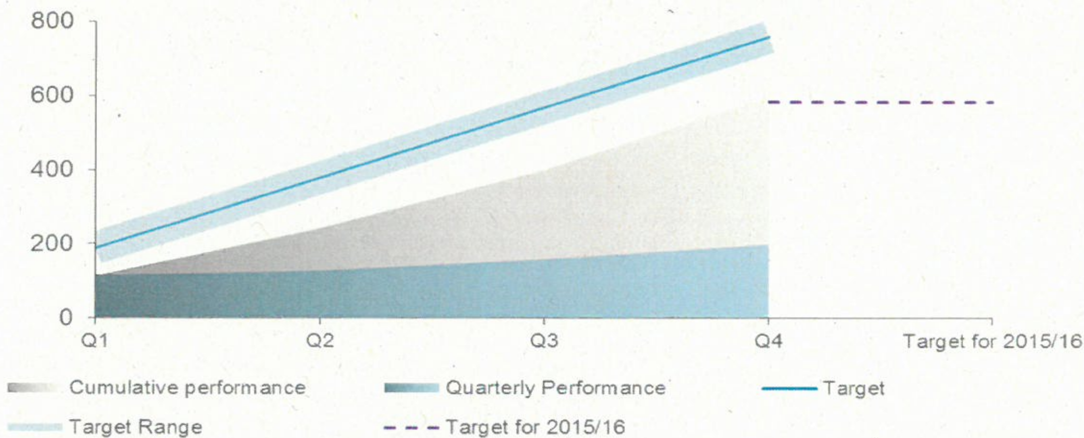
Permanent admissions to residential and nursing care home 2013/14

(per 100,00 population aged over 65 years)

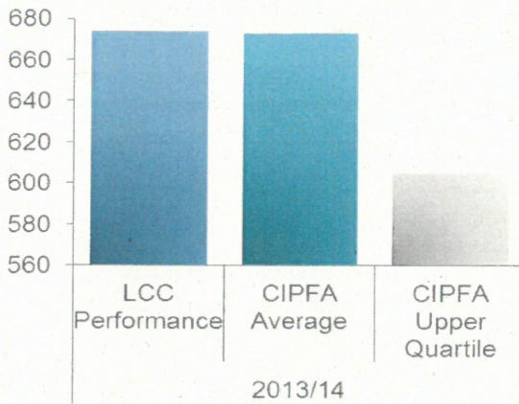


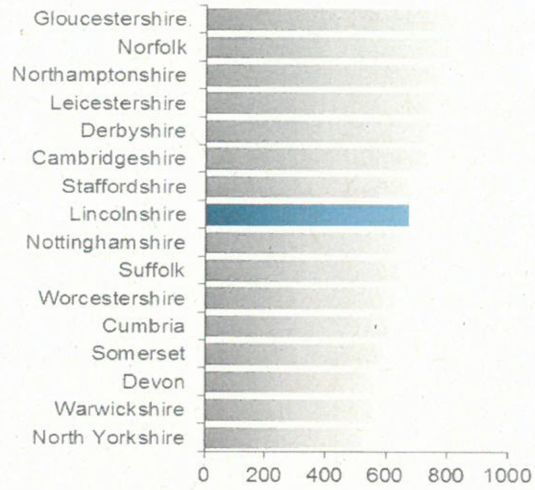
Permanent admission to residential and nursing care home 2014/15

(per 100,000 population aged over 65 years)



Measure Name	**Permanent admissions to residential and nursing care homes aged 65+**								
	2013-14				**2014-15**				
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Target for 15/16**
Cumulative performance	132.1	299.8	459.7	674.3	115.0	243.8	401.4	600.2	
Quarterly Performance	132.1	167.7	159.9	214.6	115.0	128.8	157.6	198.8	
Target					189.8	379.5	569.3	759.0	582.9
Upper Range					227.7	417.4	607.2	796.9	
Lower range					151.8	341.6	531.3	721.1	





2013/14			
LCC Performance	CIPFA Average	CIPFA Upper Quartile	LCC CIPFA Ranking
674.3	673.3	604.9	9th

Lincolnshire
COUNTY COUNCIL
Working for a better future

Health and Wellbeing is improved

The health and wellbeing of the population is improved

People remain independent for longer and feel responsible and in control of their own future.

Adult frailty, long term conditions and physical disability

The purpose of this commissioning strategy is for the most vulnerable individuals to feel safe and live independently. We think this can be achieved by eligible individuals receiving appropriate care and support, with greater choice and control over their lives.

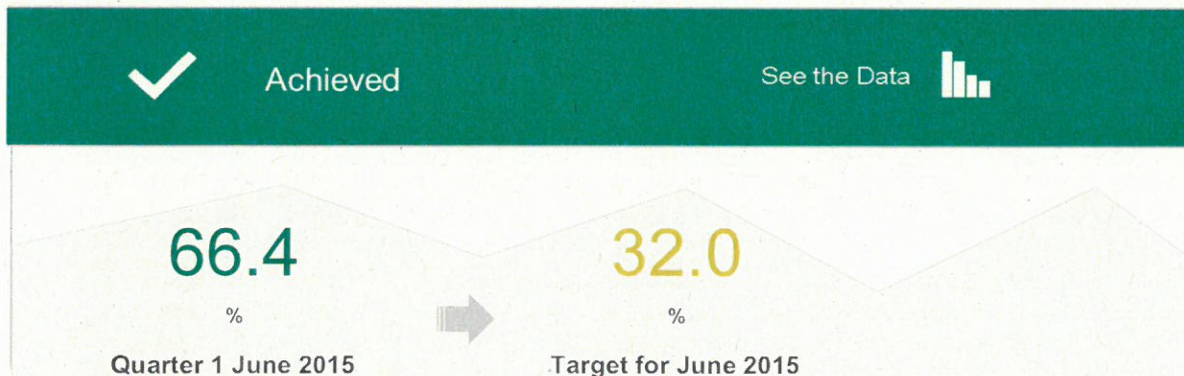
Outcome

People are supported to remain independent and at home

Measure

Requests for support for new clients, where the outcome was universal services/ signposting

Percentage of requests for support for new clients, where the outcome was universal services/ signposted to other services



The definition of this indicator has changed from last year and now includes all requests for support for new clients, and not just those at the Customer Service Centre (CSC). When using the same definition, the 2014/15 year end figure was 63.2%, showing that performance is already improving this year. Target were set based on the CSC activity reported the previous reporting-year and before the processing of this new national dataset was finalised. The target will need to be reviewed after 6 months.

About the target

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About the target range

5% +/-. Based on tolerances used by Department of Health

About benchmarking

Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

Health and Wellbeing is improved

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Outcome

The quality of life for the most vulnerable people is improved

Measure

People using the service who have control over their daily life (Annual survey)

Proportion of people using the service who have control over their daily life (Annual survey)

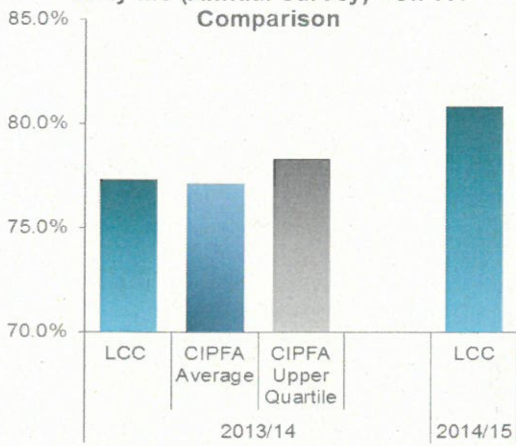
Annual Measure from the Statutory Adult Social Care Survey (ASCS)

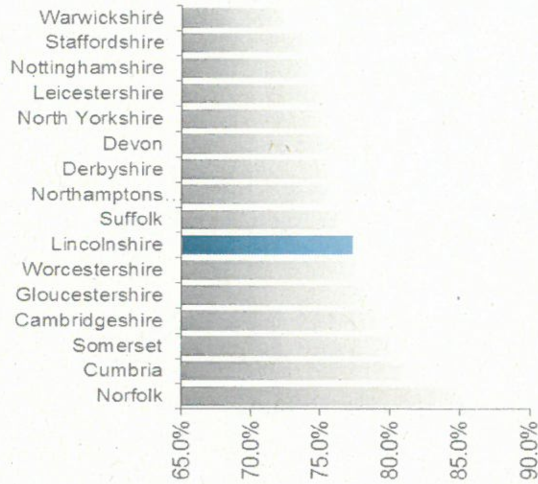
About the target
Lincolnshire County Council provides performance reports to the Chartered Institute of Public Finance and Accountancy (CIPFA) which facilitates a benchmarking services to enable Adult Social Care performance to be monitored against other local authorities. Lincolnshire County Council is in a benchmarking group of 16 authorities. Targets are based on trends and CIPFA group Averages.

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

Further details





2013/14				2014/15
LCC	CIPFA Average	CIPFA Upper Quartile	LCC CIPFA Ranking	LCC
77.3%	77.1%	78.3%	7th	80.8%

Health and Wellbeing is improved

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Adult frailty, long term conditions and physical disability

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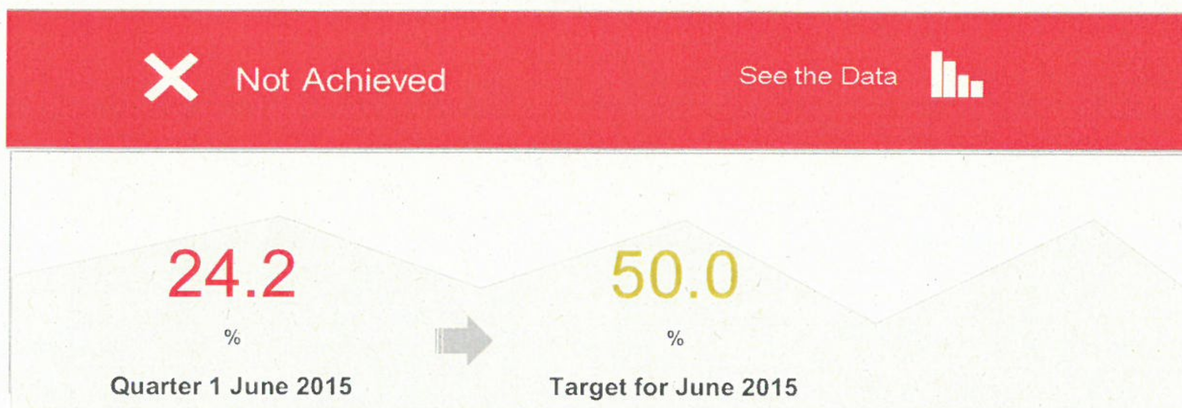
Outcome

The quality of life for the most vulnerable people is improved

Measure

Clients in receipt of long term support who receive a direct payment

Percentage of clients in receipt of long term support who receive a direct payment



This indicator was previously combined with the percentage of carers receiving a direct payment. From 2015/16 the two indicators will be reported separately. At the end of Q1 24.2% of clients in receipt of long term support were in receipt of a direct payment. Since this measure has been refined to report on client activity, the target (which relates to clients AND carers) needs to be reviewed after 6 months.

About the target

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5% +/-. Based on tolerances used by Department of Health

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Outcome

People have a positive experience of care and support

Measure

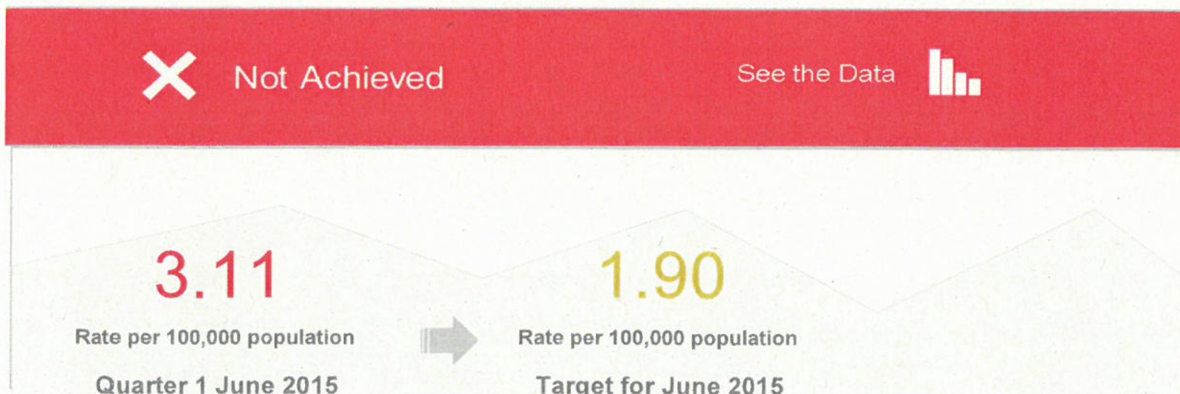
Delayed transfers of care from hospital

This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
A patient is ready for transfer when:

(a) a clinical decision has been made that the patient is ready for transfer AND
(b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND
(c) the patient is safe to discharge/transfer.

The Average figure is calculated by taking the average number of delayed transfers of care (for those aged 18 and over) on a particular day taken over the year. This is the average of the 12 monthly snapshots collected in the monthly Situation Report (SitRep). divided by the number of adult population in area (aged 18 and over) according to ONS mid year population estimates. Similarly the Quarterly figure is the average of a 3 month snapshot collected monthly divided by the number of adult population in the area aged 18 and over.



Historically, Lincolnshire has been a top performer on this measure with very low hospital delays attributable to Adult Care. Delays have been unusally high throughout May and June which has taken the value over the target. The data comes from national NHS Data and some work is being undertaken to identify where there are any recording/ submission issues in the health community. The increase delays although not directly linked to social care, relate to patients awaiting residential home placements, care packages in their own homes or community equipment. There is a month lag after the period ends before NHS England publish the data.

About the target

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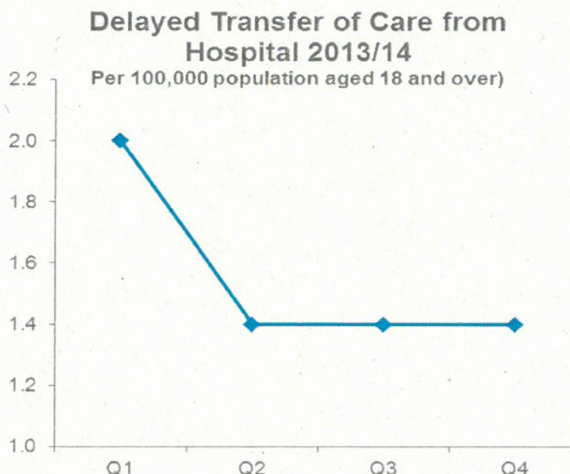
About the target range

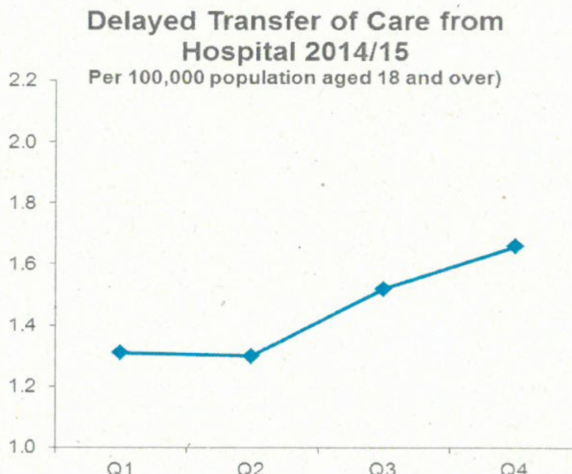
5% +/-. Based on tolerances used by Department of Health

About benchmarking

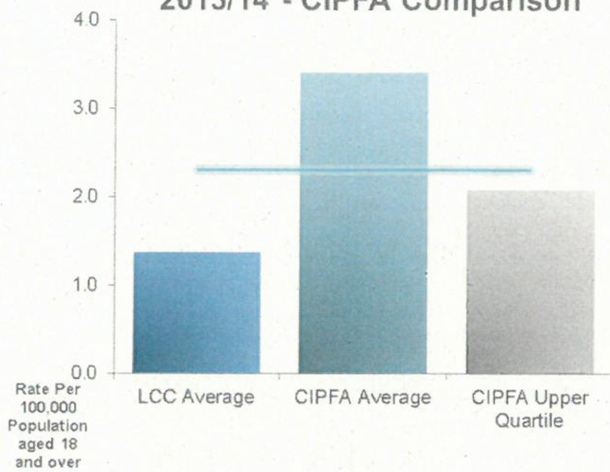
Chartered Institute of Public Finance and Aaccountancy / Adult Social Care Outcome Framework benchmarking available Autumn

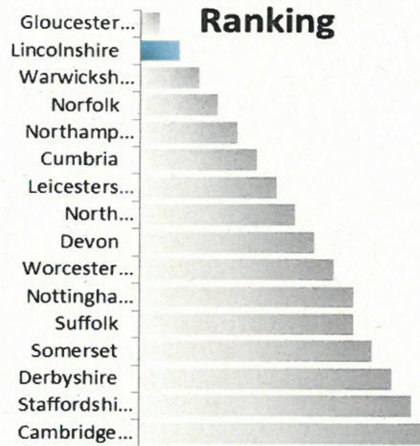
Further details





Measure Name	**Delayed transfers of care from hospital**								
	2013-14				**2014-15**				
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Target for 15/16**
Performance	2.0	1.4	1.4	1.4	1.31	1.3	1.52	1.66	





2013/14						
LCC Average	CIPFA Average	CIPFA Upper Quartile	Target	Upper Range	Lower range	CIPFA Ranking
1.4	3.4	2.1	2.3	2.35	2.25	2nd

Health and Wellbeing is improved

The health and wellbeing of the population is improved

People remain independent for longer and feel responsible and in control of their own future.

Adult frailty, long term conditions and physical disability

The purpose of this commissioning strategy is for the most vulnerable individuals to feel safe and live independently. We think this can be achieved by eligible individuals receiving appropriate care and support, with greater choice and control over their lives.

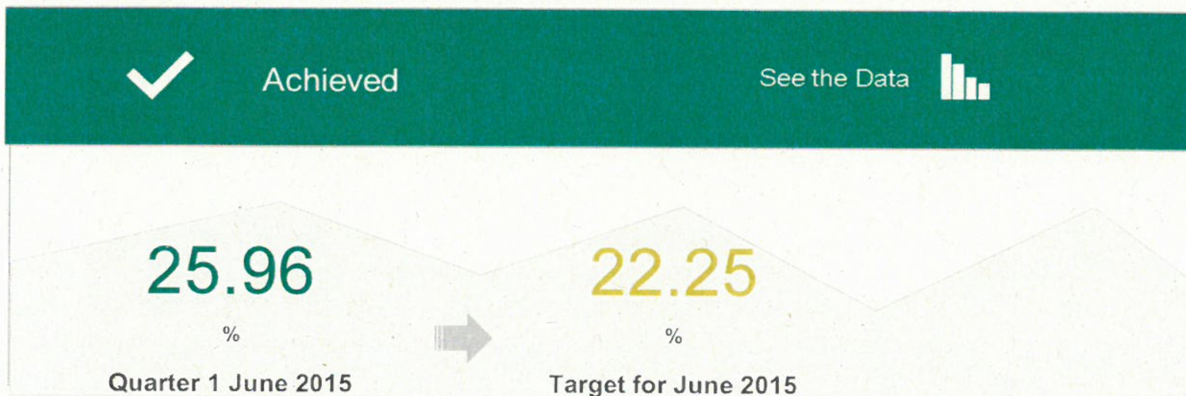
Outcome

People have a positive experience of care and support

Measure

Percentage of people in receipt of long term support who have been reviewed

Percentage of people in receipt of long term support who have been reviewed



The number of people in receipt of long term support who have been reviewed is increasing at a similar rate to the same period last year. Historically performance has dipped towards the end of the year so work will need to be done to ensure this does not happen again and year end performance is improved.

About the target
Targets are based on trends and CIPFA group averages

About the target range
5% +/-. Based on tolerances used by Department of Health

About benchmarking
None available

Open Report on behalf of Glen Garrod, Director of Adult Social Services and Judith Hetherington-Smith, Chief Information and Commissioning Officer

Report to:	**Adults Scrutiny Committee**
Date:	**9 September 2015**
Subject:	**Sensory Impairment Services Re-Procurement**

Summary:

This item invites the Adults Scrutiny Committee to consider a report entitled Sensory Impairment Services Re-Procurement which is due to be considered by the Executive Councillor for Adult Care and Health Services, Children's Services on 14 September 2015. The views of the Scrutiny Committee will be reported to the Executive Councillor, as part of her consideration of this item.

Actions Required:

(1) To consider the attached report and to determine whether the Committee supports the recommendations to the Executive Councillor set out in the report.

(2) To agree any additional comments to be passed to the Executive Councillor in relation to this item.

1. Background

The Executive Councillor is due to consider a report entitled Sensory Impairment Services Re-Procurement on 14 September 2015. The full report to the Executive Councillor is attached at Appendix A to this report.

2. Conclusion

Following consideration of the attached report, the Committee is requested to consider whether it supports the recommendations in the report and whether it wishes to make any additional comments to the Executive Councillor. The Committee's views will be reported to the Executive Councillor.

3. Consultation

a) Policy Proofing Actions Required

Not Applicable.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Report to the Executive Councillor – Sensory Impairment Services Re-Procurement
Appendix B	Equality Impact Analysis
Appendix C	Project Timeline

5. Background Papers

The following background papers as defined in the Local Government Act 1972 were relied upon in the writing of this report.

Document title	Where the document can be viewed
The Care Act 2014	Legal Services

This report was written by Clair McNally and Marie Kaempfe-Rice, who can be contacted on 01522 552778 / 01522 554087 or Clair.McNally@lincolnshire.gov.uk / Marie.Kaempfe-Rice@lincolnshire.gov.uk

Lincolnshire
COUNTY COUNCIL
Working for a better future

Report Reference:
Executive/Executive Councillor

Open Report on behalf of Glen Garrod, Director of Adult Social Services

Report to:	**Executive Councillor for Adult Care, Health Services and Children's Services**
Date:	**9 September 2015**
Subject:	**Sensory Impairment Services Re-Procurement**
Decision Reference:	
Key decision?	**Yes**

Summary:

The current sensory impairment services have been in place since April 2011. All available provision for extension within the contract has been exhausted and the existing arrangement will expire as of 31 March 2016.

The service is a preventative and reablement provision for both adults and children with a sensory impairment, both cognitive and acquired and their associated disabilities where applicable.

Recommendation(s):

That the Executive Councillor:

1. Approves a procurement be undertaken to deliver a contract to be awarded to a single provider of a county-wide service for all sensory impairment needs within a fixed budget for a period of three years with the possibility of a further two year extension.

2. Delegates to the Director of Adult Social Services in consultation with the Executive Councillor for Adult Care and Health Services, Children's Services the authority to determine the final form of the contract and to approve the award of the contract and the entering into the contract and other legal documentation necessary to give effect to the said contract.

Alternatives Considered:

1. Negotiate a revised contract with the current provider

   Whilst performance levels have been satisfactory, continuing with the current provider is not viable as all provision for extension within the current contract has been exhausted. In addition there are also other Service Providers that have expressed an interest in delivering this contract.

2. To do nothing

   This is not a viable option as Lincolnshire County Council has a statutory duty to provide Sensory Impairment Services under the following legislation as a minimum:

   - The National Assistance Act 1948;
   - The Chronically Sick and Disabled Persons Act 1970;
   - The Disabled Persons Act 1986;
   - Section 7 of the Local Authority Social Services Act 1970; and
   - The Care Act 2014

Reasons for Recommendation:

The proposal is to establish a single provider model for eligible people, both children and adults within Lincolnshire who will benefit from a time limited period of support.

