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21 November 2023

Adults and Community Wellbeing Scrutiny Committee

A meeting of the Adults and Community Wellbeing Scrutiny Committee will be held on **Wednesday, 29 November 2023 at 10.00 am in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Debbie Barnes OBE
Chief Executive

Membership of the Adults and Community Wellbeing Scrutiny Committee (11 Members of the Council)

Councillors C E H Marfleet (Chairman), A M Key (Vice-Chairman), T A Carter, M R Clarke, Mrs N F Clarke, R J Kendrick, K E Lee, Mrs M J Overton MBE, S R Parkin, M A Whittington and T V Young

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE AGENDA
WEDNESDAY, 29 NOVEMBER 2023

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Minutes of the meeting held on 18 October 2023**	5 - 10
4	**Announcements by the Chairman, Executive Councillor and Lead Officers**	
5	**Wellbeing Service Recommissioning** *(To receive a report by Derek Ward, Director of Public Health and Tony McGinty, Public Health Consultant which invites the Committee to consider a report on the Recommissioning of the Wellbeing Service on which a decision is due to be made by the Executive on 5 December 2023. The views of the Committee will be reported to the Executive as part of its consideration of this item)*	11 - 58
6	**Service Level Performance against the Corporate Performance Framework 2023-24 Quarter 2** *(To receive a report by Caroline Jackson, Head of Corporate Performance, which summarises the Service Level Performance against the Success Framework 2023-24 for Quarter 2)*	59 - 78
7	**Adults and Community Wellbeing Scrutiny Committee Work Programme** *(To receive a report by Simon Evans, Health Scrutiny Officer, which invites the Committee to consider its work programme)*	79 - 86
ITEMS FOR INFORMATION ONLY		
8	**Care Quality Commission (CQC) Pilot Assessment of Lincolnshire County Council - Adult Social Care** *(The Committee are invited to note the findings of the CQC's pilot assessment of Adult Social Care at Lincolnshire County Council, in advance of more detailed consideration of this pilot assessment at the meeting scheduled for 17 January 2024)*	87 - 124

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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

Contact details set out above.

Please note: This meeting will be broadcast live on the internet and access can be sought by accessing Agenda for Adults and Community Wellbeing Scrutiny Committee on Wednesday, 29th November, 2023, 10.00 am (moderngov.co.uk)

All papers for council meetings are available on:
https://www.lincolnshire.gov.uk/council-business/search-committee-records

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE
18 OCTOBER 2023

PRESENT: COUNCILLOR C E H MARFLEET (CHAIRMAN)

Councillors A M Key (Vice-Chairman), R J Kendrick, K E Lee, Mrs M J Overton MBE, S R Parkin, M A Whittington and T V Young

Councillors: Mrs W Bowkett and E J Sneath attended the meeting as observers

Councillors C Matthews and S Woolley also observed the meeting virtually.

Officers in attendance:-

Emily Wilcox (Democratic Services Officer), Glen Garrod (Executive Director - Adult Care and Community Wellbeing), Kiara Chatziioannou (Scrutiny Officer), Pam Clipson (Head of Finance, Adult Care and Community Wellbeing) and Alina Hackney (Senior Strategic Commercial and Procurement Manager - People Services)

30 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors T Carter, N Clarke and M Clarke.

31 DECLARATIONS OF MEMBERS' INTERESTS

None were declared.

32 MINUTES OF THE MEETING HELD ON 6 SEPTEMBER 2023

RESOLVED:

That the minutes of the meeting held on 6 September 2023 approved as a correct record and signed by the Chairman.

33 ANNOUNCEMENTS BY THE CHAIRMAN, EXECUTIVE COUNCILLOR AND LEAD OFFICERS

The Executive Director – Adult Care and Community Wellbeing announced that that the Care Quality Commission had finished undertaking the pilot assessments of Adult Social Care Services in Local Authorities, which had included an assessment of Lincolnshire County Council. A national moderation panel would meet at the end of October to consider the report of the five pilot assessments undertaken prior to proceeding with formal assessments early in 2024. The final report on the pilot assessment of Lincolnshire County Council was

being finalised and it was hoped that it could be brought for consideration by the Committee at its meeting on 27 November 2023.

34 CARE QUALITY COMMISSION - ADULT SOCIAL CARE INSPECTION UPDATE

Consideration was given to a presentation by the Operations Manager - Care Quality Commission, which provided an update on the inspection and monitoring of adult social care providers in Lincolnshire.

Consideration was given to the report and presentation and during the discussion the following points were noted:

- In comparison with Nottinghamshire, it was thought that Lincolnshire had a slightly higher number of services rated as inadequate, and a similar amount of services rated as requires improvement, although specific data was not made available at the time of the meeting.
- Most homes classified as being without a Registered Manager were likely to be in the recruitment process or have a manager in place who was in the registration process, which could take 8 to 12 weeks. It was a requirement that any homes without a registered manager for more than 28 days must notify the CQC.
- There were no specific qualifications needed to become a Registered Manager, although individuals may have an NVQ 5 or equivalent qualification, but it was not essential. Assurance was provided that the registration process was thorough, and interviews explored whether applicants had the relevant qualifications, knowledge, and experience to undertake the role.
- Some concerns were raised by the Committee over the lack of requirement for qualifications, although some members acknowledged the value of experience when recruiting to such positions. Members supported the idea of supporting staff with qualifications on the job to further skills and opportunities. It was noted that the Social Care Reform White Paper had expressed an intention to strengthen the regulations and qualifications for registered managers, which had been welcomed by the sector.
- The Head of Commercial Services – People Services assured the Committee that although CQC carried out inspections of services, Lincolnshire County Council had oversight on an ongoing basis and improvement plans would be implemented for any services deemed inadequate or requiring improvement.
- Similarly, the absence of a registered manager within a service would trigger the risk matrix and initiate further oversight from LCC.
- The Committee was reassured that CQC inspections would include conversations with staff members to identify any key issues within the services.
- Members highlighted impact of delays in discharge from healthcare services to care services could have on an individual's health and quality of life. Members were reassured that in Lincolnshire, discharge from healthcare services was working well.
- Where a service had been deemed inadequate by CQC or identified as having significant risk from assessments made by LCC, the Council would take a leading role

on intervening in the service, whilst working closely with CQC and other partners to make improvements where possible. In some cases, it was clear that the right decision was to decommission the service and find alternative arrangements for residents.

- A report on Contract Management within Adult Care and Community Wellbeing would be reported to the committee at its next meeting and would provide an insight into the intervention, management and the compliance of homes, from the perspective of the local authority.
- Judgements inadequate and requires improvement services would not be updated on the CQC's website until reinspection. Members were concerned that families lacked communication and assurance by CQC during that period, however Members were assured that services continued to be monitored by CQC and the local authority during this period, despite data not being available online. Providers of services were responsible keeping relatives informed.
- It was hoped that the new strategy and changes to the operations roles would allow CQC to keep up with the changing dynamic of health and social care and monitor the pathways into healthcare.
- Members recognised a lack of detailed analysis of the work of CQC within Lincolnshire within the report and requested that future reports provide further information on the Lincolnshire picture. It was also agreed that in future, annual update reports from CQC be scheduled for January each year to ensure as the state of care report would be published at that time.
- Further to this, it was agreed that an item on workforce development, recruitment and retention within the Adult Social Care sector be added to a future agenda.

RESOLVED:

That the report be noted.

35 POTENTIAL TOPICS FOR SCRUTINY REVIEW BY SCRUTINY PANEL A

Consideration was given to a report by the Scrutiny Officer, which invited the Committee to consider potential topics for review by Scrutiny Panel A.

Upon considering the report, the Committee agreed to await the publication of the CQC pilot assessment of Adult Social Care Services in Lincolnshire which was hoped to be published in November, before putting forward a topic for discussion as there was potential that it would identify areas of work.

RESOLVED:

That potential topics for a scrutiny review by Scrutiny Panel A be reconsidered following the publication of the CQC Pilot Assessment of Lincolnshire County Council's Adult Care Services.

36 ADULT CARE AND COMMUNITY WELLBEING BUDGET MONITORING 2023-2024

Consideration was given to the Head of Finance – Adult Care and Community Wellbeing, which invited the Committee to consider the Adult Care and Community Wellbeing Budget monitoring update for 2023-24, as set out in the report.

Consideration was given to the report and during the discussion the following points were noted:

- A £700,000 underspend was welcomed, although Members acknowledged that the level of underspend was insignificant in comparison to the daily spend within the Directorate and highlighted the impact of seasonal variations on the budget, in particular winter pressures.
- The Executive Director – Adult Care and Community Wellbeing highlighted the increasing trend by the Government to issue in year grants which was likely to continue.
- The forecasted increased cost pressures of £13.5m for 2024/25 were highlighted. Members acknowledged the difficulty in managing expectations to achieve a balanced budget for 2024/25.
- The Executive Councillor for Adult Care and Public Health thanked the Head of Finance – Adult Care and Community Wellbeing for her work to keep budgets balanced and regulated, which was echoed by the Committee. Longer term aims for the Directorate included sustaining the workforce, supporting mental health provision and how to support providers to sustain workforces.
- Members were pleased that the capital funding programme was confirmed and commended staff for their outstanding work in helping vulnerable people.
- The Council continued to invest in day services, with a number of developments ongoing. The positive impact of the investments in these services was overwhelming.

RESOLVED:

That the report be noted.

37 ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE WORK PROGRAMME

Consideration was given a report by the Scrutiny Officer, which invited the Board to consider its planned work programme.

The Committee noted the following additions to the work programme:

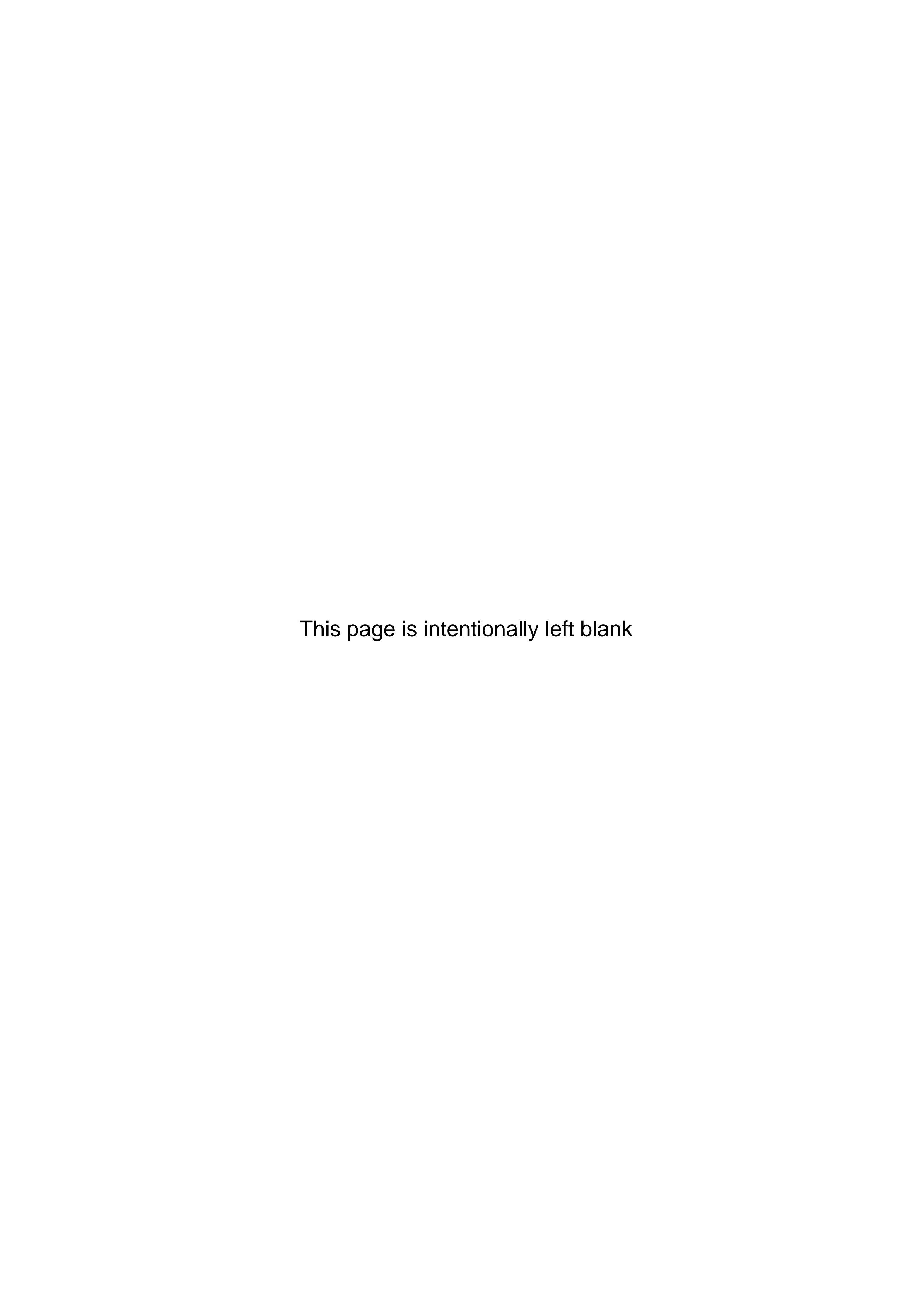
- A report on Contract Management within Adult Care and Community Wellbeing Workforce development, recruitment and retention within the Adult Social Care sector.

- Analysis of the CQC's pilot assessment of Adult Social Care in Lincolnshire.

RESOLVED:

That the report and additions to the work programme be noted.

The meeting closed at 11.52 am



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Open Report on behalf of Martin Samuels, Executive Director - Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**29 November 2023**
Subject:	**Wellbeing Service Recommissioning**

Summary:

This item invites the Adults and Community Wellbeing Scrutiny Committee to consider a report on the recommissioning and procurement of the Council's Wellbeing Service. The decision is due to be considered by the Executive on 5 December 2023. The views of the Scrutiny Committee will be reported to the Executive, as part of its consideration of this item.

Actions Required:

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

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

1. Background

The Executive is due to consider a report entitled Wellbeing Services Recommissioning on the 5th December 2023. The full report to the Executive 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. The Committee's views will be reported to the Executive.

3. Consultation

a) Risks and Impact Analysis

A copy of the Equality Impact Assessment is attached as part of Appendix A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Report to the Executive – Wellbeing Services Recommissioning

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 Tony McGinty, who can be contacted on anthony.mcginty@lincolnshire.gov.uk

Appendix A

Open Report on behalf of Martin Samuels, Executive Director - Adult Care and Community Wellbeing

Report to:	**Executive**
Date:	**05 December 2023**
Subject:	**Wellbeing Service Recommissioning**
Decision Reference:	**I029631**
Key decision?	**Yes**

Summary:

The Lincolnshire Wellbeing Service is one of a range of services commissioned by the Council to help local people maintain their independence and prevent escalation of their needs. It is a service which contributes significantly to the Council's prevention duties within the Care Act and the Council's aspirations for local people expressed in local strategies.

The County Council has commissioned a Wellbeing Service since 2014. The service was last recommissioned in 2018. The current contract has been extended to 30 September 2024 subject to a review during 2022-23.

The current service comprises these key elements: Assessment, Generic Support, Telecare Response, Small Aids for Daily Living (SADL), Resettlement and Hospital In-reach. Each of these is described in the body of this report.

To support decision making about the future scope, commissioning and procurement of this service, a commissioning review has been undertaken covering: learning from current service delivery, performance against contract measures and assessment of future demand alongside benchmarking against similar services elsewhere.

Initial market engagement has also been undertaken to understand market attitude to the service model. The review findings have been considered alongside stakeholder feedback, best practice guidance, current legislation, local and national strategies and the development of other local services during the life of the current contract.

The report presents the case for recommissioning a countywide Wellbeing Service, but with changes to the elements of the service to incorporate the findings of the review. The report seeks approval from the Executive to procure a new contract for a revised Wellbeing Service commencing October 2024.

Recommendation(s):

That the Executive:

1. Approves the commissioning of a countywide Wellbeing Service for people aged 18 and above, generally as described in section 1.6 of the Report.

2. Approves the undertaking of a procurement to establish a contract to be awarded for this service, effective from October 2024.

3. Delegates to the Executive Director for Adult Care and Community Wellbeing, in consultation with the Executive Councillor for Adult Care and Public Health, the authority to determine the final form, and approve the award of the contract.