1. Service provision under the current legal agreement has delivered required outcomes however it is considered that by exposing this service to competition it will provide the opportunity to enhance services through greater integration with Health. A review, possible revision and clarity around the scope of the current specification may enable further efficiencies. It is also expected that the market and stakeholder engagement undertaken as part of the procurement process will encourage partnership working providing bespoke solutions to delivery.

2. Appointing a single provider will ensure that services are not fragmented and eliminate any duplication. A holistic multi-disciplinary approach to the service will aid in meeting the Service Users needs through; ensuring any transition for young people to adult services is seamless, providing a higher quality service for those individuals who have a dual impairment and the delivery of a consistent service across the county. The services were previously delivered by a number of providers, offering a range of services to different clients groups. Delivering through a single provider model has indicated improved performance and consistency. It also ensures that the contract package is viable, sustainable and attractive to the market. This is essential considering the market is very limited. Whilst

it is the intention to contract with one provider effective referral mechanisms with partner organisations will ensure that the service is enhanced and that services delivered are appropriate throughout the Service Users support.

3. The alternatives considered have been deemed unacceptable in delivering the required outcomes of the service.

4. Addresses and supports the statutory requirements for this Service.

1. Background

The current service delivered is a preventative and reablement service for both adults and children with a sensory impairment, both cognitive and required and their associated disabilities. The contract encompasses visual impairment (including blind and partially sighted), hearing impairment (including those who are profoundly deaf, deafened and hard of hearing) and dual sensory impairment (deafblindness)".

Table 1 demonstrates the breakdown of allocated funding since the service was commissioned in April 2011. The funding envelope from Adult Care and Children's Services will remain at £475,020. It is proposed that £15,000 will be deducted for Carer Assessments as it is the intention these are delivered through the reprocured Carers contract. Public Health have confirmed their budget allocation for the Sensory Impairment Services. The proposed budget for 2016 - 2019 is demonstrated in **Table 2.** It is expected that the successful Service Provider will meet all demand within this fixed budget.

Table 1: Budget Allocation

	Budget Allocation per annum		
	2011 - 2013	2014 – 2015	**Proposed 2016 - 2019**
Adult Care and Childrens Services	£527,801	475,020 (including £15,000 for specific Carers Assessments)	**£460,020 (£475,020 minus £15,000 for Carer Assessments)**
Public Health	£136,300	£136,305	**£136,305**
Total	£664,101	£611,325	**£596,325**

Table 2: Proposed Budget Allocation 2016-2019

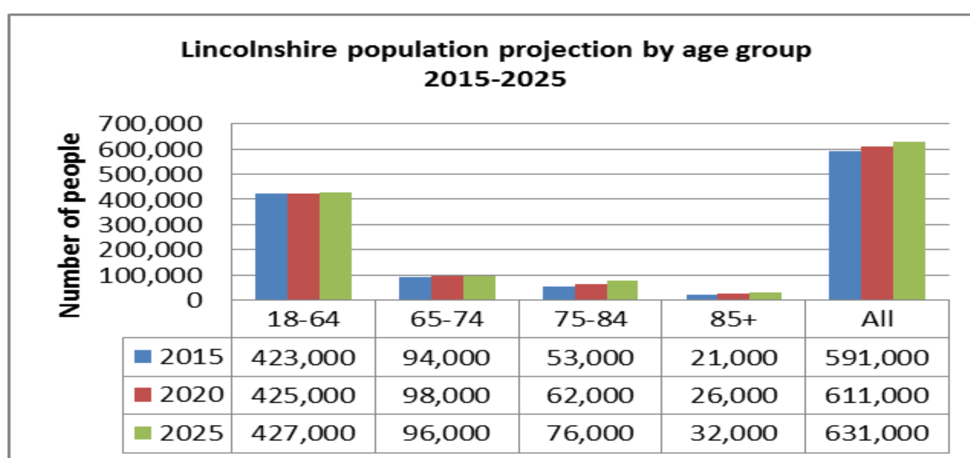
	Proposed Budet Allocation per annum	**Percentage of Budget Allocation**
Adults	£427,590	72%
Children	£32,430	5%
Public Health	£136,305	23%
Total Budget	£596,325	100%

The current contract is with BID Services. Whilst this company's Head Office is in Birmingham the contract is delivered locally, with premises in Lincoln and employing local people.

The Current Environment

The population of Lincolnshire is currently estimated to total between 724,500 - 764,325 people. According to the Office for National Statistics the 18+ Lincolnshire population estimate for 2015 is 591,000, of which 168,000 are estimated to be 65+ years (**figure 1**). East Lindsey has the greatest proportion of those aged 65+ in England. It is predicted that the elderly population in Lincolnshire will increase by 3.4% in the next ten years. The rate of increase in people aged 85+ years is particular pronounced with an expected increase of 52.4%.

Figure 1: Lincolnshire population projections by age group



	18-64	65-74	75-84	85+	All
2015	423,000	94,000	53,000	21,000	591,000
2020	425,000	98,000	62,000	26,000	611,000
2025	427,000	96,000	76,000	32,000	631,000

(Source – 2012 based Subnational Population Projections (Office for National Statistics)

Table 3: Proportion of County by age band

Age Group	Lincolnshire	East Midlands	England
0-4	5.2%	6.0%	6.3%
5-17	14.3%	15.1%	15.1%
18-29	13.7%	15.7%	16.3%
30-49	25.5%	27.3%	28.0%
50-64	20.5%	19.0%	18.1%
65-74	11.3%	9.2%	8.6%
75-84	6.8%	5.7%	5.5%
85+	2.6%	2.2%	2.2%

When comparing Lincolnshire both regionally and nationally (**Table 3**), it is evident that there are higher rates of people aged 65+ in the county.

Table 4 shows the current rate of conditions affecting people's vision within Lincolnshire. As evident, there are higher rates of people with Glaucoma Certified Visual Impairments in Lincolnshire when compared both regionally and nationally. Lincolnshire saw a slight increase (2.1%) of people with a Certified Visual Impairment between 2010/11 and 2011/12.

Table 4: Various conditions affecting vision

	Lincolnshire	East Midlands	England
Rate of Age-related Macular Degeneration CVIs per 100k people over 65	109.3	114.3	110.5
Rate of Glaucoma CVIs per 100k people over 40	16.3	10.9	12.8
Rate of Diabetic Retinopathy CVIs per 100k people over 12	4.2	4.0	3.9
Overall rate of CVI per 100k people (all ages)	52.2	45.6	44.5

Table 5 and **Table 6** highlight there are a significant number of older people living with a Visual Impairment and the numbers increase with age.

Table 5: Children and Young People living with a Visual Impairment in Lincolnshire

Age	Number	Proportion of Population	Total Number living with a VI	Proportion of age group living with VI
0-16	130,475	18.3%	261	0.2%
17-25	75,775	10.6%	152	0.2%
Overall Total	206,250	28.9%	413	0.4%

Table 6: Older People living with a Visual Impairment

Age	Number	Proportion of Population	Total number living with VI	Proportion of age group living with VI
65-75	80,273	11.3%	5,177	6.5%
75-84	48,767	6.8%	7,011	14.4%
85 and over	18,811	2.6%	7,682	40.8%
Overall Total	147,851	20.7%	19,870	13.4%

Hearing Impaired

Based on available data **Tables 7 – 11** demonstrate that there are significantly more people suffering a Hearing Impairment then a Visual Impairment – 19,870 Visual Impairment compared to 123,510 Hearing Impairment.

Table 7: Number of people classed as "deaf"

UK Total Population	UK Total Population Deaf	% Deaf	Lincolnshire Total Population	Lincolnshire Total Population Deaf
63,230,000	10,000,000	15.82%	722,705	114,331

Table 8: Number of people classed as "profoundly deaf"

UK Total Population	UK Total Population Profoundly Deaf	% Profoundly Deaf	Lincolnshire Total Population	Lincolnshire Total Population Profoundly Deaf
63,230,000	800,000	1.27%	722,705	9,179

Table 9: Number of children aged under 16 who are classed as "deaf"

UK Total Population (0-16)	UK Total Deaf Children (0-16)	UK % Deaf (0-16)	Lincolnshire Total Deaf	Lincolnshire Deaf (0-16)	Total Lincolnshire Population (0-16)
11,600,000	45,000	0.39%	114,331	516	132,232

Table 10: Number of people of a working age who are classed as "deaf"

UK Total Deaf	UK Working Age (16-64)	UK % Deaf (Working Age)	Lincolnshire Total Deaf	Lincolnshire Deaf Working Age	Total Lincolnshire Working Age	% of Lincolnshire Working Age Deaf
10,000,000	3,700,000	37.00%	114,331	42,302	447,180	9.46%

Table 11: Number of people aged 65 and over and classed as "deaf"

UK Total Deaf	UK Total Deaf (65+)	UK % Deaf (65+%	Lincolnshire Total Deaf	Lincolnshire Deaf 65+	Total Lincolnshire 65+ Population	% of Lincolnshire 65+ Deaf
10,000,000	6,300,000	63%	114,331	72,028	152,021	47.38%

Nationally more than 70% of people aged 70+ have a hearing impairment. 105,469 people aged 70 + reside in Lincolnshire equating to 73,828.

Table 12 demonstrates the number of people with both a hearing and visual impairment.

Table 12: Number of people with a hearing impairment and visual impairment

UK Total Population	UK Total Deaf/Blind	UK% Deaf Blind (All)	Lincolnshire Total Population	Lincolnshire Total Population Deaf/Blind
63,230,000	356,000	0.56%	722,705	4,047

Table 13: Numbers of people on the Sensory Impairment Registers maintained by BID Services (SILCS)

Sensory Impairment	Estimated Numbers affected in Lincolnshire	Numbers on Register held by Provider 2014	Percentage on Register	Numbers on Register held by Provider 2015
Visual Impairment	25,080	1,787	7.13%	2,894
Hearing Impairment	114,331	1,846	1.61%	2,521
Dual Sensory Impairment	4,047	313	7.73%	369
Total Figures	143,458	3,946	2.75%	5,784

Table 13 demonstrates that the number of people registered on the provider database is significantly lower than estimated demand.

Based on the demographic information and the prevalence of Sensory Impairment, it can be concluded that demand for this service will only increase.

Strategic Drivers/ Legislative Compliance
No approved Council Commissioning/Category Strategy currently exists however, Adult Care's strategic direction is to enable people to remain living independently in their own homes for as long as possible. This is further reinforced by the Care Act 2014, which attempts to rebalance the focus of social care on preventing and delaying needs rather than only intervening at crisis point.

Lincolnshire County Council has a duty to provide specialist services to Adults and Children with a Sensory Impairment and Associated Disabilities under the following legislation:

- **The National Assistance Act 1948** Section 29 (1) to make arrangements for promoting the welfare of adults and children who are Visually Impaired, Hearing Impaired and for Dual Sensory Loss (Deafblind). Section 29 (4) (g) of the National Assistance Act 1948 states a register shall be kept of clients with Visually Impairments, Hearing Impairments and for Dual Sensory Loss (Deafblind). Section 30 (1) of the National Assistance Act 1948 makes provision to allow a Local Authority to employ any appropriately registered voluntary organisation to act as its Agent.

- **The Chronically Sick and Disabled Persons Act 1970** Section 2 (1) to assist in arranging provision of services for adults and children who are Visually Impaired, Hearing Impaired and for Dual Sensory Loss (Deafblind)

- **The Disabled Persons (Services, Consultation and Representation) Act 1986** including representations, consultation and assessment of need and provision of information on services for adults and children who are Severely Sight Impaired (Blind), Sight Impaired (partially sighted) and deafblindness with their Associated Disabilities where applicable. (As at 1st January 1992 Sections 4, 5, 6, 8, 9, 10 and 11 have been implemented).

- **The Care Act 2014** stipulates the following:

  For people who are partially sighted or blind

  1) Prevent, reduce or delay needs (including rehabilitation)
  - Provide minor aids and adaptations up to £1,000 free of charge for the purpose of assisting with nursing at home or aiding daily living.
  - Offer rehabilitation for blind and partially sighted people, which should not be limited to six weeks and should be provided irrespective of a person's eligible needs.
  - When designing services, develop a local approach and understand and plan for local needs.

  2) Assessment and Eligibility
  - Any self-assessment will have to be provided in an accessible format.
  - Assessments must be carried out by a person who has the necessary skill, knowledge and competency.

  3) Information and Advice
  - Have due regard for the needs of people with a visual impairment in the provision of information and advice services.

  4) Charging
  - It is recommended that rehabilitation is not charged beyond six weeks due to the clear benefits it has on preventing care needs and delaying hospital admissions.

  5) Registers
  - Maintain registers for the blind and partially sighted people.
  - Make contact with an individual within two weeks of the CVI (Certificate of Visual Impairment) being issued.

For people who are deaf or deaf blind

- Identify, make contact with and keep a record of deafblind people in their catchment area (including those who have multiple disabilities including dual sensory impairment);

- Ensure that when an assessment is required or requested, it is carried out by a specifically trained person/team, equipped to assess the needs of a deafblind person - in particular to assess need for one-to-one human contact, assistive technology and rehabilitation;

- Ensure services provided to deafblind people are appropriate, recognising that they may not necessarily be able to benefit from mainstream services or those services aimed primarily at blind people or deaf people who are able to rely on their other senses;

- Ensure that deafblind people are able to access specifically trained one-to-one support workers if they are assessed as requiring one;

- Provide information about services in formats and methods that are accessible to deafblind people; and

- Ensure that one member of senior management includes, within his/her responsibilities, overall responsibility for deafblind services.

Children

NHS Newborn Hearing Screening Protocol says that new born babies identified as deaf must be notified by Health to the Council's specialist teacher team (STT) for post-diagnosis follow-up. A Teacher of the Deaf is required to phone the family within 24 hours and arrange a home visit.

SEN Code of Practice 2014 (6.34) requires the provision of specialist support and/or equipment to enable children with special educational needs to access their learning, or rehabilitation support. It recognises that some children and young people require special educational provision because they have a disability which prevents or hinders them from making use of the educational facilities generally provided. These difficulties can be age related and may fluctuate over time. Funding specialist equipment for children 0-4 years and pupils in schools is generally provided by the Local Authority from different budgets.

Service delivery

The service which is currently being provided undertakes the following activities:

- Assess need and produce support plans;
- Set up and maintain homes/tenancies;
- Support home management and life skills;
- Provide general support and promote well-being;
- Deliver advice, advocacy and liaison.

The service currently delivers the following outcomes:

- Build confidence and self-esteem;
- Develop communication skills;
- Promote independent skills;
- Develop mobility skills.
- It also currently provides people with more opportunities to gain employment and/or access education.

Both activities and outcomes are subject to refinement following stakeholder engagement and the development of the procurement and contract documentation.

The Invitation to Tender Document will include the following:

- A revised specification incorporating the recommendations made in the 2014 Service Performance Analysis Review; subsequent service user/ carer/public engagement/consultation activity; stakeholder interviews; benchmarking; strategic drivers and legislative guidance
- A specification that is clear in scope, interpretation and expectations;
- Feedback from the market and stakeholder consultation;
- Bespoke terms and conditions;
- Appropriate award and evaluation criteria;
- A realistic, appropriate and robust performance management framework; and
- An emphasis on partnership working and effective referral/signposting mechanism.

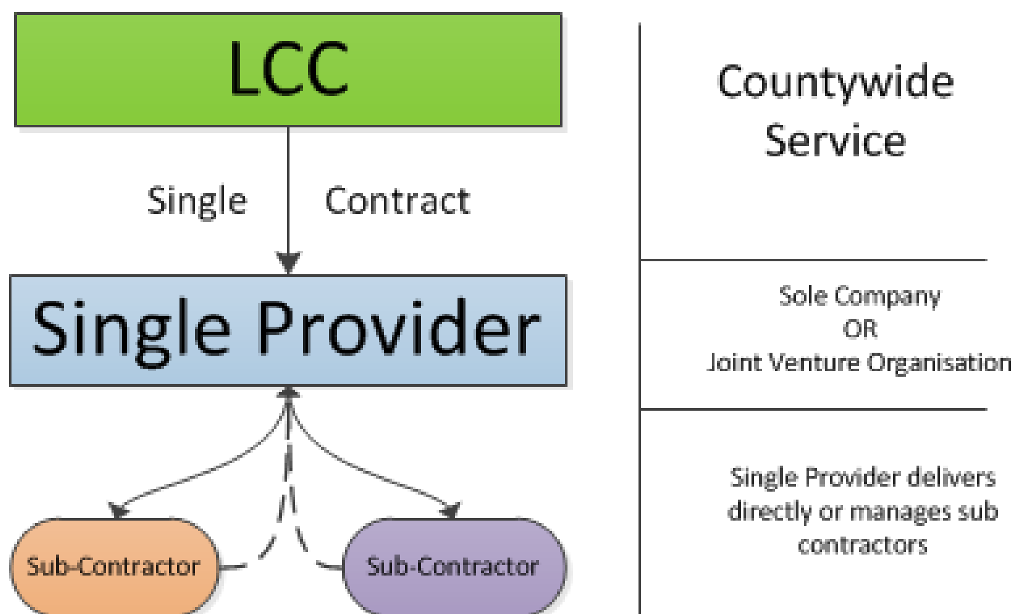
Commercial Model

Contract Structure

Evidence collected on the current service indicates that where provision has taken place it has been to a good standard. The single provider model with an emphasis on delivery of outcomes will help ensure that the future contract is sustainable.

Whilst the Council will be contracting with a single provider, the market engagement has indicated that the delivery model may include partnership or sub contractual arrangements. In this case the single provider will be responsible for the management of all partners or/and subcontractors. The delivery capability and cohesiveness of any proposed partnership arrangement will also form part of the tender evaluation.

Single provider structure



In determining a single provider the service model depends upon a number of factors:

Cost & Duration

A core principle of the Single Provider model is that a commitment of demand creates a strong commercial base for a provider and as such will help support them to deliver better value back to the Council. Similarly by guaranteeing this demand for a long period of time this would further strengthen a provider's ability to establish a sound base of business. This commitment will increase economies of scale for a provider and providers it may wish to sub contract to, as well as allow them to build better business plans, optimise resources, better manage recruitment and the opportunity to plan reablement routes better, thus improving efficiency and lowering costs.

Competition

Exposing the service to the open market will help to encourage improved value for money through quality, innovation, reduction in costs and the added value any potential providers may bring.

Risk and flexibility

In addition to this the Council should also give regard to the resulting balance of risk that follows from awarding the contract to a single provider. The Council will seek assurance and conduct due diligence through its procurement processes to ensure the single provider has the capacity to deliver the volume of hours required in the service specification. These assurances will increase the Council's ability to

manage risk as well as provide greater flexibility of service provision. This factor would also address the Council's requirement under the Care Act to effectively manage the market and address the risks of market failure.

Service User choice

Related to the points already raised the issue of service user choice should be properly considered. The Care Act 2014 states the importance of allowing a recipient of care the ability to make choices about how that care is delivered. The Act does not stipulate anything specific with regard to how any particular commercial arrangement must conform to or support this requirement. By ensuring that there is a stable high performing provider able to deliver the service across the county service users will be better equipped to achieve their chosen outcomes.

Tender process

A key phase in the procurement will be in how organisations are assessed and qualified at the tender stage. As previously stated it is essential that the single provider or any organisation the provider sub contracts work to will be able deliver the required volume and outcomes. The Council must therefore have a clear understanding of the level of financial and business capacity a tenderer must have before being allowed to proceed to bid. This must be set at a level that represents an acceptable assessment of the level of risk as well as not being unreasonably burdensome and therefore restricting consortia bids.

The Procurement is being undertaken in accordance with regulations 74 to 76 of the Public Contract Regulations 2015 under "Light Touch Regime" utilising an Open Procedure method. The ultimate decision as to which provider is awarded the single provider status will be based on their evaluation performance.

ITT evaluation will focus on service quality and the capability of the single provider and any organisations they may wish to form sub contracting arrangements with to deliver the required volume and quality outcomes across the county set against clearly defined financial budgetary controls.

Scope

It is intended that the resulting contractual arrangements of this procurement exercise will provide the following :

- A countywide Service with a single point of access for both children and adults with a sensory impairment.

- A Service that will ensure that there is a planned approach to working with relevant professionals and partner agencies with contractual mechanisms in place to facilitate and enable joint working including regular liaison, information sharing, and the development of joint working protocols.

- A Service that is both flexible and responsive to service user needs.

- A Service that will be delivered with the aim of promoting personalisation and enhancing quality of life for service users and carers.

- A Service that will focus on maximising and sustaining Service Users' choice, involvement and inclusion through the use of outcome-focused quality Support Plans, and person-centred approaches that facilitate opportunities to live fulfilled lives within a community setting.

- A Service Provider who will ensure that the service is designed to address the needs of individual service users via the achievement of identified outcomes in their Support Plan.

- A Service Provider who will meet the specific needs of people with a sensory impairment whilst maximising the use of mainstream resources.

- A Service Provider whom will work in partnership with family carers/supporters of the Service Users.

- A Service Provider whom will value difference and will respect, support, and meet the needs and preferences of people with a learning disability, whatever their: disability, ethnicity, age, gender, sexual orientation (and identity), religion or belief).

- An affordable service that meets the Council's obligations in carrying it's duties to those with sensory impairment.

Market Engagement and Feedback

A Prior Information Notice was published on 15 July 2015. This initiated a process of pre-tender market engagement. Feedback gained from this process has provided an understanding of the market's preferred approach to a number of important issues impacting on the commercial model, including the contract duration, market capacity, budget viability, performance management and pricing structure, and contract mobilisation.

The results of this engagement exercise are summarised below:

- The contract duration proposed of 3 +1+1 was acceptable to all.
- The single provider model will more likely have to involve a partnership of providers in order to deliver the whole sensory impairment service on a countywide basis.
- Whilst the providers were not keen on a payment by results mechanism they were open to some incentives but believe the block contract payment allows for increased flexibility and innovation.
- Providers were accepting of key performance indicators but would like the option of these being adaptable, relevant and responsive to the changes in the Service.
- It is proposed that the payment structure could be modelled in a similar way to that of reablement whereby five percent of the budget is allocated to a

bonus for over performance. This would however also be applied as a Service Credit if the provider under performed.

- In terms of contract mobilisation whilst three months would have been preferred, two months is viable.

Procurement implications

The Procurement is being undertaken in accordance with regulations 74 to 76 of the Public Contract Regulations 2015 under "Light Touch Regime" utilising an Open Procedure method.

It is the intention to issue a OJEU Notice for publication on 22 October 2015 and a Contract Award Notice will be issued on any award to a successful bidder.

In undertaking the procurement the Council will ensure the process utilised complies fully with the EU Treaty Principles of Openness, Fairness, Transparancy and Non-discrimination.

The procurement process shall conform with all information as published and set out in the OJEU Notice.

All time limits imposed on bidders in the process for responding to the OJEU Notice and Invitation to Tender will be reasonble and proportionate.

Public Services Social Value Act

In January 2013 the Public Services (Social Value) Act came into force. Under the Act the Council must before starting the process of procuring a contract for services consider two things. Firstly, how what is proposed to be procured might improve the economic social and environmental wellbeing of its area. Secondly, how in conducting the process of procurement it might act with a view to securing that improvement. The Council must only consider matters that are relevant to the services being procured and must consider the extent to which it is proportionate in all the circumstances to take those matters into account. In considering this issue the Council must be aware that it remains bound by EU procurement legislation which itself through its requirement for transparency, fairness and non-discrimination places limits on what can be done to achieve these outcomes through a procurement.