Alternatives Considered:

1. **Recommission the service on a like for like basis**
   - Whilst the review indicated the current service performed well against the contract and specification, some elements of the service are sub-optimal and pathways into it have become outdated.
   - Like for like recommissioning, or extending existing contracts, would be a lost opportunity to redesign the service in line with the review findings.
   - The demand for the current service model is forecast to increase to beyond the capacity of the current model, so redesign and efficiencies are required to mitigate this risk.

2. **Bring all, or some components, of the current service in-house**
   - The assumed best fit would be with elements of adult care, but this approach would blur the boundaries between statutory and non-statutory services. This risks referrals for non-statutory services moving into statutory provision at a faster rate than an external delivery model.
   - Integrating functions with existing internal services would result in disruption to those service structures and models.
   - Significant TUPE liability and capacity risks would arise from mandatory transfer of staff into the organisation.
   - From the analysis undertaken a robust business case for in-house provision cannot be evidenced.

3. **Do nothing – no longer commission a Wellbeing Service in Lincolnshire**
   - Whilst this would deliver short term saving, it will lead to a proportion of the 9,000 people referred to the service each year entering higher-cost regulated services immediately, or earlier than if the Wellbeing Service support were available.
   - The service supports the Council to deliver a range of its prevention duties, the outcome and value of which are clear in the service review findings.
   - The service is highly regarded by service users and stakeholders and ceasing it would be unpopular and damage the Council's reputation.

Reasons for Recommendations:

1. The Wellbeing Service is an established and valued component of the prevention offer to Lincolnshire's residents. It supports the Council's prevention responsibilities under the 2014 Care Act and the Corporate Plan priority of enabling people to have fulfilling lives with independence and access to the right support at the right time. The service is equally aligned to the prevention and tackling inequalities shared aims of Better Lives Lincolnshire and the Joint Health and Wellbeing Strategy The service is ideally positioned to support future integration initiatives that improve the population's health and wellbeing.

2. The service has evidenced its contribution to reduce and delay deterioration into higher-cost services across the current contract term. It has diverted and managed the needs of significant numbers of people, benefitting individuals as well as reducing costs to social care and the NHS.

3. Service user and stakeholder engagement has demonstrated clearly that a service of this type offers significant support to service user outcomes. The current service has consistently demonstrated that 98% of service users are successfully supported, with support to 'maintain independence' the most requested outcome area.

4. The revised service model proposed seeks to focus resources on the elements that are performing well, are proven in evidence base and best aligned to the strategic aims of the service. It will help reduce duplication with services commissioned elsewhere and release some resources to assist in management of demand and cost pressures.

5. The redesign will help to release some resources by removing less effective elements of the service, seeking to divert some routine needs to other services (particularly financial support aspects) and building in more controls to access, enabling the service to be recommissioned within the existing budget.

1. Background

1.1 Legislation and National Guidance

The Care Act 2014 places a 'prevention duty' on local authorities which requires them to help to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. In taking on this role, local authorities need to work with their communities and provide or arrange services that help to keep people well and independent. This should include identifying the local support and resources already available and helping people to access them.

Local authorities should also provide or arrange a range of services which are aimed at reducing needs and helping people regain skills, for instance after a spell in hospital. They should work with other partners, like the NHS, to think about what types of service local people may need now and in the future.

The NHS Long Term Plan 2019 sets out the long-term ambitions for preventative services like the Wellbeing Service. One of these ambitions, reflected in the aims of the Lincolnshire Integrated Care System (ICS), is to support people to age well by bringing together different professionals to coordinate care better, helping more people to live independently at home for longer, developing more rapid community response teams to prevent unnecessary hospital spells, speed up discharges home, and give more people more say about the care they receive and where they receive it.

The Wellbeing Service is a central mechanism for meeting the Council's prevention duty by supporting residents to identify and access local support and resources with an explicit focus on and evidenced improvement in independence for service users.

The Health and Care Act 2022 put the Care Quality Commission's (CQC's) assurance of adult social care authorities on a statutory footing from 1 April 2023. This assurance framework includes a range of themes which relate to the 2014 Act's prevention duty. They include: 'Supporting People to Live Healthier Lives; Prevention; Wellbeing and Information and Advice'. The Wellbeing Service has recently been part of a pilot review of the Council's adult care provisions, alongside other services designed to support this prevention duty and initial feedback is expected soon, although it seemed to be very well received by inspectors.

1.2 Lincolnshire Business Drivers

Lincolnshire County Council's Corporate Plan identifies key ambitions, one of which is to enable everyone to enjoy life to the full. This is underpinned by the design of an accessible and responsive health and care system within local communities, protecting people, and promoting wellbeing, whilst promoting the support offered to our communities to enable them to be self-sufficient and thriving. The Wellbeing Service provides an 'anchor' set of services and pathways to support local people achieve these ambitions.

The Integrated Care Partnership Strategy's (2023) emerging shared ambition for Better Lives Lincolnshire, by 2030, is: 'For the people of Lincolnshire to have the best possible start in life, and be supported to live, age and die well.'

The aims of the Strategy that set the strategic direction up to 2025 are to:

- Focus on prevention and early intervention.
- Tackle inequalities and equity of service provision to meet population needs.
- Deliver transformational change to improve health and wellbeing.
- Take collective action on health and wellbeing across a range of organisations.

The NHS Lincolnshire Joint Forward Plan 2023–2028 describes the priorities that Lincolnshire's NHS and its partners will jointly focus on over the next five years to meet the population's physical and mental health needs, in the context of the overall ICS ambition and aims. These priorities are a new relationship with the public; living well, staying well;

Improving access; Delivering integrated community care; and a happy and valued workforce.

1.3 Current Services Summary

Lincolnshire's Wellbeing Service (WBS) provides a range of component service elements designed to promote adults' (aged 18+) ability to live fulfilling, active and independent lives.

The WBS is preventative in focus, and aims to:

- Improve or prevent the deterioration of individuals' health, wellbeing, and overall quality of life;
- Enhance independence at home, improve individuals' ability to self-care and access appropriate supporting structures and community resources;
- Reduce or delay escalation to statutory support services.

The service currently comprises the following elements, delivered countywide:

- **Assessment** - A person-centred and strength-based assessment of all eligible individuals referred into the service, exploring the needs and outcome areas they are seeking support to improve. The assessment informs the development of a tailored support plan.

- **Generic Support** - Up to 12 weeks of generic support based on the individual's self-identified outcomes and needs identified through their assessment. This may include advice, connection and signposting to community resources, other relevant services and/or direct support to meet individual needs.

- **Telecare Response Service** - Provision of a visit to the home of a service user, who has subscribed and pays for this service, in response to a request from a telecare monitoring provider. For subscribed service users this is offered 24 hours, 7 days per week (generally where no informal carer has been or can be identified to attend). The countywide deployment of trained responders can assess and assist with a range of needs including non-injury falls, as well as providing support and reassurance in emergency situations.
- **Small Aids for Daily Living** - Rapid installation of items of preventative equipment, known as small aids for daily living (SADLs), and installing minor adaptations which are supportive to the wellbeing and independence of the service user. The costs of the equipment are met by the individual, who may source these independently or through stocks held and supplied by the Provider. Installation and support to utilise them is provided by the service free of charge.

- **Resettlement Service** – Working with health and care partners to visit and support individuals returning from a hospital stay to resettle into their home. Activities might include turning on the heating, ensuring food and drink is available, unpacking belongings and medication. This service is available between the hours of 10am to 10pm daily via referrals from acute and community hospital teams countywide.

- **Hospital in-reach** – A supporting role in hospital discharge pathways where service users' discharges could be supported by elements of the Wellbeing Service or connection with wider services.

1.4 Eligibility for Service

The core service eligibility criteria apply to the assessment, generic support and SADL adaptations components of the WBS. To be eligible for these components an individual will have met four or more of the criteria below:

- Over 65 years old
- Unable to manage a long-term health/medical condition
- Regular GP visits for the same medical condition or for non-medical reasons
- Unplanned hospitalisation/A&E attendance within the last 90 days
- Accessed/made use of the Council's social care service in preceding 12 months (assessment, day care, home care, reablement or residential care)
- Bereavement of spouse or partner or divorce within the past year
- A fall in the past three months (either at home or away from the home)
- Unable to manoeuvre around the home safely
- Lack of social support and/or interaction with family, friends, carers, or experiencing feelings of isolation
- Experiencing feelings of stress, depression or anxiety affecting mental health and wellbeing
- Work, education, or volunteering cannot be sustained
- Unable to manage money or in considerable debt

Analysis of referral data indicates that well over 90% of individuals seeking or referred to the service are eligible for support, with individuals on average meeting 5.8 service criteria in the last two contract years.

The most identified criteria during this period remained consistent as stress related concerns, mobility around the home and being over the age of 65. During the initial contract term service eligibility was amended to enable people with a learning disability and/or Autism to access the service irrespective of the above criteria as part of a joint initiative between the Provider and LCC Practitioners to improve awareness and utilisation of the service.

Eligibility for the resettlement service is at the discretion of hospital discharge teams and partners for people who are leaving hospital with relevant needs. The telecare response service is available to Lincolnshire residents who receive telecare and subscribe to the service.

The current service Provider has also played a significant role as a strategic partner in supporting the local government, health, and care system to support vulnerable people in emergency situations. These include flooding incidents, the Coronavirus pandemic response and support to Afghan refugees and Ukrainian guests in Lincolnshire.

1.5 Commissioning Review

Contract Utilisation

Over the initial 5-year contract period from April 2018 to March 2023, there have been over 39,000 referrals into the core elements of the Wellbeing Service (i.e., Assessment, which may lead to a period of generic support and/or SADLs).