Ways will be explored of securing social value through the way the procurement is structured. The operation of sub-contracting and consortium arrangements will be explored as a means of ensuring a role for local small to medium-sized enterprises (SMEs) in the delivery of the services. Evaluation methodologies will be explored so as to incentivise the delivery of a skilled and trained workforce.

Under section 1(7) of the Public Services (Social Value) Act 2012 the Council must consider whether to undertake any consultation as to the matters referred to above. The service and the value it delivers is well understood. Best practice recently adopted elsewhere has been reviewed. This and the market and other stakeholder consultation, including Service Users, carried out is considered to be

sufficient to inform the procurement. It is unlikely that any wider consultation would be proportionate to the scope of the procurement.

Equality Act 2010

The Council's duty under the Equality Act 2010 needs to be taken into account by the Executive Councillor when coming to a decision.

Section 149 of the Equality Act 2010:
The Council must, in the exercise of functions, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: Equality Act.

Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

- Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low;
- The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities;
- Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding.

- Compliance with the duties in this section may involve treating some persons more favourably than others.

The relevant protected characteristics are:

i. Age
ii. Disability
iii. Gender reassignment
iv. Marriage and civil partnership
v. Pregnancy and maternity
vi. Race
vii. Religion or belief
viii. Sex
ix. Sexual orientation

A reference to conduct that is prohibited by or under this Act includes a reference to:

i. A breach of an equality clause or rule
ii. A breach of a non-discrimination rule

Decision makers duty under the Act:
It is important that the Executive Councillor is aware of the special duties owed to persons who have a protected characteristic as the duty cannot be delegated and must be discharged by the decision maker. The duty applies to all decisions taken by public bodies including policy decisions and decisions on individual cases and includes this decision.

The key purpose of the service is to enable all those individuals who require sensory impairment services to live more independent and healthier lives. In that sense the delivery of the service helps to advance equality of opportunity. The providers' ability to provide services which advance equality of opportunity will be considered in the procurement and providers will be obliged to comply with the Equality Act.

To discharge the statutory duty the Executive Councillor must consider the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process.

An Impact Assessment has been completed for the sensory impairment service reprocurement which addresses the risk of adverse impact on service users which can be found as Appendix B.

A change of provider will impact on persons with a protected characteristic arising out of the employment impact on staff. The staff employed by the current provider will be affected by the termination of the current grant agreement. Mitigating factors will relate to the legal protections that will be in place through TUPE and general employment laws. The contract that will be entered into will also contain clauses requiring the contractor to comply with the Equality Act.

In these circumstances it is open to the Executive Councillor to conclude that having considered the duty it considers that if appropriate steps are taken to keep matters under review and address issues as they arise through the procurement process that any potential there is for differential impact or adverse impact can be mitigated.

Child Poverty Strategy

The Council is under a duty in the exercise of its functions to have regard to its Child Poverty Strategy. Child poverty is one of the key risk factors that can negatively influence a child's life chances. Children that live in poverty are at greater risk of social exclusion which, in turn, can lead to poor outcomes for the individual and for society as a whole.

In Lincolnshire we consider that poverty is not only a matter of having limited financial resources but that it is also about the ability of families to access the means of lifting themselves out of poverty and of having the aspiration to do so. The following four key strategic themes form the basis of Lincolnshire's Child Poverty Strategy: Economic Poverty, Poverty of Access, Poverty of Aspiration and Best Use of Resources.

The Child Poverty Strategy has been taken into account in this instance and the specific nature of the services to be provided under the proposed contracts are relevant as a small proportion of care activity will be delivered to children with sensory impairment which supports the key theme of Poverty of Aspiration within the strategy by increasing as much is as possible the access to services to Children with sensory impairment.

Wellbeing Strategy

The Council is under a duty in the exercise of its functions to have regard to its Joint Strategic Needs Assessment (JSNA) and its Joint Health and Wellbeing Strategy (JHWS).

The JSNA for Lincolnshire is an overarching needs assessment. A wide range of data and information was reviewed to identify key issues for the population to be used in planning, commissioning and providing programmes and services to meet identified needs. This assessment underpins the JHWS 2013-18 which has the following themes:-

i. Promoting healthier lifestyles
ii. Improving the health and wellbeing of older people
iii. Delivering high quality systematic care for major causes of ill health and disability
iv. Improving health and social outcomes and reducing inequalities for children
v. Tackling the social determinants of health

Under the strategic theme of improving the health and wellbeing of people in Lincolnshire as Sensory Impairment generally comes as a result of old age but also due to conditions from birth, there are three priorities that are relevant:

- Spend a greater proportion of our money on helping older people and children to stay safe and well at home

- Develop a network of services to help older people and children lead a more healthy and active life and cope with the challenges of living with sensory impairments

- Increase respect and support for older people and children within their communities

The Sensory Impairment Service will contribute directly to these priorities.

2. Conclusion

Lincolnshire County Council has a statutory responsibility to provide Sensory Impairment Services for residents of Lincolnshire. As demonstrated within this paper, evidence suggests that due to demographic profiling, and the prevalence of age related Sensory Impairments, there will inevitably be an increase in demand for this service in the future.

Through undertaking a procurement exercise for Sensory Impairment Services the Council will improve service quality and ensure value for money.

The focus of the procurement will be to establish a single provider for the county that will be able to fully meet the quality requirements set out by the council, guarantee that they are able to properly meet demand within budget and manage the subcontractor market effectively if appropriate.

3. Legal Comments:

The Council has the power to procure the services proposed in the manner proposed. If the recommendation was not followed, other means would need to be identified of meeting the Council's statutory responsibilities as referred to in the Report.

The other legal issues relevant to the decision and which the Executive Councillor must take into account in reaching that decision are set out in the body of the Report.

The decision is consistent with the Policy Framework and within the remit of the Executive Council as long as it is within the budget.

4. Resource Comments:

A key requirement is to ensure adequate budget provision exists to fund the proposed service/contract and this has been confirmed by all of Adult Care, Childrens Services and Public Health. The proposal to deliver the contract though a single provider should help deliver best value in addition to enhancing services through greater integration with Health.

5. Consultation

a) Has Local Member Been Consulted?

Yes

b) Has Executive Councillor Been Consulted?

Yes

c) Scrutiny Comments

This report was considered by the Adults Scrutiny Committee on 9 September 2015. The comments of the Committee will be reported to the Executive Councillor prior to reaching her decision

d) Policy Proofing Actions Required

Dealt with in the body of the report and Appendix A.

6. Background Papers

The following background papers as defined in the Local Government Act 1972 were relied upon in the writing of this report.

Document title	Where the document can be viewed
The Care Act 2014	Legal Services

This report was written by Clair McNally and Marie Kaempfe-Rice, who can be contacted on 01522 552778 or 01522 554087 Clair.McNally@lincolnshire.gov.uk / Marie.Kaempfe-Rice@lincolnshire.gov.uk

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Equality Impact Analysis to enable informed decisions

The purpose of this document is to:-

I. help decision makers fulfil their duties under the Equality Act 2010 and
II. for you to evidence the positive and adverse impacts of the proposed change on people with protected characteristics and ways to mitigate or eliminate any adverse impacts.

Using this form
This form must be updated and reviewed as your evidence on a proposal for a project/service change/policy/commissioning of a service or decommissioning of a service evolves taking into account any consultation feedback, significant changes to the proposals and data to support impacts of proposed changes. The key findings of the most up to date version of the Equality Impact Analysis must be explained in the report to the decision maker and the Equality Impact Analysis must be attached to the decision making report.

****Please make sure you read the information below so that you understand what is required under the Equality Act 2010****

Equality Act 2010
The Equality Act 2010 applies to both our workforce and our customers. Under the Equality Act 2010, decision makers are under a personal duty, to have due (that is proportionate) regard to the need to protect and promote the interests of persons with protected characteristics.

Protected characteristics
The protected characteristics under the Act are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Section 149 of the Equality Act 2010
Section 149 requires a public authority to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by/or under the Act
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not share those characteristics
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The purpose of Section 149 is to get decision makers to consider the impact their decisions may or will have on those with protected characteristics and by evidencing the impacts on people with protected characteristics decision makers should be able to demonstrate 'due regard'.

Decision makers duty under the Act

Having had careful regard to the Equality Impact Analysis, and also the consultation responses, decision makers are under a personal duty to have due regard to the need to protect and promote the interests of persons with protected characteristics (see above) and to:-

(i) consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms,
(ii) remove any unlawful discrimination, harassment, victimisation and other prohibited conduct,
(iii) consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics,
(iv) consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Conducting an Impact Analysis

The Equality Impact Analysis is a process to identify the impact or likely impact a project, proposed service change, commissioning, decommissioning or policy will have on people with protected characteristics listed above. It should be considered at the beginning of the decision making process.

The Lead Officer responsibility

This is the person writing the report for the decision maker. It is the responsibility of the Lead Officer to make sure that the Equality Impact Analysis is robust and proportionate to the decision being taken.

Summary of findings

You must provide a clear and concise summary of the key findings of this Equality Impact Analysis in the decision making report and attach this Equality Impact Analysis to the report.

Impact – definition

An impact is an intentional or unintentional lasting consequence or significant change to people's lives brought about by an action or series of actions.

How much detail to include?

The Equality Impact Analysis should be proportionate to the impact of proposed change. In deciding this asking simple questions "Who might be affected by this decision?" "Which protected characteristics might be affected?" and "How might they be affected?" will help you consider the extent to which you already have evidence, information and data, and where there are gaps that you will need to explore. Ensure the source and date of any existing data is referenced.

You must consider both obvious and any less obvious impacts. Engaging with people with the protected characteristics will help you to identify less obvious impacts as these groups share their perspectives with you.

A given proposal may have a positive impact on one or more protected characteristics and have an adverse impact on others. You must capture these differences in this form to help decision makers to arrive at a view as to where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable then it must be clearly justified and recorded as such, with an explanation as to why no steps can be taken to avoid the impact. Consequences must be included.

Proposals for more than one option If more than one option is being proposed you must ensure that the Equality Impact Analysis covers all options. Depending on the circumstances, it may be more appropriate to complete an Equality Impact Analysis for each option.

The information you provide in this form must be sufficient to allow the decision maker to fulfil their role as above. You must include the latest version of the Equality Impact Analysis with the report to the decision maker. Please be aware that the information in this form must be able to stand up to legal challenge.

Background Information

Title of the policy / project / service being considered	Sensory Impairment services in Lincolnshire re-procurement	Person / people completing analysis	Clair McNally project Manager Adult Care Sue Blakemore Quality and Development Manager
Service Area	Adult Care	Lead Officer	Pete Sidgwick Assistant Director Adult Frailty and Long Term Conditions
Who is the decision maker?	Adults Scrutiny Committee	How was the Equality Impact Analysis undertaken?	Using information which from previous consultation with service users 2014 and other stakeholders. Desk top research and data analysis
Date of meeting when decision will be made	01/09/2015	Version control	V 0.3 August 2015
Is this proposed change to an existing policy/service/project or is it new?	Existing policy/service/project	LCC directly delivered, commissioned, re-commissioned or de-commissioned?	Re-commissioned
Describe the proposed change	1. **Background:** This analysis relates to the re- procurement of the sensory impairment support service in Lincolnshire. The current sensory impairment service has been in place since April 2011 and is delivered by BID services, known locally as SILCS (Sensory Impairment Service for Adults & Children in Lincolnshire). The contract was due to end on 31st March 2014. In 2014 there was a review of the service, which included engagement with people using the current service, and it was recommended and approved that there should be a contract extension for 2 years. As all available opportunities for extension within the contract have been exhausted the existing arrangement will expire on 31st March 2016. This means that there is a requirement to re-procure sensory impairment services in Lincolnshire. 2. **Legal context:**		

Ec

There is a legal duty to provide specialist services to Adult and Children with a sensory impairment and Associated Disabilities under the following legislation:
The National Assistance Act 1948
The Chronically Sick and Disabled Persons Act 1970
The Disabled Persons (Services, Consultation and Representation Act 1986
Section 7 of the Local Authority Social Services Act 1970 and
The Care Act 2014

The current service delivered is a preventative and reablement service for both adults and children with a sensory impairment, both cognitive and acquired and their associated disabilities. The contract includes visual impairment (including blind and partially sighted), hearing impairment (including those who are profoundly deaf, deafened and hard of hearing) and dual sensory impairment (deafblindness).

3. Demographics

The re-procurement of a sensory impairment service in Lincolnshire takes place within the context of the population demographics for the county.

In Lincolnshire there is a continued growth of an aging population, with an associated increasing demands on health and social care services with life expectancy rising for both men and women
.

- The number of people aged 65 and over is projected to increase nationally by 23% from 10.3 million in 2010 to 12.7 million in 2018.
- This trend towards an ageing population profile will continue, with the proportion of people over 75 years of age predicted to increase by 101% between 2012 and 2037 in Lincolnshire
- The largest increase in Lincolnshire has been in the age group 65-69 where the population has risen by approximately 16,000 people between 2003 and 2013; an increase of approximately 45 per cent. The 85+ age group has also changed substantially, with numbers increasing from 13,800 people in 2003 to 19,700 in 2013; an increase of approximately 5,900 (approximately 43%).
- (Source Lincolnshire Observatory population trends 2013)

As part of a review which considered this contract in 2014 independent demographic information was provided by LKRS (May 2014) which indicated the numbers of children and young people and older people living with a visual impairment in Lincolnshire as below

Table 1: Children and Young people living with a visual impairment in Lincolnshire

Age	Number	Proportion of Population	Total number living with VI	Proportion of age group living with VI
0-16	130,475	18.3%	261	0.2%
17-25	75,775	10.6%	152	0.2%
Overall Total	206,250	28.9%	413	0.4%

Table 2 Older People living with a Visual Impairment in Lincolnshire

Age	Number	Proportion of Population	Total number living with VI	Proportion of age group living with VI
65-75	80,273	11.3%	5,177	6.5%
75-84	48,767	6.8%	7,011	14.4%
85 and over	18,811	2.6%	7,682	40.8%
Overall Total	147,851	20.7%	19,870	13.4%

Table 3 Illustrates the number of people classed as "deaf" based on assumptions using data from Action for Hearing 2011 (formerly Royal National Institute for the Deaf)

UK Total Population	UK Total Population Deaf	% Deaf	Lincolnshire Total Population	Approx no. Lincolnshire Total Population Deaf
63,230,000	10,000,000	15.82%	722,705	114,331

Table 4 The table below shows the number of people classed as "profoundly deaf" based on assumptions using data from Action for Hearing 2011 (formerly Royal National Institute for the Deaf)

UK Total Population	UK Total Population Profoundly Deaf	% Profoundly Deaf	Lincolnshire Total Population	Approx no. Lincolnshire Total Population Profoundly Deaf
63,230,000	800,000	1.27%	722,705	9,179

Table 5 This table illustrates estimated numbers of people living with a hearing and visual impairment

UK Total Population	UK Total Deaf/Blind	UK% Deaf Blind (All)	Lincolnshire Total Population	Lincolnshire Total Population Deaf/Blind
63,230,000	356,000	0.56%	722,705	4,047

The predicted levels of physical disability and sensory impairment (source JSNA May 2011) highlight

- Predicted numbers of people aged 18-64 with a moderate or severe physical disability are currently 45,691, rising to 47,344 in 2020 and 47,607 in 2030
- Predicted numbers of people aged 18-64 with a severe visual impairment are currently 272, rising to 276 in 2020 and 279 in 2030
- Predicted numbers of people aged 18-64 with a moderate or severe hearing impairment are currently 18,590, rising to 19,586 in 2020, and dropping to 19,514 in 2030

- Predicted numbers of people aged 18-64 with a profound hearing impairment are currently 170, rising to 184 in 2020 and dropping to 182 in 2030

In Summary

Sensory impairment, in particular hearing impairment is often a hidden disability and its prevalence increases as people get older. Nationally more than 70% of the population over 70 have some form of hearing loss. Likewise the numbers of people with a visual impairment increases with age and the life expectancy rates are rising for both men and women.

Lincolnshire has an increasing ageing population which means the demand for this service is predicted to increase

4. Current activity levels

Although there are projected increases in demand for this service based on demographic information and projections the numbers of people who are currently on the Sensory Impairment Registers maintained by BID services (SILCs) are fewer than anticipated .

Table 6 : illustrates the numbers of people on the Sensory Impairment Registers maintained by BID Services (SILCS)July 2015

Sensory Impairment	Estimated Numbers affected in Lincolnshire	Numbers on Register held by Provider 2014	Percentage on Register	Numbers on Register held by Provider 2015
Visual Impairment	25,080	1,787	7.13%	2,894
Hearing Impairment	114,331	1,846	1.61%	2,521
Dual Sensory Impairment	4,047	313	7.73%	369
Total Figures	143,458	3,946	2.75%	5,784

Table 7: illustrates the numbers of referrals (including self- referrals) since 2011-2015

	2011/12	2012/13	2013/14	2014/15	Total (contract)
No of adult referrals	1082	1287	1207	1032	**4608**
No. of children/young people referrals	49	65	75	102	**291**
Total no. of referrals	1131	1352	1282	1134	**4899**
Actual number of referrals acted upon (due to refusal of service as not eligible)	**1131**	**1268**	**1235**	**1098**	**4732**

The findings of the review of this service which was undertaken in 2014 included service user and stakeholder consultation which was generally positive. Some areas for improvement were also identified which can now be built into this re-procurement exercise as it provides an opportunity to make sure the service remains fit for purpose and future proofed in line with the implementation of national and local priorities.

Evidencing the impacts

In this section you will explain the difference that proposed changes are likely to make on people with protected characteristics.
To help you do this first consider the impacts the proposed changes may have on people without protected characteristics before then considering the impacts the proposed changes may have on people with protected characteristics.

You must evidence here who will benefit and how they will benefit. If there are no benefits that you can identify please state 'No perceived benefit' under the relevant protected characteristic. You can add sub categories under the protected characteristics to make clear the impacts. For example under Age you may have considered the impact on 0-5 year olds or people aged 65 and over, under Race you may have considered Eastern European migrants, under Sex you may have considered specific impacts on men.

Data to support impacts of proposed changes

When considering the equality impact of a decision it is important to know who the people are that will be affected by any change.

Population data and the Joint Strategic Needs Assessment

The Lincolnshire Research Observatory (LRO) holds a range of population data by the protected characteristics. This can help put a decision into context. Visit the LRO website and its population theme page by following this link: http://www.research-lincs.org.uk If you cannot find what you are looking for, or need more information, please contact the LRO team. You will also find information about the Joint Strategic Needs Assessment on the LRO website.

Workforce profiles

You can obtain information by many of the protected characteristics for the Council's workforce and comparisons with the labour market on the Council's website. As of 1st April 2015, managers can obtain workforce profile data by the protected characteristics for their specific areas using Agresso.

Positive impacts
The proposed change may have the following positive impacts on persons with protected characteristics – If no positive impact, please state *'no positive impact'.*

Age	• This service is for people with sensory impairment across all age groups. • We know that there are more older people living with sensory impairment (highlighted in the previous section of this document) • This proposal is for the re-procurement of a sensory support service which will provide a continuing service with and is not a reduction or decommissioning of service • The re-procurement exercise will benefit people of all ages who are eligible to access this service as the revised service specification and contract will provide the opportunity make sure it is fit for purpose and in line with current national and local priorities • The re-procurement will provide the opportunity to set out clearer/ increased activity expectations for the service which it is anticipated will have a positive impact across the age groups, in particular for older people where there are the greatest numbers of people with sensory impairment
Disability	• This service is for people with diagnosed sensory impairment and therefore it will affect people with those impairments • The estimated numbers of people with a sensory impairment in Lincolnshire are • Visual impairment 25,080 • Hearing impairment 114,331 • Dual sensory impairment 4,047 • Total 143,458 (source Sensory Impairment Registers SILCS July 2015) • The re-procurement exercise will benefit people of all ages who are eligible to access this service as the revised service specification and contract will provide the opportunity make sure it is fit for purpose and in line with current national and local priorities • The re-procurement will provide the opportunity to set out clearer/ increased activity expectations for the service which it is anticipated will have a positive impact for people with sensory impairment under the protected characteristics of disability

Gender reassignment	There are no specific positive impacts for people with the protected characteristic of gender res. This service is for people with a sensory impairment regardless of gender reassignment
Marriage and civil partnership	There are no specific positive impacts for people with the protected characteristic of marriage and civil partnership . This service is for people with a sensory impairment regardless of marriage or civil partnership i
Pregnancy and maternity	There are no specific positive impacts for people with the protected characteristic of marriage and civil partnership . This service is for people with a sensory impairment regardless of marriage or civil partnership
Race	• This service is for people with sensory impairment and therefore it will affect people with those impairments regardless of their race. • Desktop research has identified that people from BME groups often have a higher incidence of visual impairment • Currently there is limited information regarding the race of those people with sensory impairment. The award of a new contract with clearer monitoring expectations will improve the information available relating to the protected characteristic of race
Religion or belief	There are no specific positive impacts for people with the protected characteristic of marriage and civil partnership . This service is for people with a sensory impairment regardless of marriage or civil partnership
Sex	• This service is for people with sensory impairment and therefore it will affect people with those impairments regardless of their sex • Because of the longer life expectancy of females it is estimated that more women may benefit from this service as sensory impairment increases with age • The re-procurement exercise will benefit people of all ages who are eligible to access this service as the revised service specification and contract will provide the opportunity make sure it is fit for purpose and in line with current national and local priorities • The re-procurement will provide the opportunity to set out clearer/ increased activity expectations for the service which it is anticipated will have a positive impact for people with sensory impairment under the protected characteristics of sex •

Sexual orientation	There are no specific positive impacts for people with the protected characteristic of sexual orientation . This service is for people with a sensory impairment regardless of sexual orientation

If you have identified positive impacts for other groups not specifically covered by the protected characteristics in the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Adverse/negative impacts
You must evidence how people with protected characteristics will be adversely impacted and any proposed mitigation to reduce or eliminate adverse impacts. An adverse impact causes disadvantage or exclusion. If such an impact is identified please state how, as far as possible, it is justified; eliminated; minimised or counter balanced by other measures.
If there are no adverse impacts that you can identify please state 'No perceived adverse impact' under the relevant protected characteristic.

Negative impacts of the proposed change and practical steps to mitigate or avoid any adverse consequences on people with protected characteristics are detailed below. If you have not identified any mitigating action to reduce an adverse impact please state *'No mitigating action identified'*.

Age	• The re-procurement of this service is for people with sensory impairment and therefore it will affect people with those impairments regardless of age • Although the re-procurement exercise is to recommission a service not decommission , and there are anticipated benefits of a revised service specification and contract including improved service delivery levels It is acknowledged that service users who are currently using the service may have concerns about any potential changes as a result of this exercise . • We know that the greatest proportion of current service users are older adults • Mitigation : the re-procurement timescales will includes a planned transition period and plan which will include clear and accessible communication considerations for service users •
Disability	• This service is for people with sensory impairment which is a protected characteristic of disability • Although the re-procurement exercise is to recommission a service not decommission , and there are anticipated benefits of a revised service specification and contract including improved service delivery levels It is acknowledged that service users who are currently using the service may have concerns about any potential changes as a result of this exercise . • We know that the greatest proportion of current service users are those with hearing impairment • Mitigation : the re-procurement timescales will includes a planned transition period and plan which will include clear and accessible communication considerations for service users

Gender reassignment	There are no specific negative impacts for people with the protected characteristic of gender reassignment. This service is for people with a sensory impairment regardless of gender reassignment
Marriage and civil partnership	There are no specific negative impacts for people with the protected characteristic of marriage and civil partnership. This service is for people with a sensory impairment regardless of marriage or civil partnership
Pregnancy and maternity	There are no specific negative impacts for people with the protected characteristic of pregnancy and maternity. This service is for people with a sensory impairment regardless pregnancy or maternity
Race	There are no specific negative impacts for people with the protected characteristic of race . This service is for people with a sensory impairment regardless of race
Religion or belief	There are no specific negative impacts for people with the protected characteristic of marriage religion or belief. This service is for people with a sensory impairment regardless of religion or belief
Sex	• This service is for people with sensory impairment and therefore it will affect people with those impairments and include the protected characteristic of sex • Although the re-procurement exercise is to recommission a service not decommission , and there are anticipated benefits of a revised service specification and contract including improved service delivery levels It is acknowledged that service users who are currently using the service may have concerns about any potential changes as a result of this exercise . • We know that the greatest proportion of current older service users a re likely to be women • Mitigation : • The feedback from service user has informed the procurement exercise and is continuing to feed into the service specification development • The re-procurement timescales will includes a planned transition period and plan which will include clear and accessible communication considerations for service users

Sexual orientation	There are no specific negative impacts for people with the protected characteristic of sexual orientation . This service is for people with a sensory impairment regardless of sexual orientation

If you have identified negative impacts for other groups not specifically covered by the protected characteristics under the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Stakeholders

Stake holders are people or groups who may be directly affected (primary stakeholders) and indirectly affected (secondary stakeholders)

You must evidence here who you involved in gathering your evidence about benefits, adverse impacts and practical steps to mitigate or avoid any adverse consequences. You must be confident that any engagement was meaningful. The Community engagement team can help you to do this and you can contact them at consultation@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place by stating who you involved when compiling this EIA under the protected characteristics. Include organisations you invited and organisations who attended, the date(s) they were involved and method of involvement i.e. Equality Impact Analysis workshop/email/telephone conversation/meeting/consultation. State clearly the objectives of the EIA consultation and findings from the EIA consultation under each of the protected characteristics. If you have not covered any of the protected characteristics please state the reasons why they were not consulted/engaged.

Objective(s) of the EIA consultation/engagement activity
This EIA relates to re- procurement of the sensory impaired services .This service is for people who share the protected characteristic of disability (sensory impairment) and includes children and young people and older people. Prior to this exercise the review of this service in 2014, ahead of the recommendation and approval of an extension of the current contract until 31st March 2016, included service users and stakeholder consultation. This included seeking the views of people in receipt of this service including parents of young children. People were invited to attend a service user consultation event in May 2014 and /or return a service user feedback survey. There was a 17% response rate. As part of the re-procurement exercise further work is currently being undertaken with stakeholders to inform the development of the service specification. This has included Interviews with parents of those who have children who are hearing impaired , all mothers interviewed

1 interview undertaken with mother of a Boy with hearing impairment – 3 years of age
2 interviews undertaken with mothers of Girls with hearing impairments – both 4 years of age

Appendix 3 Plan on a page Sensory Impairr

The attachment sets out the current engagement activity to inform the service specification

Who was involved in the EIA consultation/engagement activity? Detail any findings identified by the protected characteristic

Age	The results of the consultation exercise for the review in 2014 provided the following findings. It has not been possible to break this information down further by the protected characteristics of age, sex and disability • 95% of service users confirmed they were satisfied with the service they had received from SILCS • 96% of service users stated that their support worker offered clear advice and support • 91% of service users felt that the SILCS service supported their independence • 14% of service users indicated that they encountered problems with contacting their support worker or the service they received • Almost a quarter of service users completing the Exit Survey were not aware that they could request a review of their support plan at any time • Only 3% of stakeholders are of the opinion that the service has ***not*** improved since SILCS were awarded the contract • 70% of stakeholders feel that SILCS staff have received adequate training/support to be able to deliver the services • 87% of stakeholders believe that the service is currently providing what it should be • There is a lack of awareness amongst service users that the service exists – improved signposting to and promotion of the service needs to be implemented • It has been suggested more resources are needed as there can be delays in delivering services due to the high volume of caseloads that each support worker has • Both SILCS staff and service users believe that a full-time BSL interpreter is needed to assist staff members • It is felt that a continuous support service is needed rather than the current reablement service
Disability	As above
Gender reassignment	

Marriage and civil partnership	
Pregnancy and maternity	
Race	
Religion or belief	
Sex	As above
Sexual orientation	
Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	There is confidence that we have included the views of people with sensory impairment and other stakeholders during the review in 2014 and the views of service users continue to be sought to inform the service specification in line with current plan and timelines
Once the changes have been implemented how will you undertake evaluation of the benefits and how effective the actions to reduce adverse impacts have been?	The re-procurement and award of a new contract and service specification will be subject to improved contract monitoring and management arrangement including a greater emphasis on equality monitoring information

Further Details

Are you handling personal data?	No If yes, please give details.

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Actions required Include any actions identified in this analysis for on-going monitoring of impacts.	**Action**	**Lead officer**	**Timescale**
	A clear and accessible communication plan in place for existing service users to make sure they are informed and understand any changes as part of the re-procurement exercise	Clair Mcnally Project Manager Adult Carec	To re-procurement timescales re-procurement timeframes
Signed off by		**Date**	26/08/2015

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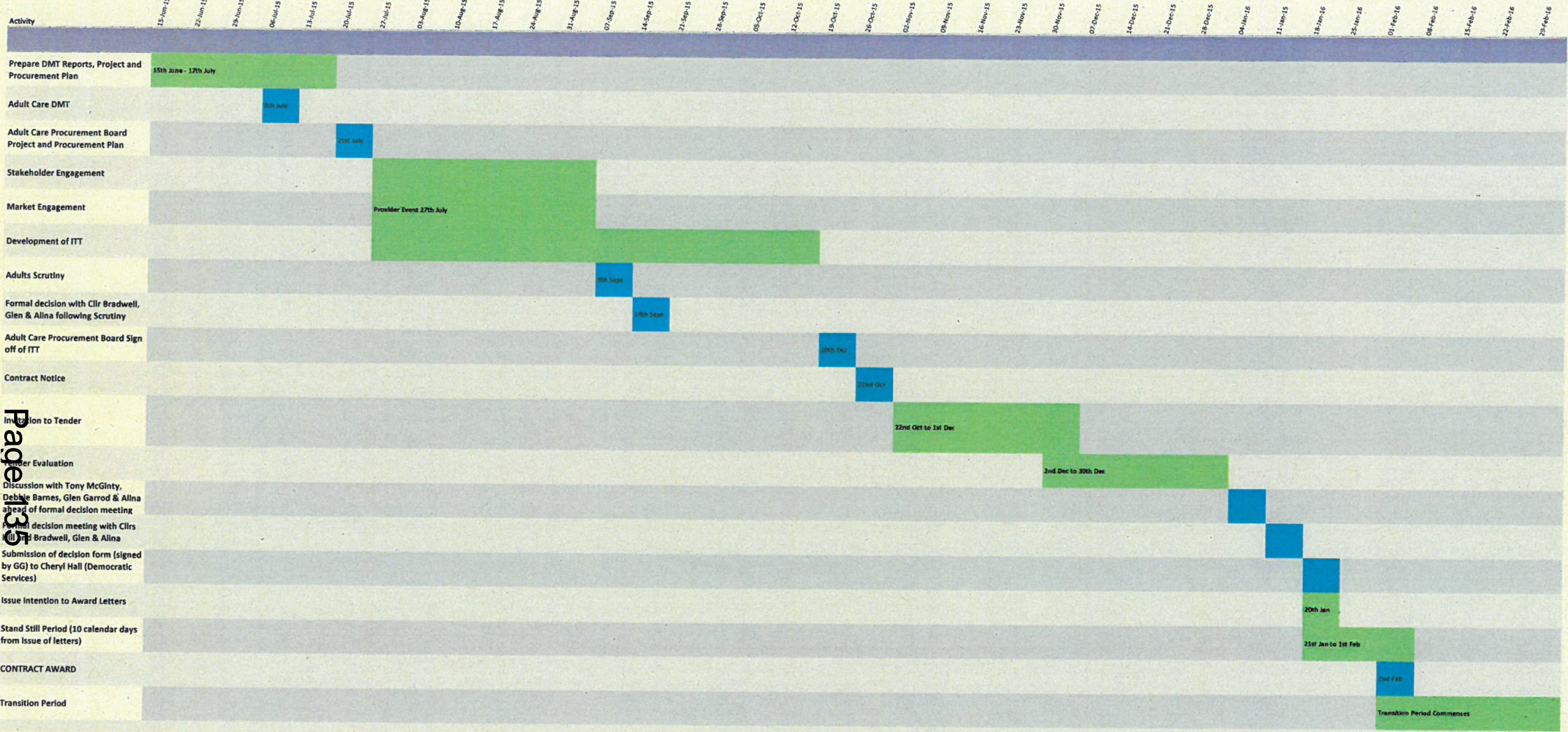
Sensory Impairment Procurement Timeline



Please note
Darker blue represents meetings where a decision is required.

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Open Report on behalf of the Director of Adult Social Services and the Chief Information and Commissioning Officer

Report to:	**Adults Scrutiny Committee**
Date:	**9 September 2015**
Subject:	**Adult Care Market Position Statement 2015-2016**

Summary:

This item invites the Adults Scrutiny Committee to note the attached Adult Care Market Position Statement 2015-2016. The document is intended to be public facing and aims to encourage dialogue with the care and support sector.

Actions Required:

To note the online publication of the Adult Care Market Position Statement 2015 - 2016

1. Background

Market Development is a statutory requirement for all Local Authorities following the implementation of the Care Act 2014. Key to this is the development of a Market Position Statement which the guidance states should include information on the local authority's direction of travel, policy intent, key information and statistics on needs, demand and trends, (including for specialised services, personalisation, integration, housing, community services, information services and advocacy, and carers' services).

The Market Position Statement serves as an increasingly important part of the Council's relationship with the care and support sector. The document is a tool which the Council can use to spark debate, encourage new ideas and proposals of how we can design and deliver care and support services differently.

The attached Adult Care Market Position Statement 2015 - 2016 has been compiled by staff across the Adult Care Directorate, obtaining the most up to date and relevant information to help inform the market. The document sets out what the Council aims to achieve, the current financial challenge, commissioning intentions and the types of partners we wish to work with, focusing on quality and the market opportunities for providers.

It is the intention to make the Adult Care Market Position Statement 2015-2016 accessible online, via the Lincolnshire County Council website, in addition to the production of 50 copies, which will be issued to key stakeholders through targeted marketing. This will include, our local health partners, our current and potential providers, the third sector, the Chamber of Commerce, University of Lincolnshire, Council buildings and resource centres.

2. Conclusion

To note the attached Adult Care Market Position Statement 2015 – 2016

3. Consultation

a) Policy Proofing Actions Required

Not Applicable.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Adult Care Market Position Statement 2015 - 2016

5. Background Papers

The following background papers as defined in the Local Government Act 1972 were relied upon in the writing of this report.

Document title	Where the document can be viewed
The Care Act 2014	Legal Services

This report was written by Clair McNally Clair.McNally@lincolnshire.gov.uk and Rebecca Walukiewicz rebecca.walukiewicz@lincolnshire.gov.uk.

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Adult Social Care Market Position Statement

2015 - 2016

Lincolnshire
COUNTY COUNCIL
Working for a better future

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Foreword

"Pressures on the care system are increasing. Providing adequate adult social care poses a significant public service challenge and there are no easy answers.... Need for care is rising while public spending is falling, and there is unmet need. Departments do not know if we are approaching the limits of the capacity of the system to continue to absorb these pressures." (National Audit Office 2014)

The National Audit Office describes a financial landscape that applies in Lincolnshire as elsewhere. However, Lincolnshire County Council (The Council) has prioritised Adult Care and sought to protect services for vulnerable adults as much as possible. This means additional funding for commissioned services has been secured, though The Council recognise the levels of funding available are not ideal. In Lincolnshire The Council are proud of the quality of service provided by independent colleagues and in some measure this is due to the quality of relationship with providers and Lincolnshire Independent Care Association (LINCA). (See page 12).

The Council will continue to prioritise quality and safeguarding and encourage providers to improve consistency and supply of service. We will also continue to find ever more creative ways of improving service and relationships with both other commissioners (such as the NHS) and providers themselves.

The Council recognises that nothing is possible without an adequate supply of good quality, well trained and motivated staff. In particular care workers are a vital component.

The Care Act addresses quality of service, a sustainable mixed market of provision, and an open and constructive dialogue, which The Council will strive to honor.

Cllr Patricia Anne Bradwell

Deputy Leader of the Lincolnshire County Council, Executive Councillor for Adult Care and Health Services, Children Services

The purpose of the Market Position Statement

The Council is committed to stimulating a diverse market and this Market Position Statement (MPS) has been produced to encourage dialogue with current and potential providers of care and support. It will help providers to:

- decide how to respond to the personalisation of social care
- identify tendering opportunities
- develop their services to meet local need and demand

The Council needs to be fully engaged with people who use services, carers, providers and partner agencies about the vision for the future of the local care and support market. Our intention is to build a creative and vibrant market, which promotes independence, choice and control, for people and their carers. The Council is also keen to support providers who work collaboratively to improve the range of services and support on offer.

The MPS should be read in conjunction with the Joint Strategic Needs Assessment, which includes a detailed demography of Lincolnshire.

The Council commissions a range of social care services for adults, but this MPS seeks to highlight those services that are subject to being reviewed or are scheduled for tendering in 2015/16.

The MPS is a dynamic document that will be updated regularly to ensure that emerging policy developments and financial challenges are addressed. The Council will therefore continue to involve and engage existing and potential providers and key stakeholders in the future versions of this document.

Feedback is welcome from providers and other interested parties. If you have any comments about the MPS then please email **commissioningsupport@lincolnshire.gov.uk**.

National developments

The Care Act 2014

The Care Act 2014 is the single biggest legislative change affecting the most vulnerable adults and their carers in more than 50 years. The Care Act 2014 provides the new social policy framework for developing adult care and support into the future. The promotion of people's wellbeing will be at the heart of everything The Council does and the focus will be on all adults needing care and support in Lincolnshire whether they receive care through the Council or are self-funding.

The Care Act 2014 identifies the following duties for local authorities, in relation to prevention, information and market shaping:

- make available, services that help prevent or delay people deteriorating such that they would need on going care and support
- provide information and advice about local care and support services
- support a market that delivers a wide range of sustainable, high quality services accessible to their communities
- consider services that might affect a person's wellbeing

In addition, many other aspects of the Care Act 2014, influence the council's role as a market shaper, such as:

- Personal Budgets recognised in law and Direct Payments must be given if a service user requests them
- creation of a single consistent route for establishing entitlement to public care, and a national eligibility threshold for the statutory needs assessment
- bringing the rights of carers into line with those of the people they care for. Carers will no longer need to be providing a "substantial amount of care on a regular basis" to qualify for an assessment

The Council have calculated that in order to satisfy the duties imposed by the Care Act 2014 an additional £157m will be needed within the first ten years, with £6m required for 2015/16.

The Dilnot Funding Reforms, are expected to come into force in 2016. This will introduce a cap on care costs, so that the maximum anyone will have to pay towards their personal care in their lifetime is £72,000.

Whilst the government has committed to 'fully funding' the Care Act 2014 and subsequent Dilnot Funding Reforms there remain significant gaps in the available intelligence, for example there is no detail about the costs arising from meeting the new duty to prisoners and, although there is an estimated increase in the number of self-funders or carers seeking assessment and support, it is not yet known how many more assessments this will mean. In Lincolnshire, Adult Care supports approximately 6,000 carers but estimate the total eligible carer population is 79,000.

The Care Act 2014 reduces the level of discretion available to Councils to help them manage budget pressures and make necessary savings. For example new national eligibility criteria will apply and opportunities to increase income will, in time, be limited by the consequences of the Dilnot reforms.

The Care Act 2014 presents both commissioners and providers with a new set of challenges, which in turn become opportunities for business development.

Better Care Fund (BCF)

The second national driver with a profound effect upon adult care is the Better Care Fund (BCF). The national allocated budget is £3.8bn with an additional 'top-up' from local systems which makes the total for 2015/16 £5.3bn.

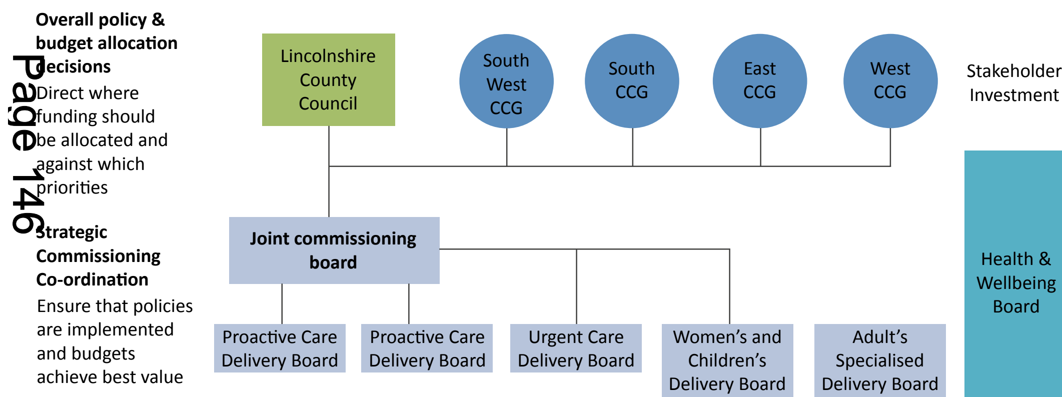
The Better Care Fund is one of several significant policy initiatives for determining future market opportunities. It has been established to support integrated health and care provision with a particular emphasis on preventing, reducing and delaying the need for care to be provided in hospitals unless that is the appropriate setting. BCF spending must be agreed by The Council and the four Lincolnshire Clinical Commissioning Groups (CCG).

In 2015/16 the value of the pooled fund in Lincolnshire will reach £197.3m, demonstrating the potential for market growth and diversification and our collective ambition to integrate services.

Local Developments – Health and Social Care Integration

The Council continues to work proactively with key partners across Lincolnshire, including the four Clinical Commissioning Groups and the three NHS provider trusts, (United Lincolnshire Hospital Trust, Lincolnshire Community Health Service and Lincolnshire Partnership Foundation Trust). Together, we are working to integrate services, improve outcomes and minimize cost, whilst improving service design and delivery. This work is overseen by a Joint Commissioning Board that advises the Lincolnshire Health and Wellbeing Board as demonstrated in figure 1.

Figure 1: Demonstrates the health and social care governance in Lincolnshire



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Lincolnshire Health and Wellbeing Board

The Health and Social Care Act 2012 established Health and Wellbeing Boards. The Board is a forum for health and care leaders to work together to improve the health and wellbeing of their local population, reduce health inequalities, and work on integrating the health and social care system through a joint Health and Wellbeing Strategy. Lincolnshire Health and Wellbeing Board meet a minimum of four times per year. All formal meetings are open to the public to attend as observers.

Lincolnshire Health and Care

Lincolnshire Health and Care (LHAC) began as a result of health and social care organisations in Lincolnshire who recognized that current services did not adequately meet the needs of local people or have a financially sustainable future. This led to a significant step forward in partnership working to design new models of health and social care.

The development of neighbourhood teams is an important pillar of The Council's work to improve the level of coordination between health and care professionals in supporting vulnerable adults in local communities. There are currently eight neighbourhood teams in Lincolnshire, with plans to introduce more in 2015, leading to twelve in total covering the whole county. These teams continue to evolve and represent a clear intent to bring services closer together for the benefit of local communities.

Integrated Personal Commissioning and Direct Payments

Lincolnshire has been chosen by NHS England as one of nine areas in the Country, (called 'demonstrator sites') where a new system for combining health and social care funding the Integrated Personal Commissioning Budget (IPCB) is now being developed. The IPCB is an amount of money that a person with both health and social care needs can use to purchase services to improve their health and wellbeing. This proposal gives greater choice and control to adults with profound needs in securing services to better support them at home.

The aim of the programme is that people accessing services, their carers or families have better outcomes and quality of life through greater involvement in their care. People will be able to design their own support around their needs and circumstances.

Direct Payments have been in operation for over ten years and is a precursor to the development of Personal Health Budgets and Integrated Personal Commissioning. There is clear evidence that where people have greater choice over their care, who provides it and when, they have better outcomes and feel more in control. The Council is committed to increasing the provision of Direct Payments and fully supports the integrated personal commissioning agenda.

Local Context

The county of Lincolnshire is situated in the east of England and is the fourth largest county in England. The population of Lincolnshire is one of the most dispersed in the country and this represents one of the biggest challenges in providing a consistent range of quality services.

Lincolnshire is made up of, seven district councils (figure 2), four clinical commissioning groups and three NHS provider trusts. This makes the local context particularly challenging given the need to work collectively in securing the most cost effective and high quality services at a time of severe financial constraints.

Figure 2: Map of Lincolnshire with districts

The population of Lincolnshire is currently estimated to total 724,500 people, however, the GP registered population is approximately 764,325 people. Figure 3 shows the number of people The Council supports of those registered and the expenditure for 2013/14.

In Lincolnshire 12% of the population (using the Indices of Multiple Deprivation 2010) is living within the 20% of the most deprived areas in England compared with 11% in 2007. 18% of Lincolnshire live in England's least (20%) deprived areas and 70% live in the middle (figure 4). The most deprived Lower Level Super Output Area (LLSOA) in Lincolnshire is in Lincoln. This is now the 132nd most deprived in England, out of 32,482 LLSOAs.