Figure 1: Core Service Referral Volumes Contract Years 1 to 5

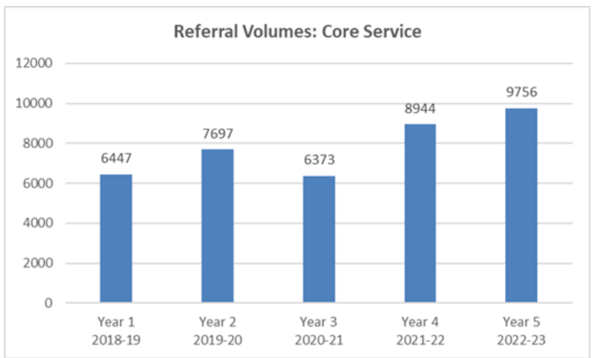


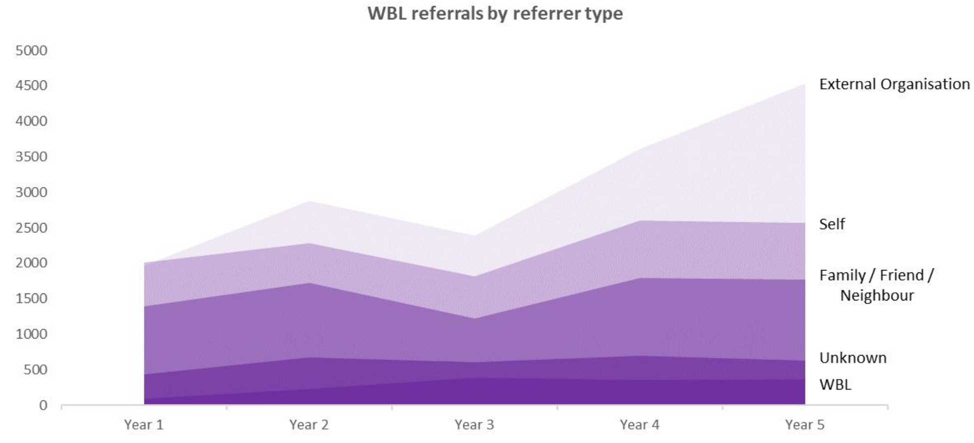
Figure 1 presents the trend of referral volumes increasing year on year, except for 2020-21 due to the Coronavirus pandemic. Referrals increased 40% from Year 3 to Year 4 as the service and referral partners recovered from the disruption caused by the pandemic. Further increases of 9% were experienced between Year 4 and 5 with the highest referral volumes to date recorded in March 2022, potentially linked to recent cost-of-living challenges.

Overall, the service has experienced a 51% growth in referrals from Year 1 to Year 5. Referral volumes show some seasonal variation but are consistent across the year.

Referral pathways into the core service have evolved during the lifetime of the current service. At contract commencement, the predominant referral route (for both professional and self-referrals) was via the dedicated service telephone line, managed through the Customer Service Centre (CSC). As the service transitioned to full case management via Mosaic in 2019 this facilitated direct (in system) referrals from some professionals. As a result, professionals completing Mosaic screening has increased from 9% in Year 2 to 13% in Year 5.

The service has also introduced electronic referrals for professionals who do not currently have access to Mosaic (including GPs). This referral route has also increased from 3% of all referrals when launched in Year 3 to 13% in Year 5.

Figure 2: Core Wellbeing Service Referrals Year 1 to 5



During the initial 5-year contract term, 39% of people have been referred into the service by professionals. The top 5 teams/organisations referring into the service are Adult Care, GPs, LPFT, Occupational Therapy and United Lincolnshire Hospital Trusts (ULHT). Self-referrals account for 28% of total referrals followed by referrals made by family/friend/neighbour. Over the past five years there has been an increase in the proportion of referrals being referred by professionals and a decrease in the proportion of self-referrals and referrals by friends and family. External organisations have an average annual growth rate (AAGR) of +26% which is greater than the +13% AAGR of overall referrals.

This growth reflects how the service has become embedded across the health and social care landscape supported by the work of the Wellbeing Service's Partnership and Network Development Officers and improved referral pathways.

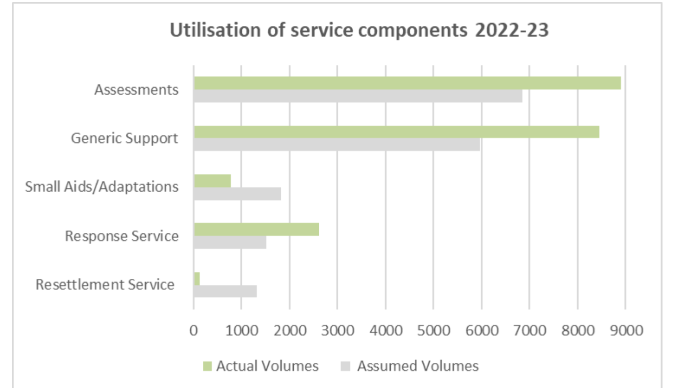
Assumed volume projections for some of the service elements were established at contract commencement in 2018. These were based on a predicted growth of 2.5% per component per year and were informed by previous service data. Figure 3 below sets out the percentage of projected volumes realised over the initial five-year contract term.

Figure 3: Percentage of Assumed Service Volumes Realised

Service Element compared to original volume levels	**Year 1 2018-19 %Volumes**	**Year 2 2019-20 %Volumes**	**Year 3 2020-21 %Volumes**	**Year 4 2021-22 %Volumes**	**Year 5 2022-23 %Volumes**
Assessments	82%	90%	76%	115%	130%
Generic Support	94%	103%	87%	134%	142%
Small Aids/Adaptations	34%	47%	28%	50%	43%
Response Service	55%	98%	110%	146%	172%
Resettlement Service	5%	7%	2%	13%	10%

Analysis of utilisation within the service components has highlighted that elements of Assessment, Generic Support and Telecare Response have exceeded projected volumes in the previous two contract years. In 2022-23, 8,900 assessments were conducted by the service, over 2,100 more than projected representing a 7% increase on the previous year, well above the 2.5% year on year growth modelled in the contract. Conversely, the resettlement and SADL service elements have experienced lower than anticipated demand as illustrated in Figure 4 below.

Figure 4: 2022-23 Volumes and Utilisation of Service Components



Contract Performance and Outcomes

The current Wellbeing Service contract is monitored against seven Key Performance Indicators (KPIs) the annual performance of these across the initial contract term is set out in Table 1 below. Overall, the Provider has maintained a good level of performance across the range of stretching targets. This includes strong delivery against the timescale indicators despite the increased demand outlined above for Assessments, Generic Support and Telecare Response.

The proportion of individuals referred during each contract year who subsequently receive long term funded support and/or adult care support has remained below the target level of less than 5%. This suggests, given the demographic profile of those accessing the service, the service positively contributes to preventing or delaying escalation to statutory support services.