Figure 3 : Lincolnshire Clinical Commissioning Group (CCG) Registered Population and the number of people supported by The Council 2013/14

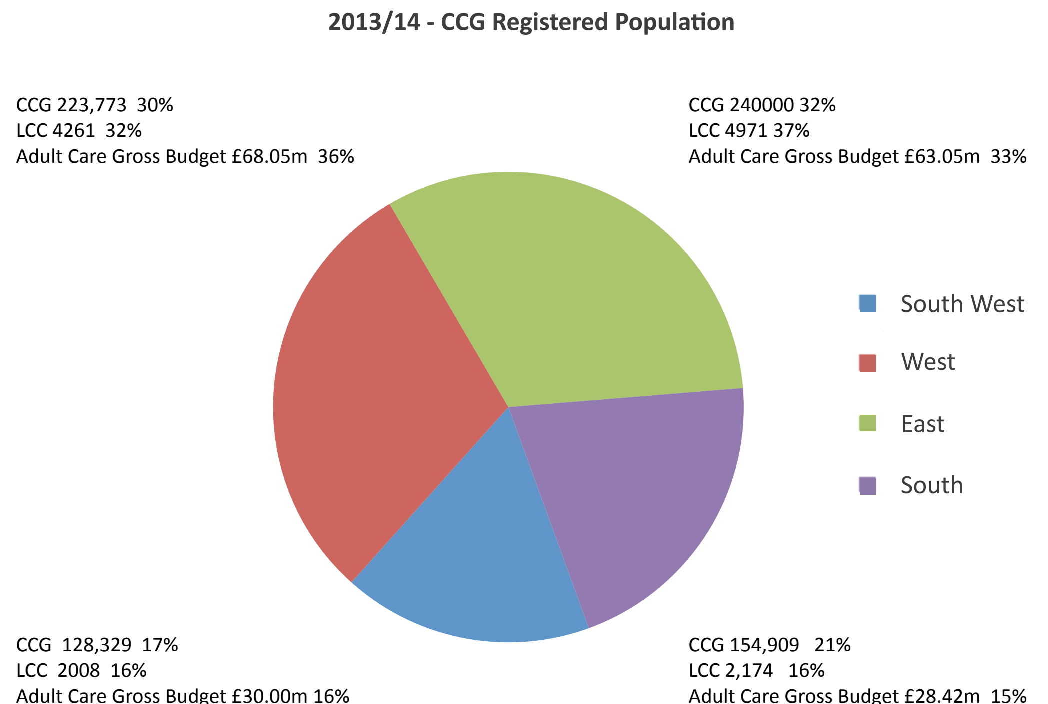
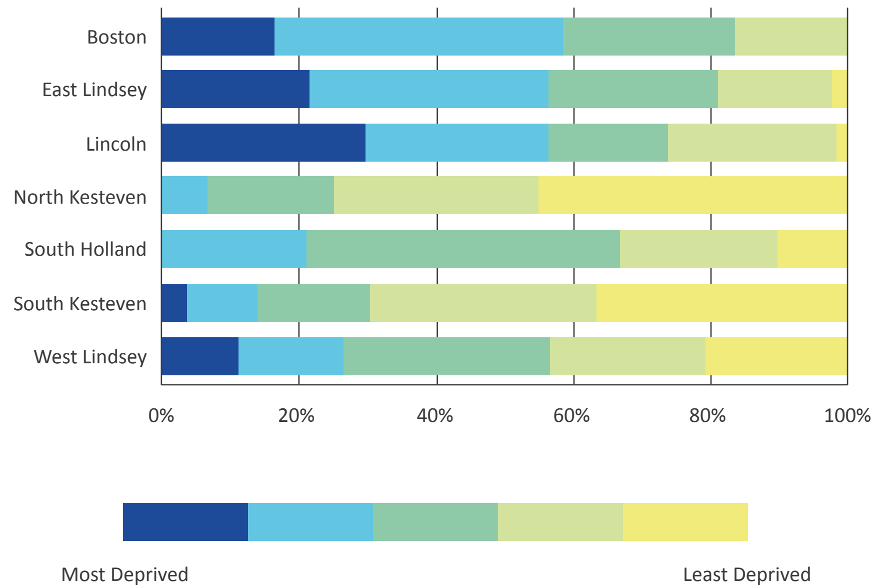


Figure 4: Deprivation in Lincolnshire by district compared to England



Current and future demand for Adult Care Services

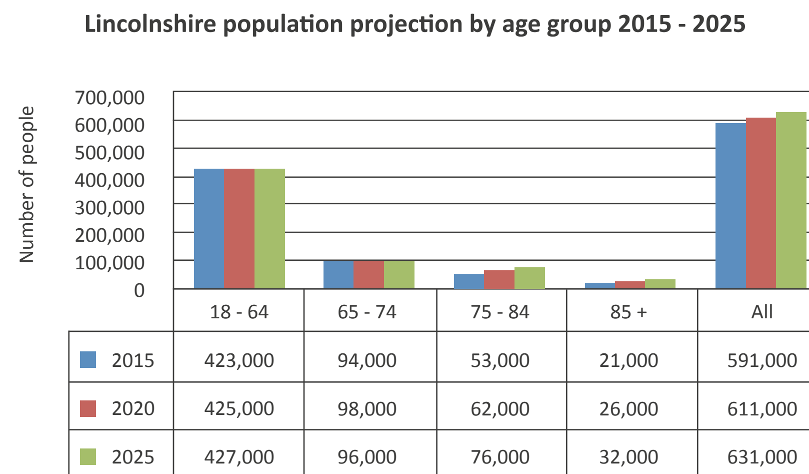
A large proportion of the most vulnerable adults and older people in our communities have needs that are becoming more complex, more demanding and more expensive to support. There are more people coming into the county who are legally entitled to care and support through ordinary residence rules (estimated to cost £450,000pa) and, more young people coming through with profound needs that will live longer than before.

Counties such as Lincolnshire have a higher percentage of older people with care needs, as people choose counties like Lincolnshire to retire. According to the County Council Network (CCN) counties such as Lincolnshire have on average 20% over 65s, 9.2% aged over 75 and 2.7% aged over 85. These proportions are significantly higher than the national average and the averages in other parts of the country. (APPGCounty: The State of Counties) the 18+ Lincolnshire population estimate for 2015 is 591,000, of which 168,000 are estimated to be over 65 years (figure 5).

It is predicted that the elderly population in Lincolnshire will increase by 3.4% in the next 10 years. The rate of increase in people aged 85+ years is particular pronounced with an expected increase of 52.4%.

According to the Office for National Statistics, East Lindsey has the greatest proportion of the population aged 65 and over in both mid-2012 and mid-2022. The total population of East Lindsey is projected to grow by 5.4% over the 10 years to mid-2022 whereas the population aged 65 and over is projected to grow by 19.7% over the same period.

Figure 5: Lincolnshire population projections by age group



	18 - 64	65 - 74	75 - 84	85 +	All
2015	423,000	94,000	53,000	21,000	591,000
2020	425,000	98,000	62,000	26,000	611,000
2025	427,000	96,000	76,000	32,000	631,000

*Source – 2012 based Subnational Population Projections (Office for National Statistics)

Figure 6 demonstrates the current and potential demand for health and social care services in Lincolnshire for those aged 65+. The demand will be influenced by the potential increase in long term conditions figure 7. According to statistics in Lincolnshire County Council's Short and Long Term (SALT) LTS001a return, over 10,000 people were in receipt of long term support. Nationally, people with more than one long-term condition account for £7 in every £10 spent on health and social care. The average cost per year to the NHS of someone with one long-term condition is approximately £1,000, with the cost of someone with three conditions £8,000. (CountyAPPG: The State of Care in Counties)

Figure 6: Demonstrates key factors that may influence potential changes in demand for health and social care in people aged 65+ living in Lincolnshire

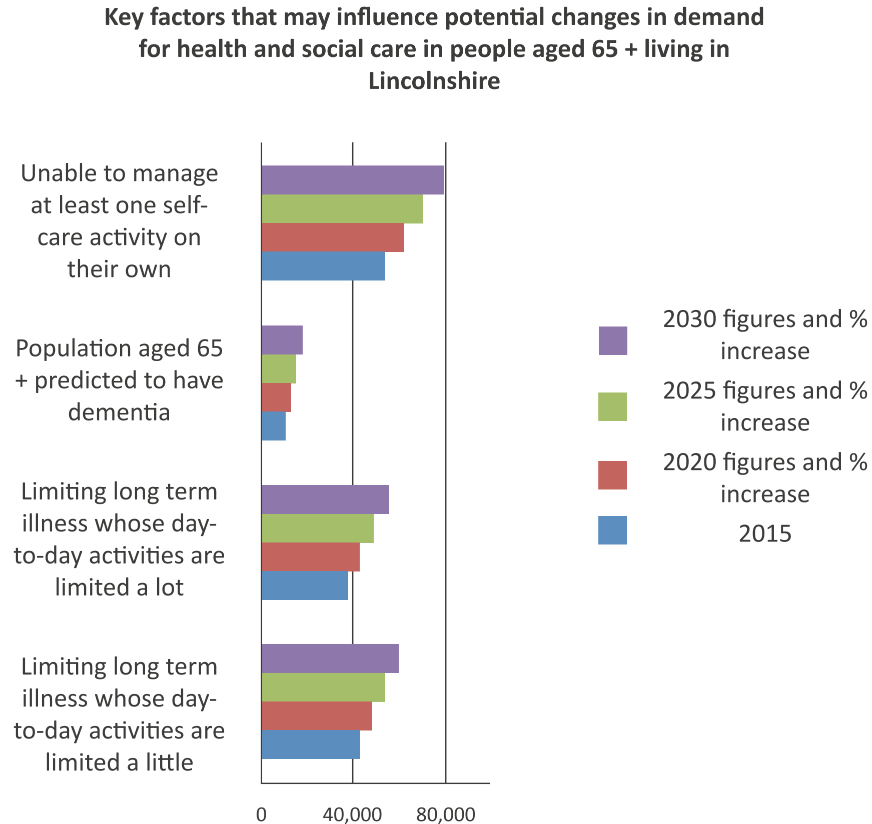
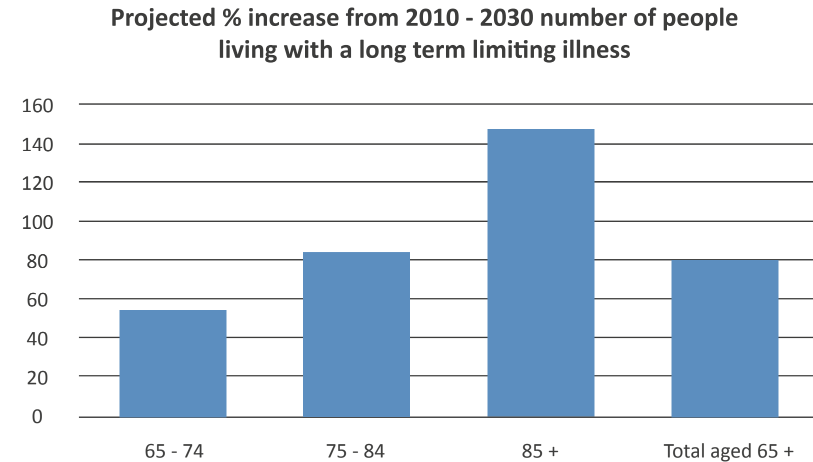


Figure 7: Demonstrates the projected increase between 2010 to 2030 of people aged 65+ living with a long term condition



The current and future demand for services in Residential Care (figure 8), Nursing Care (figure 9), and Community Based Services (figure 10) is set out below. Figure 11 demonstrates the projected change in number of people by service setting and age group. It should be noted, that although predictions can be made, there is an expectation that the Care Act 2014 will have an impact on demand and therefore uptake on services.

Figure 8: Actual and projected number of people in Residential Care in Lincolnshire 2012- 2025

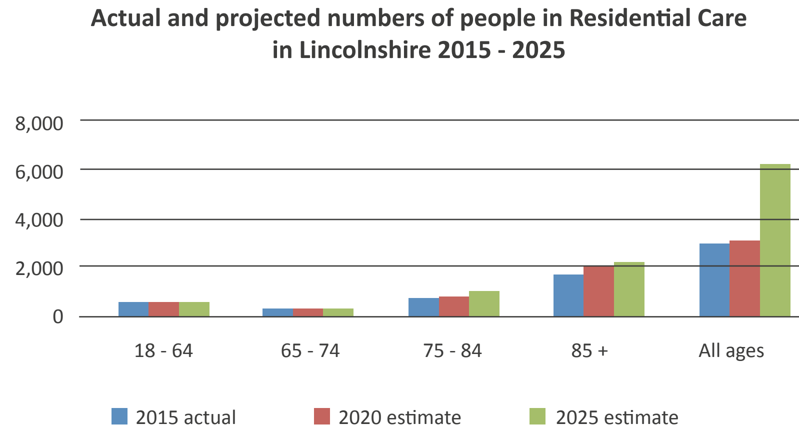


Figure 10: Actual and projected total number of people accessing Community Based Services in Lincolnshire 2015 - 2025

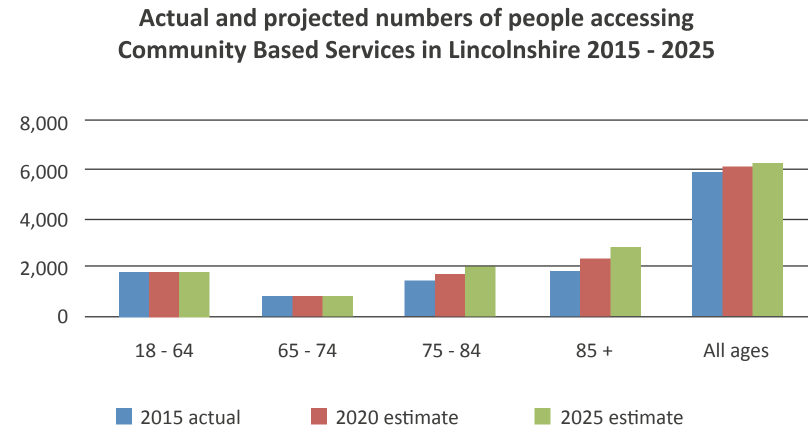


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Figure 9: Actual and projected number of people in Nursing Care in Lincolnshire 2015 - 2025

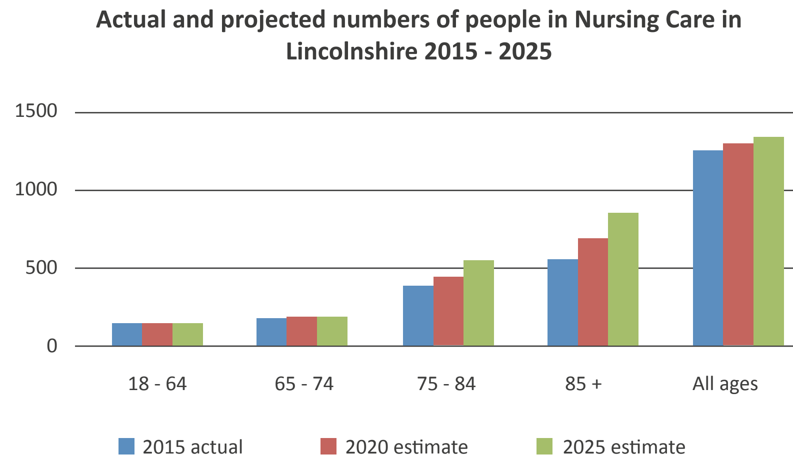
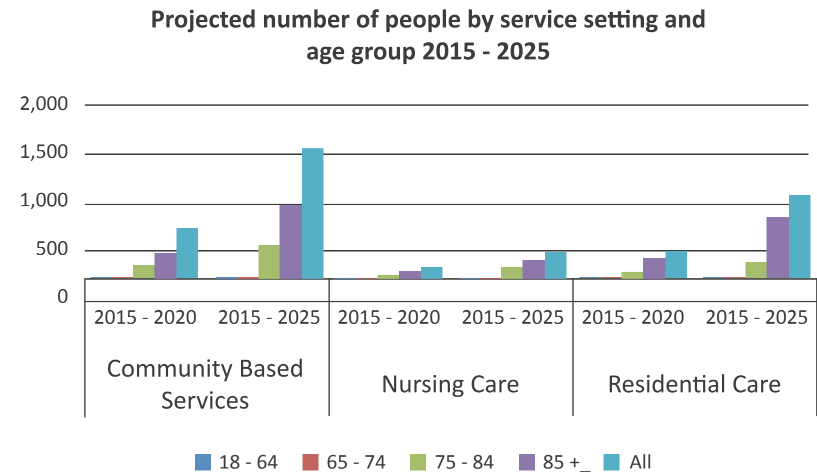


Figure 11: Projected total number of people by service setting and age group in Lincolnshire 2015 - 2025



Quality

The Council's approach to quality services

Of the total Adult Care budget over 90% is spent on services provided by independent providers and there is a legal obligation for The Council to meet eligible needs. This means that the care market must be healthy enough to supply services when required whether residential, nursing or community based support.

Not only must a service be arranged to meet an eligible need, but that service must meet certain standards. Quality of service is a high priority for the public and notably those who require services and their families. The Council is committed to delivering high quality care and support services for the people of Lincolnshire. Quality services are a prerequisite to achieving wellbeing outcomes. The principle of wellbeing is enshrined in the Care Act 2014; therefore The Council are committed to making sure that there is a market which offers quality care services for people.

Quality means services which are safe and effective and where people receive a positive experience. People's experience of their care is seen as a key measure of quality.

The Council's Quality and Safeguarding Board, chaired by the Director of Adult Social Services, meets monthly to oversee the market at a strategic level. Associated with this are a diverse set of formal and informal meetings with providers, the CQC, health colleagues and representative bodies – notably the Lincolnshire Independent Care Association 'LINCA'.

The Lincolnshire Independent Care Association (LINCA) has a membership that makes it the most representative body for regulated residential providers in Lincolnshire. It also incorporates the majority of Housing Associations and, a minority proportion of homecare providers. Their intention is to expand the stakeholder group representation, which the council supports.

How the Council assure quality services

During 2014/15 the Care Quality Commission (CQC) made changes to regulatory inspections and introduced judgement ratings. In response to these changes, The Council aligned its definition of quality against the measures in the Adult Social Care Outcomes Framework (ASCOF), in conjunction with the new CQC Key Lines of Enquiry.

The rationale for this is to set clear expectations to current and future providers, of care and support, within Lincolnshire.

Figure 12: Lincolnshire County Councils Quality Framework

Assuring quality	Safe	Effective	Positive Experience
Adult Social Care Outcomes Framework	**Domain 4:** Safeguarding adults whose circumstances make them vunerable and protecting from avoidable harm	**Domain 2:** Delaying and reducing the need to care and support	**Domain 1:** Enhancing quality of life for people with care and support needs
			Domain 3: Ensuring that people have a positive experience of care and support
NHS Outcomes Framework	**Domain 5:** Treating and caring for people in a safe environment & protecting them from avoidable harm	**Domain 1:** Preventing people from dying prematurely	**Domain 2:** Enhancing quality of life for people with long-term conditions
		Domain 3: Helping people to recover from episodes of ill health or following injury	**Domain 4:** Ensuring that people have a positive experience of care
CQC Regulatory Framework	**Safe** key lines of enquiry	**Effective & well led key** lines of enquiry	**Caring & responsive key** lines of enquiry

The framework (figure 12) will support high standards of quality throughout the care and support process and ensure that those standards are met through effective monitoring.

The Council will work with all stakeholders to ensure a thorough understanding of the quality of care is understood and to take appropriate action when it is not of the required standard.

The Council recognise that quality care is dependent on the skills and commitment of the people providing the care and are committed to supporting the care workforce. The Council will set out expectations in contracts, in addition to reviewing and further developing the approach to workforce development.

Provider quality performance in Lincolnshire

Figure 13 demonstrates the current level of compliance with the sixteen Care Quality Commission Standards. Lincolnshire's regulated services have a record of high compliance rates by the Care Quality Commission (CQC) .

Figure 13: Compliance rates for care in Lincolnshire

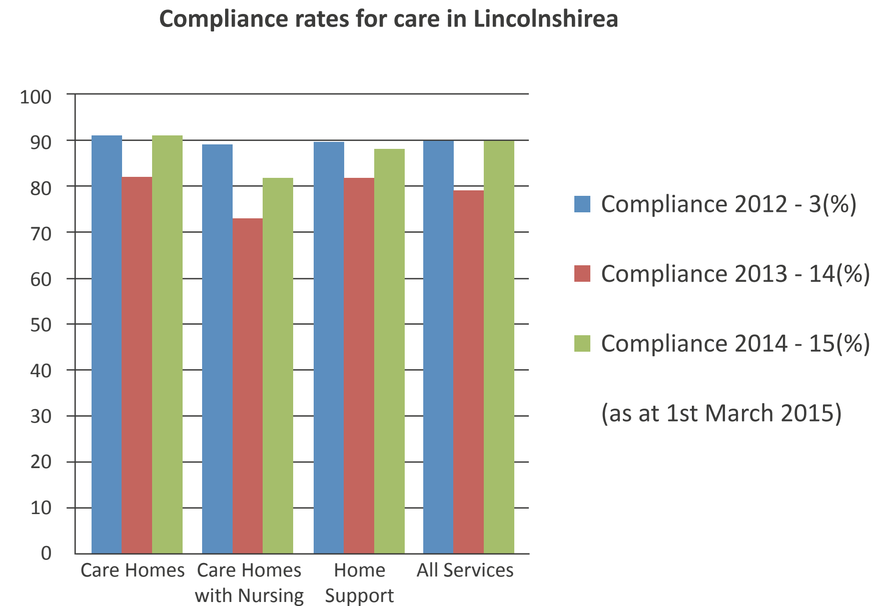


Table 1 shows that Lincolnshire in comparison with other East Midlands authorities has a high level of compliance. However, as can be seen in the table below, levels of compliance were lower in 2013/14 than in 2012/13.

Table 1: Compliance levels regionally

<table>
<tr><th colspan="2">2012/13</th><th colspan="2">Compliance in % order</th><th>2013/14</th></tr>
<tr><td>Lincolnshire</td><td>91%</td><td>91%</td><td colspan="2">Rutland</td></tr>
<tr><td>Leicester &</td><td rowspan="2">86%</td><td>83%</td><td colspan="2">Lincolnshire</td></tr>
<tr><td>Leicestershire</td><td>82%</td><td colspan="2">Leicester</td></tr>
<tr><td>Rutland</td><td>80%</td><td rowspan="2">78%</td><td colspan="2" rowspan="2">Northamptonshire & Leicestershire</td></tr>
<tr><td>Northamptonshire</td><td>76%</td></tr>
<tr><td>Derby</td><td>70%</td><td>74%</td><td colspan="2">Derbyshire</td></tr>
<tr><td>Nottinghamshire</td><td>69%</td><td>64%</td><td colspan="2">Nottingham</td></tr>
<tr><td>Derbyshire &</td><td rowspan="2">64%</td><td rowspan="2">55%</td><td colspan="2" rowspan="2">Derby & Nottingham</td></tr>
<tr><td>Nottingham</td></tr>
</table>

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What people who use services say about quality

As part of the government's programme to consult with people who use services, the Health and Social Care Information Centre (HSCIC) asks all authorities in England to conduct an Adult Care User Experience Survey on an annual basis. The survey aims to learn more about whether or not council funded services are helping people to live safely and independently.

In Lincolnshire, 914 people who use services were randomly selected from across the county to take part in the survey. In total 442 people responded, equating to 48.4%, which is higher than the national average response rate of 37%.

The main findings from the survey are detailed in figure 14.

Local people also raise issues with Healthwatch Lincolnshire -the local consumer champion for health and social care. Healthwatch ensure that the service user's voice is heard in the quality and provision of services. The statutory role and function of Healthwatch is laid down in the NHS and Social Care Act 2012, but local areas have discretion about how their local Healthwatch delivers its services. As a provider of health and social care services it is important that you understand the role and function of Healthwatch Lincolnshire and its statutory powers.

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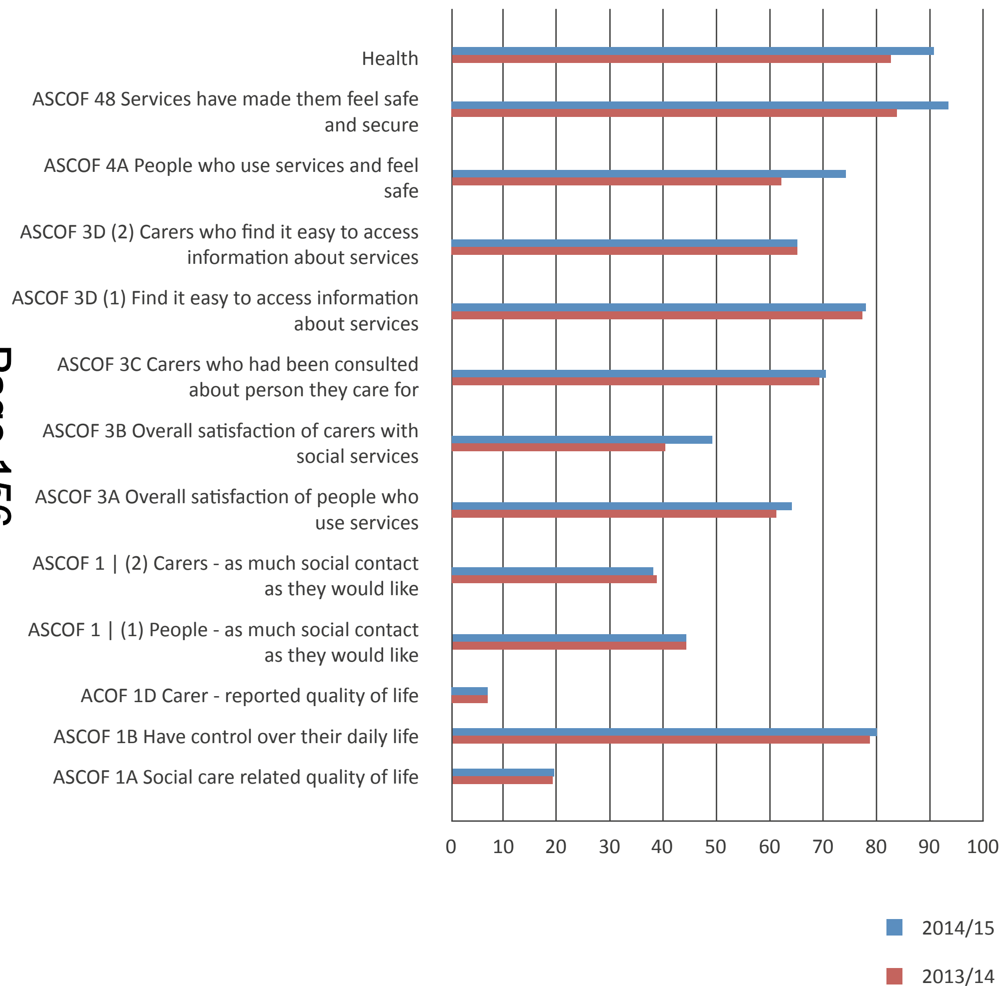
Figure 14: Demonstrates service user opinion about local care and support services across Lincolnshire



Market Opportunities

The following suggestions are ways in which providers can improve the quality of the services they deliver:

Work with stakeholders

Involve relevant council staff, people who use services and their carers/ family in the design and development of any services, their feedback is key to improving the quality of your service. Consider how feedback can be applied practically to develop new or improve existing services. Apply the learning from feedback surveys and complaints to develop new or improve existing services.

Monitor and review performance

Tracking performance and auditing service delivery ensures you can identify ways to improve quality,identify good practice and benchmark with others in order to learn and improve services.. Assure quality with clear standards, consistency and compliance to service delivery expectations. A cycle of plan-do-check-act ensures improvement can be monitored and demonstrated.

Review marketing tools used

Providers can promote their services in the most effective places. Consider whether information provided to people regarding services is accessible and easy to understand.

Improving outcomes for people

As part of the increased focus on quality for people who use services, commissioners need to see good quality outcomes for people. The Council will be looking for providers who can deliver flexible person centered services. The Council will expect good providers to recognize that the people using their services and their carers are experts in their own lives and are therefore essential partners in the design and development of services.

Focus on workforce development

Appropriately trained, qualified and competent staff who are well supervised and managed improves the quality of the service delivered. Regular supervision and low turnover levels are important as well.

Financial Challenge

National financial profile

The social care system is facing an exceptional financial challenge at a time of rapidly increasing demand. A few national statistics illustrate the scale of the issue:

- The Association of Directors of Adult Social Services (ADASS) say that since 2010 spending on social care has fallen nationally by 12%.
- At the same time, the number of those needing support has increased nationally by 14%.
- This has forced local authorities to make savings of 26% in their budgets – the equivalent of £3.53bn over the last four years.
- The Local Government Association (LGA) estimates that the funding gap between March 2014 and the end of 2015/16 for adult social care alone stands at £1.9bn, nationally. By 2020 the gap will be £4.3bn
- Total spending on adult social care and support accounts for just two per cent of total public expenditure.
- On average, excluding dedicated schools grants, adult social care will account for 49% of all expenditure for the average County Council by 2019/20. ((LGA Future Funding Outlook (2013))

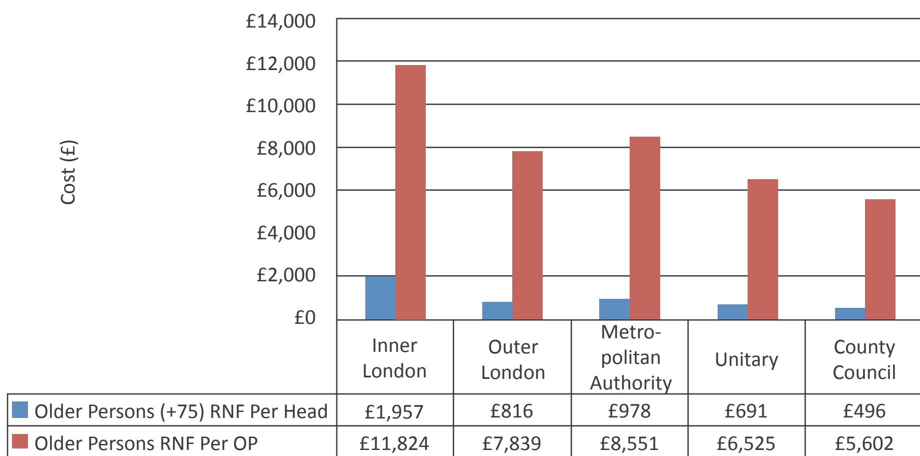
Whilst all local authorities are facing similar pressures, the situation is particularly acute for county councils and county unitary authorities (CountyAPPG: The State of Care in Counties). Whilst councils, especially counties, have done their utmost to protect social care budgets, there has been an inevitable impact on local services and those needing to access care.

Counties are under resourced in comparison with inner city areas, receiving around a quarter of the funding per head of that received by inner cities (figure 15).

The County Councils Network (CCN) recently published 'Our Plan for Government 2015-20' which showed that counties receive significantly less funding per head for those aged 75 and over and funding per adult social care person.

demonstrates that county councils receive significantly less older persons Relative Needs Formula (RNF) per head of population than all other local authority areas.

Figure 15: Demonstrates the Relative Needs Formula (RNF) per head of population



Source : CountyAPPG: The State of Care in Counties)

Local financial profile

Since 2011 The Council has found savings of approx £150m. However, due to reductions in government funding, The Council needs to save an additional £120m annually by 2019.

Meanwhile the demand for services is rising and The Council have additional cost pressures to consider. This means changing the way we work in order to fulfil not only our statutory duties as a local authority, but also our desire to provide a range of quality services to the people of Lincolnshire.

During 2013/2014 The Council's net spend was £494.3m net, of which approximately £133.1m was attributed to expenditure in Adult Care. In 2014/15 Adult Care expenditure had risen, with a net spend of approximately £138.68m and a gross spend of approximately £215.31m.

The projected increase in older people, younger adults with complex disabilities, and for meeting the support needs of the growing number of family carers based on the current pattern of spending is not affordable in the future. In addition to this, The Council has estimated the annual cost of inward migration for adult social care services to be £450,000.

To date, Adult Care has made the following savings:

- £13.078m of savings in 2011/12,
- £8.981m in 2012/13,
- £11.012m in 2013/14
- £9.479m in 2014/15

Adult Care has agreed to save an additional £8.983m over the next three years.

Figure 16 and figure 17 demonstrates the breakdown of total expenditure in Adult Care during 2014 – 2015.

Table 11: Demonstrates the breakdown of expenditure in Adult Care 2014-2015

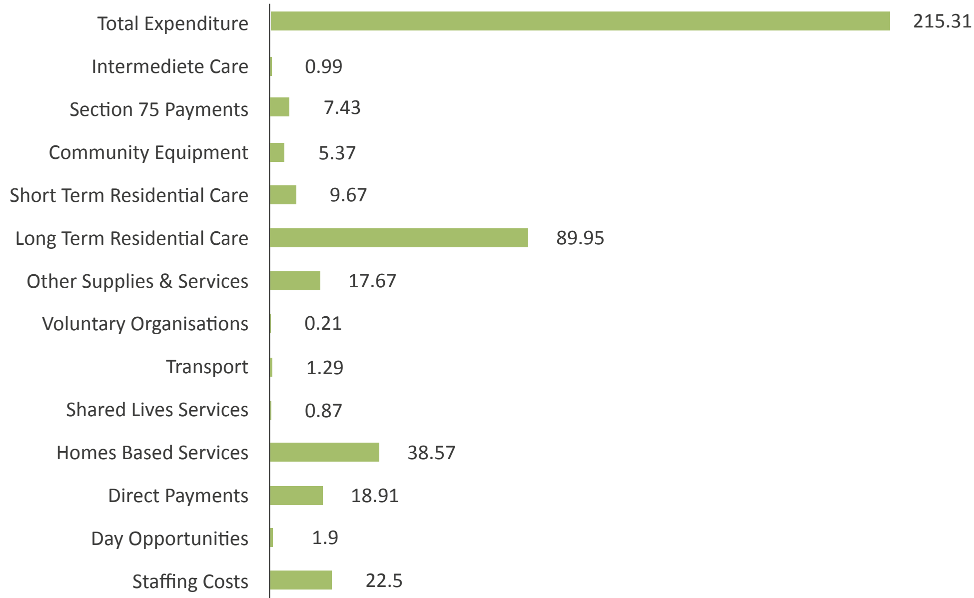


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Figure 8: Demonstrates the percentage of Adult Care Expenditure 2014/2015

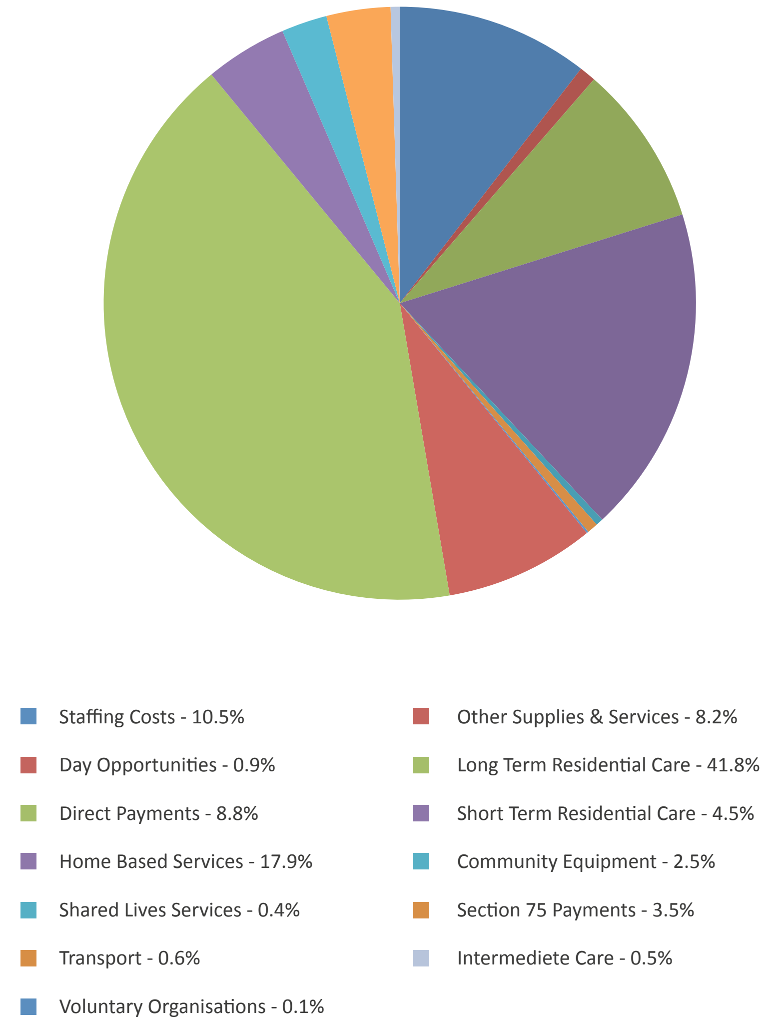

Figure 18, demonstrates the actual gross and estimated spend on Residential, Nursing and Community Based Support Services within Lincolnshire. Figure 19 shows the actual and estimated number of people receiving services between 2015 to 2025 and figure 20 demonstrates the unit cost. It is evident that there will be an increase in demand for services and hence will create further budget pressures for the Council.

Figure 18: Actual gross and estimated spend on services for Residential, Nursing and Community based support services in Lincolnshire 2015-2025

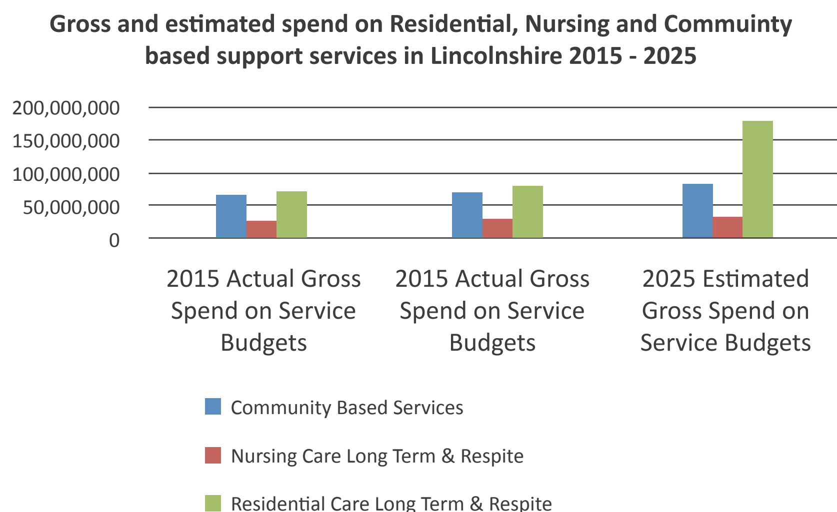

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Figure 19: Actual and estimated number of people receiving services in Residential, Nursing and Community based support services in Lincolnshire 2015-2025

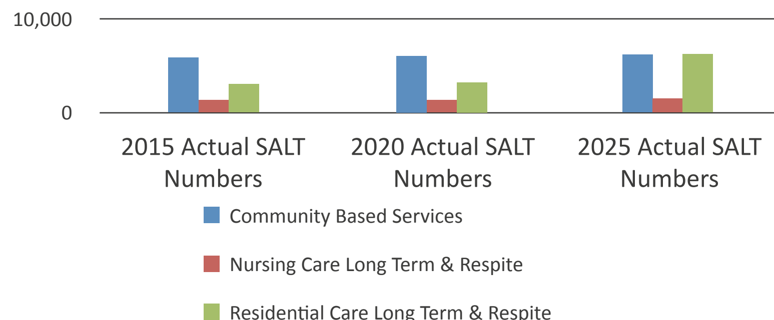
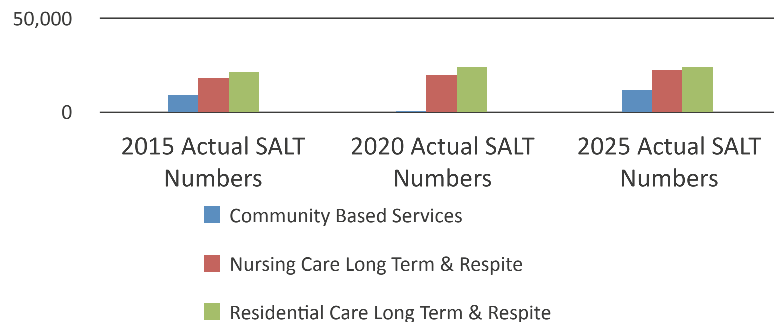


Figure 20: Actual and estimated unit cost for Residential, Nursing and Community based support services in Lincolnshire 2015-2025



Commissioning Intentions 2015/16

Lincolnshire County Council intends to use the following principles when commissioning Adult Care services in 2015/16:

Enhancing quality of life for people with care and support needs

- Helping people manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs
- Carers are supported to balance their caring roles and maintain quality of life
- People with care and support needs are able to find employment, maintain a family and social life, contribute to community life and avoid loneliness or isolation

Delaying and reducing the need for care and support

- Adults with care and support have the opportunity for the best health and wellbeing throughout their life, and have access to support and information to help them manage their care needs
- Health and care organisations working in partnership to achieve earlier diagnosis, intervention and reablement so that people and their carers are less dependent on intensive services
- When people develop care needs, they receive care and support in the most appropriate setting (most often at home),
- People are enabled to regain their independence

Ensure that people have a positive experience of care and support

- People who use health and social care and their carers are satisfied with their experience of care and support services
- Carers feel that they are respected as equal partners throughout the care process
- People know what choices are available to them locally, what they are entitled to and who to contact when they need help
- People with care and support needs are treated with respect and dignity and support is sensitive to the circumstances of each person

Workforce Development

Care workers and professionals working in Social Care

In Lincolnshire The Council estimate that more than 10,000 people work in the care sector providing critical support to the most vulnerable people in local communities. Nationally, it is perceived that care workers are not as valued as they should be and their terms and conditions are not always fair.

The Council supports improved skills training for care workers in Lincolnshire, to ensure the workforce is able to continue to undertake its vital role.

The East Midlands branch of ADASS and Skills for Care have recently analysed the skills gap for care workers providing direct care . This indicates that a large proportion of care workers have no qualifications as demonstrated in figure 21.

Figure 21: The percentage of qualifications held by Care Workers

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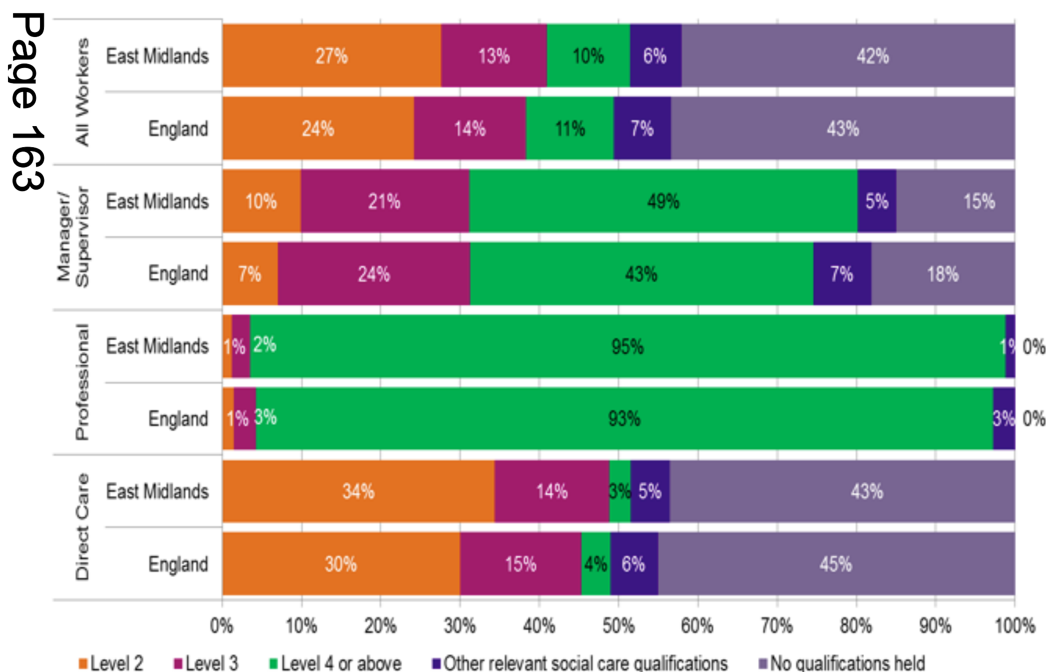


Source: Skills for care NMDS

Homecare

Throughout the financial year 2013/2014 the Council contracted with 73 providers to deliver more than 1,550,000 hours of homecare services to approximately 5,500 people. Despite significant spend on homecare services within the market in Lincolnshire, the operational framework is not financially sustainable, if The Council is to continue to provide high quality. This problem is not unique to the marketplace within Lincolnshire. Local Authorities around the country are facing these issues, as identified in the recent 'Homecare Deficit Report'.

The latest national figures on delayed transfers of care (DTOF), a key indicator of local pressures, shows an increase in the number of people ready to leave hospital but who are prevented from doing so, due to lack of service provision, such as homecare. However compared with other authorities, Lincolnshire has far fewer delayed discharges caused by adult care. In the last three years The Council has had one of the best performing Adult Care services, in relation to delayed transfers of care. Keeping delayed transfers of care low will continue to be a priority.

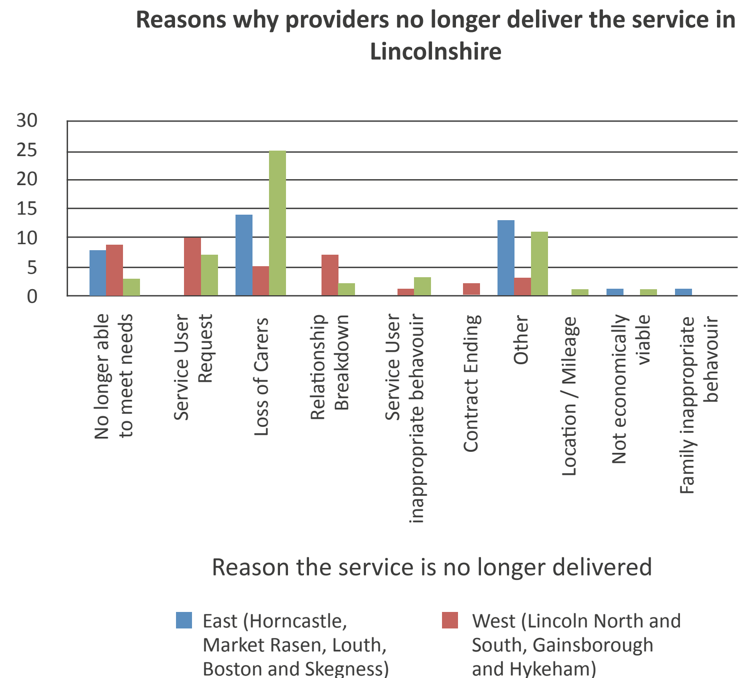
Nationally, people spent a total of 143,000 days in hospital last year, when they should have been sent home. Delayed transfers of care rates in 'Shire' counties are 43% higher compared to the national average and the delayed transfer of care days are 29% higher in counties compared to the national average, placing more pressure on the system. (County APPG:The State of Care in Counties).

Over the last eighteen months the demand for new home care packages in Lincolnshire has risen by 8.4%. This increase in demand coupled with an increase in demand for reassessments escalates demand to 17.8%. The greatest demand can be found in the east of the county at 22.22%. .

It has become increasingly difficult to find providers who are able to deliver packages of care to people in their own homes. Consequently, this is causing delays for newly assessed people, taking on average, an additional seven days to place a person.

Figure 22 demonstrates the principal reason for providers unable to deliver care packages.

Figure 22 : Reasons why providers no longer deliver the service in Lincolnshire



The Council have redesigned the model of homecare delivery in Lincolnshire, with the aim of creating a more flexible, personalised service that should improve people's satisfaction and address the growing demand in this area. The new model divides the county into twelve zones as demonstrated in figure 23. The concept of the new model is that within each zone, there will be one main provider, who may sub contract to other providers if appropriate.

The aim of this exercise has been to ensure people continue to receive the services they need and at a price that is fair to the providers. This new model for home care will allow providers to deliver a more reactive service for people and support the market to meet rising demand.