Table 1: Contract Performance Year 1 to Year 5

Key Performance Indicator	Target	Year 1 18-19	Year 2 19-20	Year 3 20-21	Year 4 21-22	Year 5 22-23
Service users supported to achieve an overall improvement across their outcomes	98%	96.4%	97.3%	99.4%	99.1%	98.9%
Overall improvement in all outcomes across all service users	200%	180.1%	305.3%	315.3%	338.2%	330.2%
Service users who go on to receive long term support from ASC post service intervention	>5%	3.1%	0.4%	2.6%	0.7%	TBC
Telecare call outs attended within 45 minutes of alarm being notified	90%	48.3%	80.3%	86.2%	90.6%	88.6%
Assessments which take place within 7 days of referral	90%	51.5%	53.3%	97.7%	88.8%	92.8%
Generic support sessions which take place within 10 days of assessment	95%	81.4%	86.6%	98.1%	94.0%	89.7%
Non-urgent SADLs installations fitted within 7 days of referral	90%	51.4%	70.8%	88.6%	83.3%	72.8%

The key outcome measure, linked to the Council Business Plan, has consistently demonstrated that individuals are achieving an overall improvement in their outcomes through service interventions. People's outcomes are self-identified as part of their assessment across the eight domains of: Staying Safe; Improving Independence; Substance Misuse; Mental Health and Wellbeing; Physical Health. Social Contact; Participation and Managing Money.

The most common outcome achieved with people who draw on services was an improvement in their independence, which is the primary goal of the service. Service data clearly indicate that a range of the other outcomes are being achieved with people as part

of their personalised ‘generic support’ plans, which support the improvements in independence for them.

Engagement Findings

Over 300 responses (ranging from those aged 18 – 84) were received through the engagement activities carried out as part of the service review. Overall, feedback was very positive, and the service considered well run, supportive and appreciated by people who drew on the service and professionals. The work the service provides to keep people independent, prevent hospital admission and relieve pressure on higher cost health and care services was valued greatly. The importance of the role the service plays in keeping people safe at home and avoiding or delaying the need for a more costly package of care was flagged.

Engagement with the market was undertaken in June 2023 and responses were received from six organisations. The participation and feedback from the market was broadly positive and indicative of the likelihood of there being market interest in delivering the service. Existing contract principles of a single provider model, block payment with volume-based targets and additional unit costs to support exceptional demand, and outcome focussed performance management approach were all supported as appropriate and viable. A longer-term contract (minimum 5 years initial term) was also preferred to support the development and growth of services.

Stakeholder engagement about the current service and its future was positive about the role the service plays and can continue to play. There was a view that the service would be beneficial to even more local people than had accessed it to date, should there be resources to maximise marketing and meet the demand generated.

Benchmarking activity did not identify any directly comparable services, packaged ‘as a whole’ in the way the Lincolnshire Wellbeing Service is currently designed. Comparison of key components of the Lincolnshire service with those components elsewhere identified that the Lincolnshire model was equivalent or better than models elsewhere with comparable costs. The main area of practice found in other areas, which warrants development in any revised local service, was around ‘true’ trusted assessor approach to SADLs and minor adaptations.

Key Findings of Review in Summary

The review of the current service has involved analysis of performance, management information and several focus sessions with the delivery teams of the various service components to capture their insights and explore the learning from the past five years as well as benchmarking, literature review, market engagement and stakeholder feedback. The key findings of the review were as follows:

- Eligibility and user outcomes should be revised to re-focus future resources and interventions allowing for targeting of specific cohorts and maximising service impacts.
- A remodelling of service entry and access points incorporating digital, self-screen/assessment options and promoting self-serve/information for commonly identified needs e.g., money management and benefits advice, local social support groups and activities.

- Moving to a mixed model of delivery (telephone and face-to-face) has improved efficiency without impacting the ability to capture the needs of individuals. Moving forward, incorporating a risk stratification tool would bolster assurance that face-to-face interventions are being used when necessary.
- The Resettlement Service element has been poorly utilised despite service efforts to embed awareness in discharge pathways. Equally, the Hospital In-reach function has struggled to evidence impact within a 'crowded' and complex hospital discharge landscape. Continuing to allocate resources to these elements would not constitute value for money for the Council.
- Telecare Response has consistently delivered timely support which best practice guidance tells us prevents deterioration and mitigates risk for those seeking help through their telecare systems. The 45-minute response time drives the current delivery model requiring staff to be on standby to deploy from around the county and could be lengthened to 60 minutes without significant deterioration in outcomes.
- There is an opportunity to broaden the scope of SADLs to include assistive technologies and closer alignment with Occupational Therapy teams to maximise the utilisation of adaptions and aids to maintain individuals' safety and independence at home.
- The service has made a valued contribution to respond and flex to emergencies such as the Covid-19 pandemic, flooding incidences and assisting the arrival of refugees, and has supported the Council to react and divert resources at pace. Formalising this within a revised service scope would support future resilience and emergency planning.

1.6 Proposed New Service Model

Referral demand has consistently increased year on year since 2018 (except for 2020-21 due to the pandemic). Projections suggest this trend will continue should eligibility and entry pathways remain unchanged. Forward modelling indicates ongoing growth in referral for assessment and subsequent intervention, especially in 65- to 84-year-olds and 85+ year olds at rates of 10.1% and 14.7% over the next 5 years.