Figure 23: Demonstrates the twelve zones for the delivery model of Homecare in Lincolnshire

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Homebased Reablement

Reablement provides services for people with poor physical health to help them accommodate their illness by learning or relearning the skills necessary for daily living. This enables them to live as independently as possible in their own home. Reablement services primarily encourage a person to regain motivation and confidence to learn new ways of coping with their health and care needs.

The Council is working with its health partners to redesign models of care and support for frail elderly people in the community in order to avoid and/or reduce the length of stay in hospital. People will need to be enabled or reabled to stay independent at home.

In 2015 the Council will be seeking a service provider to deliver a countywide home based reablement service. They will be solely accountable for meeting the required hours and outcomes. The provider will be expected to ensure that people across the county get the same level of support, including those living in more rural and remote areas.

Personal Assistants

Demand for personalised social care is growing in Lincolnshire. Many people who use personal assistants take a Direct Payment to pay for the service they receive. Currently 5,725 people and carers are in receipt of a Direct Payment, which continues to increase steadily (figure 24). In Lincolnshire Direct Payments are significantly higher than the national average (figure 25) and are expected to continue to grow. This will increase demand for personal assistants.

Adult Care has recently recommissioned its Direct Payment support service in order to respond to legislation in the Care Act 2014 and the increasing demand for the service.

Figure 24: Percentage of Direct Payments provided in Lincolnshire 2012 - 2015

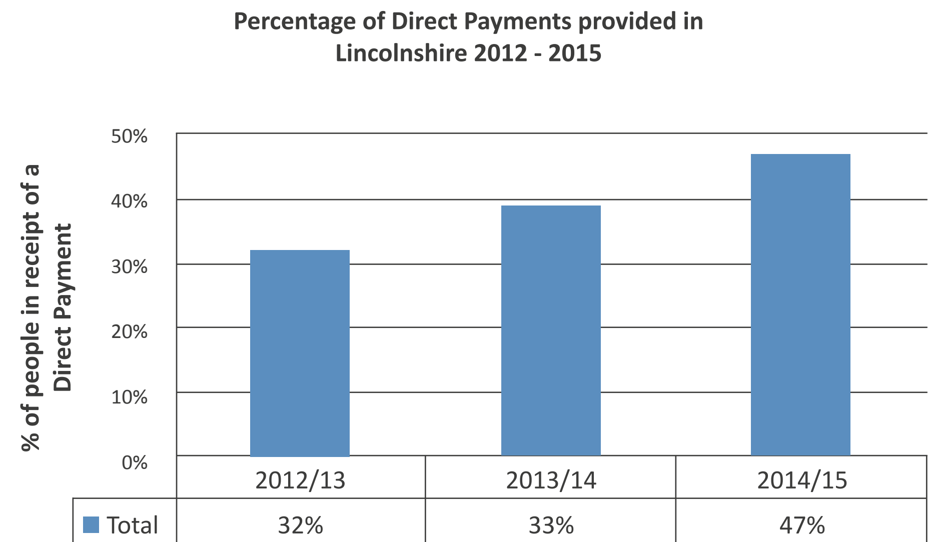
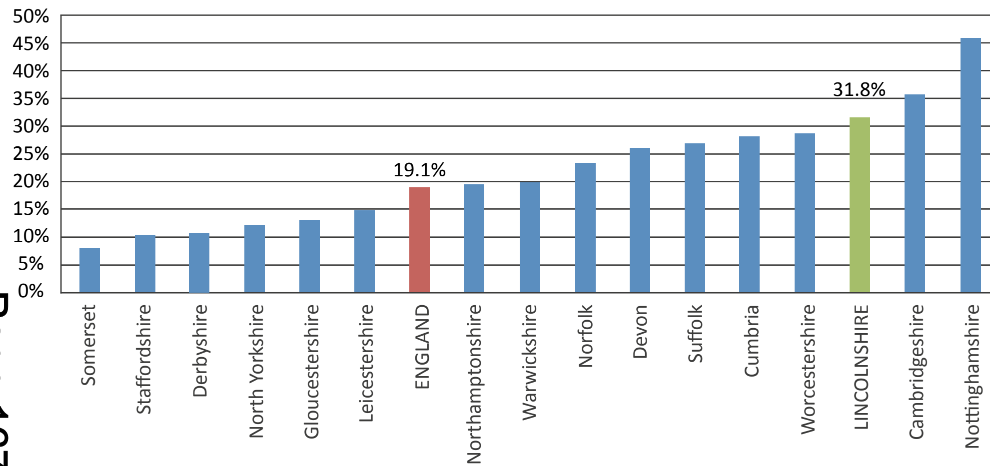


Figure 25: Number of people in receipt of Direct Payments Nationally

ASCOF 1c Part 2 - Number of adults, older people and carers receiving self-directed support via a direct payment in the year to 31 March as a percentage of all clients receiving community based services and carers receiving carer specific services 2013 - 14



Source: NASCIS online analytical processor

Market Opportunity

Opportunities still exist in providing a range of services for personal assistants and direct payment support to self-funders. Given the right market there is huge potential for market entrants.

Carers

The Care Act 2014 significantly improves the rights of carers in England. For the first time in law, carers are placed on an equal footing with those they support as local authorities now have a duty to assess carers where they appear to have a need for support. This means more carers will be entitled to an assessment and, if eligible, receive support from Adult Care.

The 2011 census identified 79,000 carers in Lincolnshire. A well informed and supported carer will be more able to sustain their caring role and approximately 6000 carers currently receive support from the Council to access a range of preventative services. . This support can reduce or delay costly impacts on primary and acute health services, and long term social care.

In May 2014 the Joint Carers Strategy 2014-18 'And how are you?' was published. The strategy identifies the issues faced by unpaid carers in Lincolnshire and a vision of how health and care organisations aim to resolve them.

Taking into account new rights for carers alongside the challenges facing health and care, The Council intends to remodel its carers' support services to make sure that they are sustainable, and provide high quality services that meet a range of needs.

Market Opportunity

In 2016 The Council will recommission the face-to-face delivery of its Carers Service. The Council will be looking for expert providers, with a strong track record of delivering similar services, to deliver comprehensive support to carers in Lincolnshire in partnership with the Council and Serco. The service will include statutory carers assessments, support planning and signposting to information and advice to support carers in their caring role.

Footnote: Carers -unpaid carers typically family or friends.

Advocacy

Following extensive market engagement with providers, a new joint Adults and Children's Advocacy service in Lincolnshire will be delivered from July 2015 by 'Voiceability'. The service will provide an 'advocacy hub' and a single point of contact for people to give improved accessibility to independent advocacy. It will also consider all implications of the new statutory requirements from the Care Act 2014 and Children's and Families Act 2014, and the likely increase in Deprivation of Liberty referrals.

Residential and Nursing Care

As of 2014/2015 data, there are approximately 202 Residential Homes and 92 Nursing Homes some of which are dual registered within Lincolnshire. The Council contracts with around 98% of these care homes.

Residential care placement rates are falling (figure 26) but people who do require residential care will have more complex care needs such as specialist dementia care and nursing. Initiatives such as the Better Care Fund (BCF) have contributed towards the continuing reduction of residential care admissions by providing community based alternatives. These reductions are a key outcome of the BCF and are in line with The Council's commitment to support people to remain independent at home for as long as possible. Concurrently, available capacity in the market has fallen in the last year within the South, East and West Clinical Commissioning Group areas (figure 27).

Figure26: Demonstrates permanent admissions to residential and nursing care

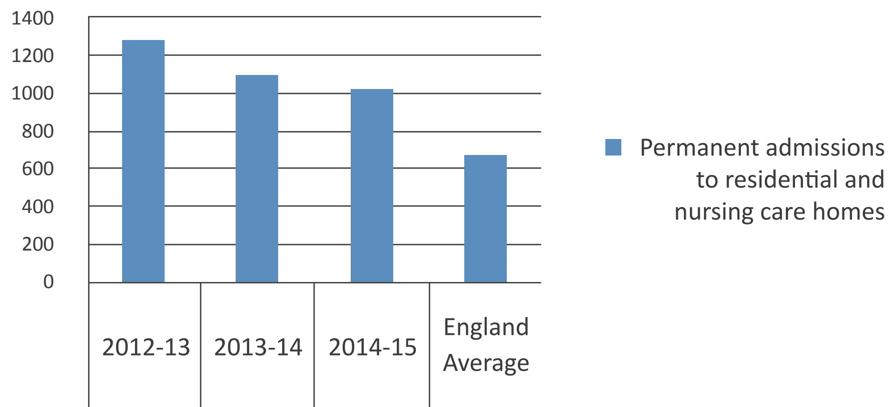
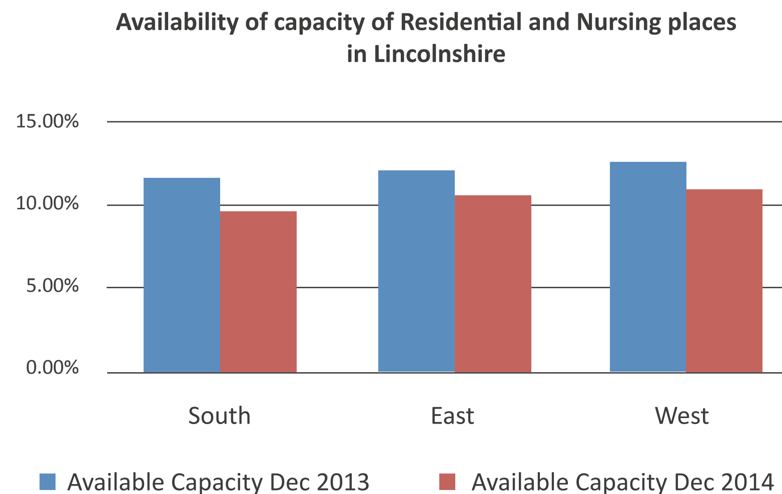


Figure 27: Availability of capacity of Residential and Nursing places in Lincolnshire



In terms of general demand for residential care the south west of the county consistently has lower available capacity, averaging 5% whilst other areas have on average 10% of beds vacant at any one time. Evidence suggests that nursing beds are difficult to source because homes are struggling to recruit nurses.

In July 2014 The Council commissioned Laing & Buisson to conduct an independent evaluation of the residential care market in Lincolnshire. This was to enable the Council to set a fair and realistic usual cost level for residential and nursing care for all types of need (older people, physical disabilities, learning disabilities and mental health) over the three year period 2015/16 to 2017/18.

Setting a usual cost level provides a number of benefits to the Council and the wider market. These include:

- Helpful in market shaping and choice regulation compliance.
- Meeting needs and complying with people's choice of accommodation.
- Meeting responsibilities in relation to personal budgets.
- Evidencing that contract terms, conditions and fee levels are appropriate to provide the delivery of the agreed care packages with agreed quality of care.
- Avoiding any actions which may threaten the sustainability of the market as a whole, such as setting fee levels below an amount which is sustainable for providers in the long term.
- Ensuring that remuneration must be at least sufficient to enable service providers to comply with the national minimum wage legislation for hourly pay or equivalent salary.

The Laing and Buisson work is set out in their Review of Care Only & Nursing Care Market in Lincolnshire and their Report on Revenue Costs of Care Only & Nursing Home Places for Older People and Young Disabled Adults in Lincolnshire. The findings of these pieces of work have informed the setting of the Council's usual costs for residential and nursing care for the period April 2015 to March 2018.

Market Opportunity

The Council is looking for care home providers whose specialisms are in complex care needs, especially dementia.

Extra Care Housing

Extra care housing offers accommodation in self-contained flats which benefit from a wide range of support services and on site facilities. Residents can live independently and securely, with the reassurance that help is at hand when they need it. Extra care housing offers people an alternative to moving in to residential care.

Figure 28 demonstrates the availability of extra care housing across comparable authorities by looking at the number of people aged 65+ per extra care housing place. In other words, the lower the number the easier it will be for a person to access extra care housing.

The Council's ambition is to offer older people greater choice in accessing suitable housing and support, to enable them to remain in their own homes and close to their local communities. Increasing extra care housing across the county will promote independence and well-being and be a viable alternative to residential care.

Lincolnshire has fewer extra care places than its comparable authorities, and by a significant margin. Somerset has over six times the availability of extra care housing compared to Lincolnshire. Again there is a correlation between the number of available places and the rate of admission to care.

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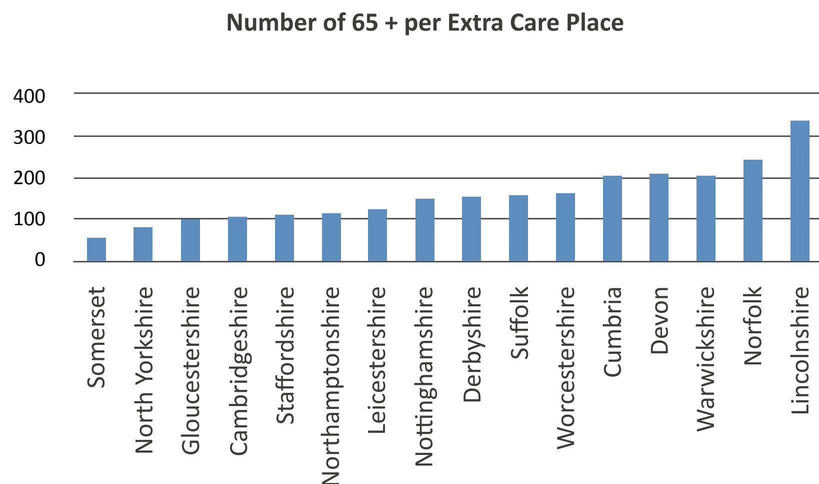
Figure 28: Demonstrates the availability of extra care housing in Lincolnshire against other Local Authorities



In Lincolnshire there are currently eight extra care schemes with a total of 288 units.

The Council estimate somewhere in the region of six hundred more extra care housing units will be required to meet the potential demand over the next 20 years. Figure 29 demonstrates the current extra care housing Schemes and high demand areas.

The Council objectives are to:

- Provide choices for housing, support and care services, to meet future demand
- Design and develop more extra care schemes that provide options in lifestyle, accommodation size, location, tenure and services
- Work in partnership with health, housing, district councils, public health, independent sector providers and voluntary groups
- Maintain and enhance older people participation in the design and implementation of the schemes.

Market Opportunity

The Council are actively looking at ways to encourage the future development of extra care units in Lincolnshire and have forged links with the district, and city councils within the county to help us identify potential future development locations.

Figure 29: Extra Care Housing Schemes and high demand areas

People with Mental Health Difficulties

The joint commissioning arrangements and pooled budget for 'specialist' adult services including Mental Health, Learning Disabilities and Autism ensures that collaboration is on everyone's agenda. It is hoped that integrated personal health and social care budgets will enable the delivery of efficient and sustainable solutions for those who access our services.

Market Opportunity

The Council is committed to reducing the stigma of mental health and to promoting recovery through all of the services we commission. Services and care packages will be reviewed to ensure that they meet the person's needs, are outcome focused and that they provide value for money.

People with Dementia

There is a wealth of information about dementia as a condition, and its impact on people and families. The Prime Minister's Challenge on Dementia sets out ambitions for local communities to become more dementia-friendly, to improve diagnosis rates, increase the quality of health and social care, and invest in research. This challenge runs until 2015 and it is likely that dementia will remain a national priority beyond this date. Local information about dementia can be found in the recently published Lincolnshire Joint Strategy for Dementia 2014-2017.

The Council continues to work actively with partners to achieve the objectives of the National Declaration on Dementia by supporting the Dementia Action Alliance. There are currently two DAA branches in the county : Lincoln DAA, and South Lincolnshire DAA. Further branches are in the process of forming in other districts of Lincolnshire.

Lincoln DAA held a one-day conference on 23 April 2015 with the theme "Creating a Dementia Friendly Lincoln"

The conference was timed to mark the acceptance of Lincoln's application for accreditation at foundation level as a Dementia Friendly Community under the national Alzheimer's Society programme. Lincoln DAA's future plans include seeking to create links with the local business sector including banks, post offices, supermarkets and other commercial and retail outlets.

Lincoln DAA's work parallels a similar approach in Bourne which achieved Dementia Friendly Community accreditation in 2014 following an application by South Lincolnshire DAA.

Market Opportunity

Commissioners recognise that some people with dementia and their carers do need specialist support. During 2015 The Council is commissioning a Dementia Family Support Service. This new service model will provide information, advice and ongoing support to families after a diagnosis through to end of life.

People with Physical Disabilities

Adult Care is now in the process of developing a commissioning strategy for frail adults and long term conditions, which will include people with physical disabilities. The number of people considered eligible for services at 2013/14 was 2,113.

The Council recognise that the numbers of people with physical and sensory impairments of working age are projected to rise, partly because people are working and living longer. In 2014/15, there were 575 adults, aged 18-64 with complex needs being supported to live independently through home based care services. The new service model for home care services in Lincolnshire will place a particular emphasis on the importance of promoting the health, wellbeing and quality of life of people.

Market Opportunity

The Council are committed to offering personalised care and support to adults with a physical disability. The number of vulnerable adults between the ages of 18-64 supported with a Direct Payment in 2014/15 was 517. The Council expect this figure to continue to grow and as such have recently recommissioned our Direct Payment Support Service. This service will promote the understanding and uptake of direct payments among adults with a physical disability and provide a range of services to assist and protect them.

People with Sensory Impairment

'BID' Services, are a voluntary sector provider who are currently funded by The Council to deliver sensory impairment services for adults and children who are visually, hearing or dual impaired.

Nationally there are 1.86 million people living with sight loss. By 2020 this number is predicted to increase by 22% and will double to almost four million people by the year 2050.

More than 10 million people in the UK are living with some form of hearing loss, or one in six of the population. By 2031, it is estimated that there will be 14.5 million people with hearing loss in the UK.

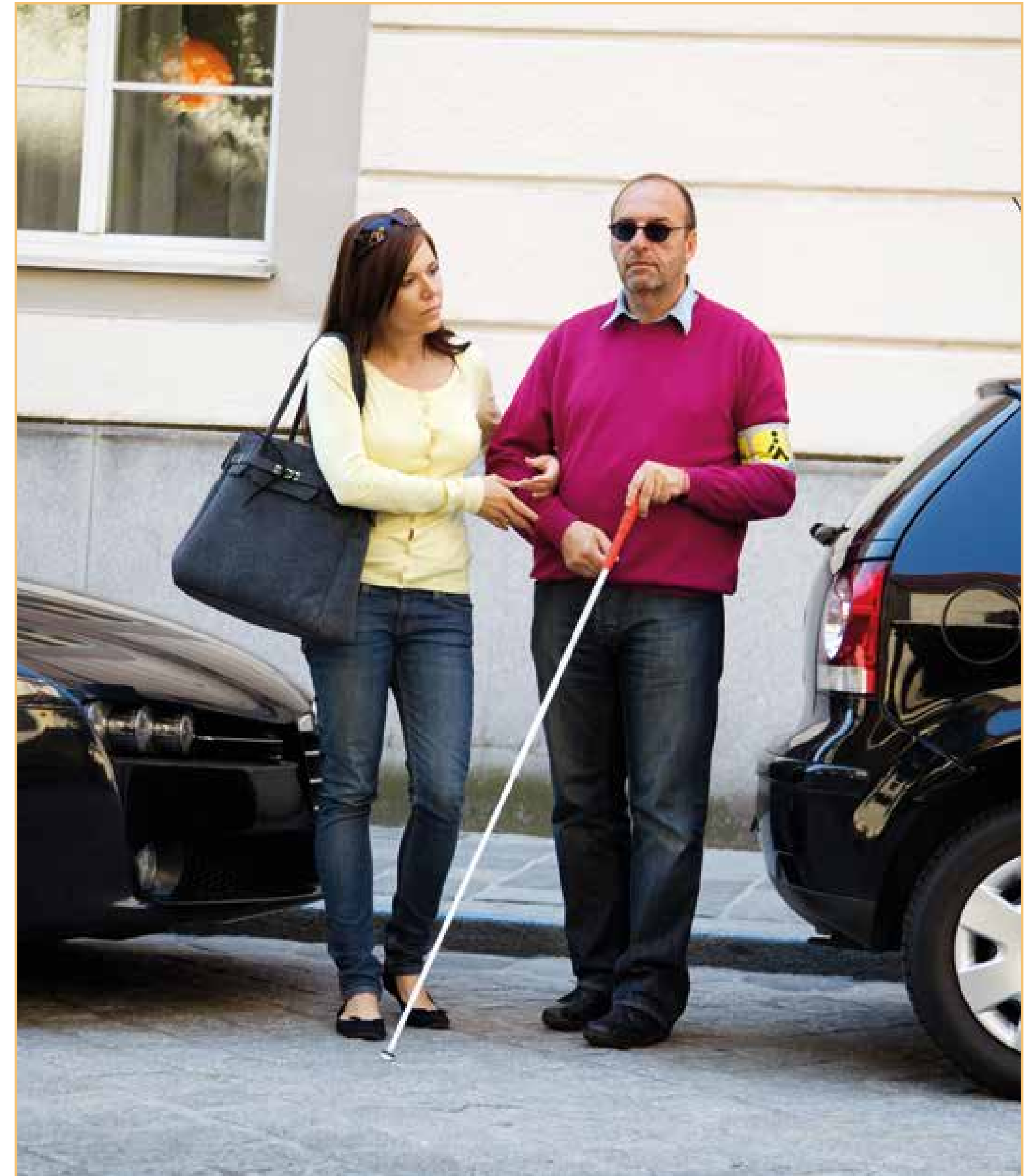
Approximately 356,000 people in the UK are living with combined visual and hearing impairment.

The sensory impairment contract is due to expire in March 2016, so The Council is currently undertaking a complete review of the service and will be seeking to recommission later this year.

Prior to the recommissioning of the service The Council will be engaging with key stakeholders, to ensure that a quality service is provided.

Market Opportunity

The Council will be recommissioning the Sensory Impairment Service during 2015/16.



The Integrated Community Equipment Store (ICES)

Lincolnshire's Integrated Community Equipment Service (ICES) provides community equipment on behalf of health and social care to help meet the needs of people of all ages, including children, who have long term conditions and disabilities.

The provision of a good quality and timely community equipment service supports a number of the Commissioners' strategic objectives, and contributes to promoting independence; well-being, dignity and choice for people, helping them remain independent in their own homes. It also helps prevent avoidable hospital admissions and helps to facilitate early discharge and readmission.

The Service is jointly commissioned by The Council and NHS Health Partners. The Council manages the contract on behalf of this partnership.

The ICES needs to be responsive to the growth in Lincolnshire's older population and long term limiting illness in addition to budgetary pressures and national and local policies and strategies.

Since the time that the Service was initially outsourced, it has seen exponential growth; with nearly 5,000 people currently being issued with community equipment per month.

The type and range of community equipment that is supplied, maintained, collected, recycled and stored through Lincolnshire's ICES are summarised below:

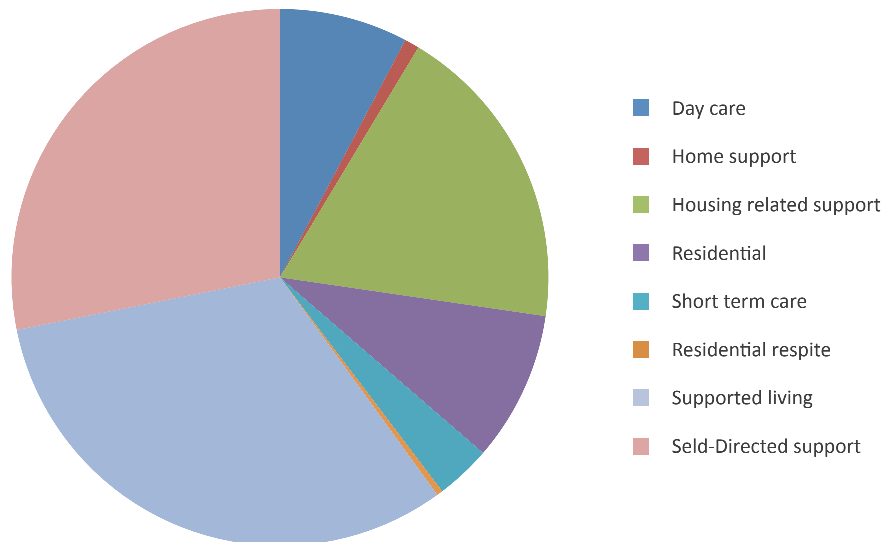
- Simple Aids to Daily Living (SADLs) – small selection of products to aid independent living including perching stools, trolleys, bathing and toileting aids, mobility equipment / walking aids;
- Complex Aids to Daily Living (CADLs) – includes hoists and other moving and handling equipment, slings, powered equipment and specialist bathing equipment; beds / accessories, pressure care equipment and commodes;
- Bespoke / Non-Stock Equipment – includes items that do not form part of the standard equipment product range and are instead additional 'one-off' items that meet the Patient's / Customer's assessed needs;
- Provision of Ceiling Track Hoists, Ramps and Rails.

People with Learning Disabilities

According to Projecting Adult Needs and Service Information (PANSI), in 2014 there were 13,858 adults aged 18 +with a learning disability in Lincolnshire. This number is projected to increase to 14,703 by 2020. This 6% increase is expected to be partly from inward migration and partly as a result of young people making the transition from Children's to Adult Services. In order to support this, a transitions practitioner has been appointed. The aim is to develop this role and produce clear information about the transition process for young people, their families and carers.

The Council is the joint commissioner in a pooled budget arrangement with the four CCGs in the county, purchasing services for people with a learning disability. The Council works closely with health colleagues to ensure that people have access to the services they need locally, including respite, accommodation and healthcare. Figure 30 demonstrates the number of people with a learning disability who accessed services in 2014 -2015.

Figure 30 : Number of LD people who accessed services during 2014/15



The introduction of the integrated health and social care budgets will enable us to develop our vision to offer greater choice, control and quality of life for people with complex needs.

The Council continues to develop and review the seventeen day opportunities services, to ensure that they are fit for purpose and provide meaningful activity. Currently The Council are in the process of mapping all provision and intend to develop a day opportunities strategy, with input from people who use services and providers.

One of the priorities during 2015-17, is to support people with learning disabilities to access meaningful and paid employment, through working with colleagues to pilot services which are designed to help people with disabilities access work.

People with a learning disability are living longer which means that many of their carers are older and more likely to have their own health and care needs. The Council works closely with community carers' services, to enable carers to support their relative for as long as they wish. The Council encourages carers to seek help when struggling in order to prevent a crisis situation, allowing timely intervention of care and support.

The Council is committed to promoting the independence of adults with learning disabilities. Recently, the Council tendered for a re-modelled advocacy service aimed at providing support for people that have communication difficulties.

Until recently there was an emphasis on ensuring that people with a learning disability were discharged from hospital in a timely manner. The current focus is on reducing new admissions so they are kept to a minimum and that all other options to treat the person in a community setting are considered before hospital admission is agreed, except in cases of clear emergency.

To plan for the future, the health and social care economy may need to consider additional investment in community based solutions, to allow people to remain at home whilst receiving treatment.

People with Autism

It has been nationally recognised that people with an autistic spectrum disorder are not having their health and social care needs met. The Lincolnshire all age autism strategy is striving to better meet the needs of people with autisme through an ambitious action plan which focuses on:

1. Service provision
2. Training and awareness raising
3. Collaboration and participation of those with lived experience at every stage
4. Information and data

The Autism Partnership Board, which includes people with autism and their carers, is working collaboratively with key stakeholders to develop four working groups, for the above domains, complete with their own action plan.

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The Council is currently reviewing the way in which people with an autistic spectrum disorder are diagnosed. Health and care organisations are striving to offer an integrated response when and if diagnosed.

The Council is in the process of analysing the needs of people with autism locally in order to identify key priorities. To date, the main areas of need identified are:

- Support and guidance for those who do not meet the Care Act 2014 criteria but still have needs that impact on their functioning
- Those with autism who are (or otherwise may end up) in the criminal justice system
- Meaningful employment opportunities

The Autism Partnership Board is very clear that mainstream services for physical and mental health care locally will need to make reasonable adjustments for people with autism to help them access services. Only a minority of people with an autism spectrum disorder will require specialist intervention and treatment.

Community and preventative services may identify needs earlier and lower the risk of further physical and mental health needs. These services should also expect to make reasonable adjustments.

Training and raising awareness is key and involvement of those with lived experience, carers and family members will be crucial in the future development of services.

Future aspirations and next steps

What the care market will look like in the future as a result of the development and changes listed above is difficult to accurately predict. However we do expect the provision of care and support to continue to undergo significant transformation. We are moving away from a 'one size fits all' approach to service delivery. People are increasingly looking for a more bespoke service to meet their increasingly complex care needs. In response to this, commissioners will need to support providers to adapt their business models and service operations away from a service specification towards an outcomes framework.

In Lincolnshire demographic changes and budgetary restrictions will continue to place increased pressure on the capability of current services to respond to increasing demand. Therefore increased investment in prevention, reablement and assistive technologies will likely replace traditional support and care options. This will involve integrated commissioning arrangements across health, social care and the wider commissioning agencies.

The Council recognises that meeting these challenges requires a collective response and we will continue to work closely with partners to develop the solutions the market needs. We are ambitious and confident that through working together, we can secure good quality care and support to the people of Lincolnshire.

Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Richard Wills, the Director responsible for Democratic Services

Report to:	**Adults Scrutiny Committee**
Date:	**9 September 2015**
Subject:	**Lincolnshire Safeguarding Boards Scrutiny Sub-Group – Update**

Summary:

This report enables the Adults Scrutiny Committee to have an overview of the activities of the Lincolnshire Safeguarding Boards Scrutiny Sub-Group, in particular the Sub-Group's consideration of adult safeguarding matters. The draft minutes of the last meeting of the Scrutiny Sub-Group held on 15 July 2015 are attached.

Actions Required:

That the draft minutes of the meeting of the Lincolnshire Safeguarding Boards Scrutiny Sub-Group, held on 15 July 2015 be noted.

1. Background

The Lincolnshire Safeguarding Boards Scrutiny Sub-Group considers both adults' and children's safeguarding matters, in particular focusing on the activities of the Lincolnshire Safeguarding Children Board and Lincolnshire Safeguarding Adults Board.

The last meeting of the Sub-Group was held on 15 July 2015 and the draft minutes are attached at Appendix A to this report. As the remit of the Adults Scrutiny Committee includes adult safeguarding, the Committee is requested to focus on those minutes from the Sub-Group, which are relevant to this remit.

2. Conclusion

The draft minutes appended to this report are for the Committee's information.

3. Consultation

a) Policy Proofing Actions Required

This report does not require policy proofing.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Minutes of the Lincolnshire Safeguarding Boards Scrutiny Sub-Group held on 15 July 2015.

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Catherine Wilman, who can be contacted on 01522 55(3788) or catherine.wilman@lincolnshire.gov.uk.

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Appendix A

LINCOLNSHIRE SAFEGUARDING BOARDS SCRUTINY SUB-GROUP

WEDNESDAY 15 JULY 2015, COMMITTEE ROOM 3, COUNTY OFFICES, NEWLAND, LINCOLN

PRESENT: COUNCILLOR C R OXBY (CHAIRMAN)

Councillors S R Dodds, Mrs S Ransome and Mrs L A Rollings.

Added Members: Mrs Emma Olivier-Townrow (Parent Governor Representative).

In attendance: Chris Cook (Independent Chair, Lincolnshire Safeguarding Children Board (LSCB)).

Officers in attendance: David Culy (Lincolnshire Safeguarding Adults Board (LSAB) Business Manager), Tracy Johnson (Scrutiny Officer), Caroline Mogg (Child Sexual Exploitation Co-ordinator), Jade Sullivan (LSCB Audit and Policy Officer), Catherine Wilman (Democratic Services Officer).

1. ELECTION OF VICE CHAIRMAN

RESOLVED

That Councillor S R Dodds be elected as Vice Chairman of the Lincolnshire Safeguarding Board Scrutiny Sub Group for the remainder of the year.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors D Brailsford and A M Austin and from Councillor C Burke (District Councils Representative), Elaine Baylis (Independent Chair – Lincolnshire Safeguarding Adults Board) and Andrew Morris (Lincolnshire Safeguarding Children Board (LSCB) Business Manager).

3. DECLARATIONS OF MEMBERS' INTERESTS

No interests were declared.

4. MINUTES OF THE LINCOLNSHIRE SAFEGUARDING BOARDS SCRUTINY SUB-GROUP HELD ON 7 JANUARY 2015

AGREED

That the minutes of the meeting of the Lincolnshire Safeguarding Boards Scrutiny Sub-Group held on 7 January 2015 be confirmed and signed by the Chairman as a correct record.

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LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD (LSCB) BUSINESS

5. UPDATE ON THE WORK OF THE LSCB AND ITS SUB-GROUP

Consideration was given to a report which provided an update on the work currently being undertaken by the Lincolnshire Safeguarding Children Board (LSCB) and its subgroups.

The Group received an update on the position of Serious Case Reviews currently being considered by the Board.

There was potential danger of radicalisation of youngsters through the internet, however there had been no cases of this in Lincolnshire as yet. All work undertaken on this issue was being built into an evidence chest.

An update was provided on Section 11 audits which had been taking place. It was reported that both the British Transport Police and EMAS (East Midlands Ambulance Service) had been reluctant to cooperate, however EMAS had now agreed to take part following negotiations by Jade Sullivan.

AGREED

That the report be noted.

6. SERIOUS CASE REVIEW (SCR) – BABY W

Consideration was given to the Serious Case Review of the death of Baby W, who died shortly after his birth. His mother, a 16 year old girl, had concealed/denied her pregnancy and had given birth alone and unassisted in her bedroom at home. Concealed/denied pregnancies were very rare.

The SCR concluded that Baby W's death could not have been prevented due to the pregnancy having been concealed/denied. There was no media interest in the case following this conclusion.

It was reported that a multi-agency task group had been set up as a result of the case to discuss the figures on concealed pregnancies and the potential to not pick up on the early signs. The early help model and the pre-birth protocol would be used for this in future. GPs were unable to force an examination on any patient.

Following a discussion on the issue of concealed/denied pregnancies and gaining proof from patients, the following points were noted:

- It was suggested that GPs ask suspected concealed/denied pregnancy patients for a water sample. This would be taken back to the task group for its thoughts;
- Some of the female members of the Sub Group reported that their GPs often asked them if there was a chance they could be pregnant. It was suggested that this policy should be extended to younger patients too;

- The girl's GP had asked all the right questions during appointments, but as she had been so strongly in denial about her pregnancy, she had not answered truthfully.

It was requested that the findings of the task group be brought to a future meeting of the Sub Group.

AGREED

That the report be noted and that the findings of the task group be brought to a future meeting of the Lincolnshire Safeguarding Boards Scrutiny Sub Group.

7. CHILD SEXUAL EXPLOITATION (CSE)

Consideration was given to a report which provided the Sub Group with an update on the work currently being undertaken by the Lincolnshire Safeguarding Children Board on Child Sexual Exploitation. The Sub Group received a presentation on the Board's response to CSE in Lincolnshire.

During the presentation, the following points were noted:

- Work was being done on the number of referrals in the county and why certain areas received more than others. A report on this work would be brought to a future meeting;
- Online grooming was more prevalent in Lincolnshire due to its rurality, compared to cities, where street grooming was more common;
- The police was strengthening the role of neighbourhood policing;
- The form of CSE could sometimes be subtle, with some victims not accepting that they had been the subject of exploitation:- jokey photos containing nudity, over the internet, for example;
- Parents tended to take risks online, so their children probably copy them. In addition, teenagers were known to take more risks due to mental development at that age.

AGREED

That the report and presentation be noted.

8. NEGLECT STRATEGY

A report was considered which presented the Neglect Strategy, developed by the Lincolnshire Safeguarding Children Board and its partners.

Following on from the publication from Ofsted of "In the Child's Time", it was recognised that all children's boards should have a neglect strategy to monitor, address and coordinate the response and awareness of the signs and symptoms of neglect.

The strategic objectives were:

- Promoting the effects of neglect in an attempt to minimise repeat cases;

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- Ensuring plans were put place before a neglect case was closed to ensure it was not repeated;
- Effective training;
- Different tools and mechanisms to look at reducing neglect.

Officers had already received training on the issue and the strategy would be revised and improved to pick up on resource changes.

A recommendation from the audit was to make clear when practitioners needed to utilise Early Help and Team Around the Child (TAC).

AGREED

That the report be noted.

9. EARLY HELP AUDIT

The Sub Group considered a report and presentation on the findings and recommendations from the Early Help audit and Team Around the Child (TAC) audit which took place in 2013.

As part of the audit, 11 families were interviewed including teenagers and children.

TAC cases had brought a lot of positive outcomes for families and individuals. However, it had become apparent that the TAC process was complex and needed to be fully explained to parents, otherwise they struggled to understand it.

A workshop to examine the recommendations from the Early Help audit had been set up.

AGREED

That the report be noted.

LINCOLNSHIRE SAFEGUARDING ADULTS BOARD BUSINESS

10. KEY MESSAGES FROM THE LINCOLNSHIRE SAFEGUARDING ADULTS BOARD

Consideration was given to a report which provided an update on the key issues from the Lincolnshire Safeguarding Adults Board meetings held in January and April 2015.

A programme of awareness and training events for frontline staff around the Mental Capacity Act had been set up as a part of the Regional Mental Capacity Act Programme. Close to 100 members of staff attended over two days, with two further events planned for October/November 2015 and more to be arranged in 2016.

The number of Deprivation of Liberty Safeguards (DoLS) cases being dealt with by the Council was currently close to 1400. Legal proceedings were underway to ascertain whether the Cheshire West ruling should be altered to reduce the number of applications being made. Councils across the country had been inundated with applications since the judgement in March 2014.

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Funds to pay for DoLS applications in 2016 had already been secured by Adult Care.

AGREED

That the report be noted.

11. MAKING SAFEGUARDING PERSONAL

Consideration was given to a report which updated the Sub Group on the guidance supplied by the Department of Health and subsequent implementation of *Making Safeguarding Personal.* This programme was a key component for sector led improvement which was designed to support the implementation of the Care Act 2014 and associated statutory guidance.

It was reported that the Board would achieve the Silver Standard in 2015, for Making Safeguarding Personal.

AGREED

That the report be noted.

12. SAFEGUARDING ADULT REVIEWS

The Sub Group considered a report which provided an update on current Safeguarding Adult Reviews (SARs), formerly known as Serious Case Reviews. This report would become a regular item on the Sub Group's agenda.

The Care Act provided clear guidelines on what would define a SAR.

Further updates on existing SARs would be provided at the next meeting.

AGREED

That the report be noted.

JOINT BUSINESS

13. JOINT BOARD WORKING

AGREED

That this item be deferred until the next meeting.

14. JOINT DOMESTIC ABUSE PROTOCOL

Consideration of this item was deferred until the next meeting. However, the Sub Group was asked to nominate a delegate to attend the Domestic Abuse Protocol launch event on 29 September 2015. It was agreed that Mrs Emma Olivier-Townrow (Parent Governor Representative) would attend on behalf of the Sub Group.

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AGREED

1. That this item be deferred until the next meeting;
2. That Mrs Emma Olivier-Townrow (Parent Governor Representative) attend the Protocol launch event on 29 September 2015, on behalf of the Sub Group.

15. LINCOLNSHIRE SAFEGUARDING BOARDS SCRUTINY SUB GROUP WORK PROGRAMME

In order to allow equal time for the business from both Boards, it was agreed to consider items relating to the Lincolnshire Safeguarding Adults Board first at the next meeting.

AGREED

That the work programme and changes made therein be noted.

The meeting closed at 4.35 pm.

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Open Report on behalf of Richard Wills, Executive Director responsible for Democratic Services

Report to:	**Adults Scrutiny Committee**
Date:	**9 September 2015**
Subject:	**Adults Scrutiny Committee Work Programme**

Summary:

This report enables the Adults Scrutiny Committee to consider its work programme for its forthcoming meetings, which is attached at Appendix A.

Actions Required:

To consider and comment on the work programme as set out in Appendix A to this report.

1. Background

Current Work Programme

The current work programme for the Committee is attached at Appendix A to this report. Also attached at Appendix B is a 'tracker' of the items previously considered by the Committee.

Forward Plan

The current relevant entries in the County Council's Forward Plan are attached at Appendix C.

Scrutiny Activity Definitions

Set out below are the definitions used to describe the types of scrutiny, relating to the items:

Budget Scrutiny - The Committee is scrutinising the previous year's budget, the current year's budget or proposals for the future year's budget.

Pre-Decision Scrutiny - The Committee is scrutinising a proposal, prior to a decision on the proposal by the Executive, the Executive Councillor or a senior officer.

Performance Scrutiny - The Committee is scrutinising periodic performance, issue specific performance or external inspection reports.

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Consultation - The Committee is responding to (or making arrangements to respond to) a consultation, either formally or informally. This includes pre-consultation engagement.

Status Report - The Committee is considering a topic for the first time where a specific issue has been raised or members wish to gain a greater understanding.

Update Report - The Committee is scrutinising an item following earlier consideration.

Scrutiny Review Activity - This includes discussion on possible scrutiny review items; finalising the scoping for the review; monitoring or interim reports; approval of the final report; and the response to the report.

1. Conclusion

The Committee is invited to consider its work programme.

3. Appendices - These are listed below and attached at the back of the report

Appendix A	Adults Scrutiny Committee Work Programme
Appendix B	Adults Scrutiny Committee Tracker
Appendix C	County Council's Forward Plan

4. Background Papers - No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk.

APPENDIX A

ADULTS SCRUTINY COMMITTEE WORK PROGRAMME

Chairman: Councillor Hugo Marfleet
Vice Chairman: Councillor Rosie Kirk

9 September 2015		
Item	**Contributor**	**Purpose**
Care Quality Commission – Update on Inspections in Lincolnshire	Deanna Westwood, Inspection Manager, Adult Social Care Directorate Central Region Care Quality Commission	Update Report
Better Care Fund – Outcomes and Finance	Glen Garrod, Director of Adult Care	Status Report
Deprivation of Liberty Safeguards	Mandy Cooke, County Manager, Safeguarding	Status Report
Adult Care – Presentation of Performance Information	Jasmine Sodhi, Performance and Equalities Manager, Commercial Team	Performance Scrutiny
Sensory Impairment Services Re-Procurement	Clair McNally Project Manager Commissioning Team - Older People and People with Physical Disability Marie Kaempfe-Rice, Senior Commercial and Procurement Officer, People Services	Pre-Decision Scrutiny *Executive Councillor Decision* *14 September 2015*
Adult Care Market Position Statement	Clair McNally, Project Manager Commissioning Team - Older People and People with Physical Disability	Status Report
Safeguarding Boards Scrutiny Sub Group – Report of 16 July 2015 Meeting	Catherine Wilman, Democratic Services Officer	Update Report

28 October 2015		
Item	**Contributor**	**Purpose**
Non-Residential Care Contributions Policy – Outcome of the Consultation	David Laws, Adult Care Strategy Financial Advisor	Pre-Decision Scrutiny *Executive Decision 4 November 2015*
Implementation of the Care Act 2014	Pete Sidgwick, Assistant Director, Adult Frailty and Long Term Conditions,	Status Report
Care Farming	To be confirmed	Status Report
Adult Care Budget Monitoring Report	David Laws, Adult Care Strategy Financial Advisor	Budget Scrutiny
Adult Care – Local Account 2014-15	Glen Garrod, Director of Adult Care	Status Report
Wellbeing Service Evaluation (or 9 December 2015)	Chris Weston, Consultant in Public Health	Update Report

9 December 2015		
Item	**Contributor**	**Purpose**
Adult Care – Quarter 2 Performance Information	Emma Scarth, County Manager, Performance, Quality and Development	Performance Scrutiny
Safeguarding Boards Scrutiny Sub Group – Report of 7 October 2015 Meeting	Catherine Wilman, Democratic Services Officer	Update Report

For more information about the work of the Adults Scrutiny Committee please contact Simon Evans, Scrutiny Officer, on 01522 553607 or by e-mail at simon.evans@lincolnshire.gov.uk

APPENDIX B

Adults Scrutiny Committee
Work Programme Tracker

	2013					2014								2015							
Item	12 June	24 July	27 Sept	30 Oct	27 Nov	24 Jan	26 Feb	9 Apr	2 May	4 June	30 Jul	1 Oct	26 Nov	23 Jan	25 Feb	1 Apr	27 May	8 July	9 Sept	28 Oct	9 Dec
Adult Care – General Strategic Items			✓						✓											✓	
Adult Care Market Position Statement																					
Advocacy Re-commissioning				✓																	
Autism Items		✓												✓							
Better Care Fund Items														✓	✓				✓		
Care Bill / Care Act 2014 Items						✓					✓					✓				✓	
Care Quality Commission Items							✓	✓											✓		
Carers Strategy and Related Items			✓							✓			✓								
Case Management Partnership Programme										✓											
Community Support / Home Care															✓						
Contributions Policy – Non-Residential Care																	✓			✓	
Day Services Items							✓					✓									
Deferred Payment Agreements																	✓				
Dementia Related Items						✓															
Direct Payment Items			✓								✓										
Extra Care Housing											✓					✓					
Healthwatch Items									✓												
Hospital Discharge Arrangements	✓																				
Independent Living Team					✓																
Integrated Community Equipment Services			✓									✓									
Learning Disability Items									✓												
Lincolnshire Assessment and Reablement					✓												✓				
Mental Health Items													✓	✓							
My Choice My Care Website				✓																	
Neighbourhood Teams																		✓			
Procedures Manual									✓												
Quality Assurance Items			✓			✓															
Residential Care Items												✓			✓						
Safeguarding Adults						✓													✓		
Sensory Impairment Service Items																			✓		
Staff Absence Management				✓																	
Wellbeing Service & Related Items		✓					✓			✓						✓				✓	
RECURRING STANDARD ITEMS																					
Adult Social Care Outcomes Framework	✓											✓									
Budget Items	✓	✓		✓		✓				✓				✓			✓			✓	
Quarterly Performance	✓		✓		✓		✓		✓		✓	✓	✓			✓		✓		✓	
Safeguarding Board Minutes	✓		✓		✓		✓					✓	✓		✓		✓		✓		✓

APPENDIX C

LIST OF PLANNED EXECUTIVE KEY DECISIONS RELEVANT TO THE ADULTS SCRUTINY COMMITTEE

MATTER FOR DECISION	REPORT TYPE	DECISION MAKER	PEOPLE/ GROUPS CONSULTED PRIOR TO DECISION	HOW AND WHEN TO COMMENT PRIOR TO THE DECISION BEING TAKEN	DIVISIONS AFFECTED
14 September 2015					
Sensory Impairment Services – Re-Procurement	Open	Executive Councillor: Adult Care and Health Services, Children's Services		Senior Commercial and Procurement Officer Tel: 01522 554087 Email: marie.kaempfe-rice@lincolnshire.gov.uk	All

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