The service and demand review, benchmarking, market engagement, stakeholder feedback and a review of how this service should sit within the Lincolnshire 'system of services' has refined the proposed future Wellbeing Service model as depicted below. The broad strategic aim of the service should remain to promote independence and prevent deterioration of need for adults of all ages across Lincolnshire. The key features of the proposed revised commercial model are summarised as follows.

Specification Improvements

- Continuation of an accessible service, but with access criteria that can be flexed to support demand management and targeting of resources. A key element here will be to ensure that the service is effectively positioned within the wider suite of services that are available across the county, whether funded or delivered by the County Council or others. This will ensure individuals receive the service that is most appropriate for them and their circumstances (which may be a service other than

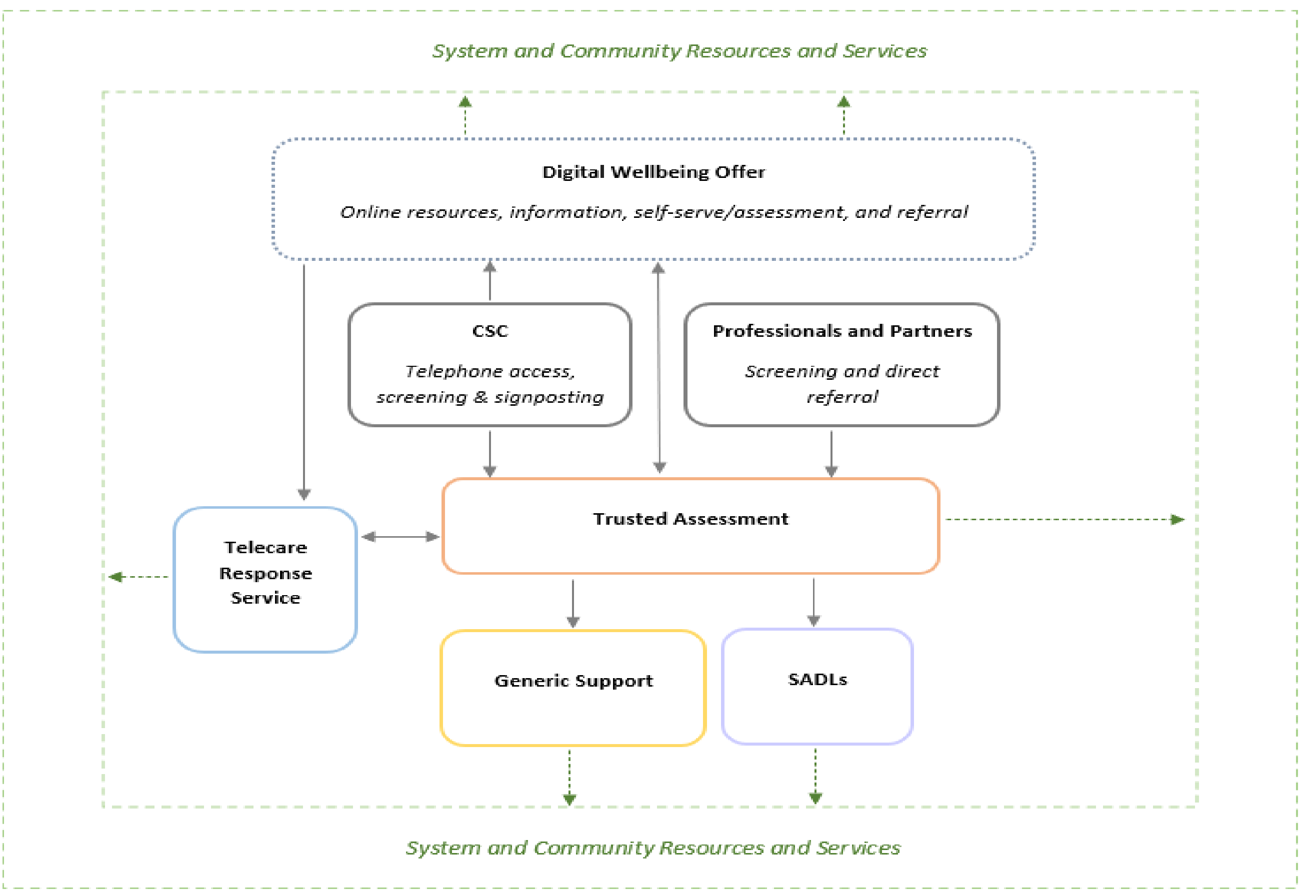
the Wellbeing Service) and will minimise the potential for overlap or duplication between services. For example, signposting people who need support with money management to other digital resources and services.

- Refinement of the current eligibility criteria, which almost anyone can meet, towards a defined strength-based eligibility criteria aligned to the purpose and functions of the service.

  A key element here will be to have the primary purpose of the service leading access to it i.e. If a person is at risk of losing their ability to live well and independently at home, then they meet the main eligibility criteria for access.
- Secondary access criteria would then be applied to check which service would be the best fit for the person. For example, a person at risk of losing independence at home might identify the solutions to this risk to be an adaptation to improve access to and from the building and help to build a social network – which the service can support.

  Another person might identify that their housing is unfit or unsafe and would be referred to housing services as the Wellbeing Service is not the correct service to support this need.

  A strength-based approach to this sort of criteria would, for example, be: '*I want to be able to carry on shopping and cooking for myself and this would be easier if the steps to the house were easier to use or if I could find a shopping buddy'.*
- Enhanced digital access including self-serve/assessment and resources to enable people to access frequently identified information and signposting advice negating the requirement for a full trusted assessment in some cases. This shift would have some dependence on our CSC capability and capacity.
- Adoption of a 'trusted assessor' role to initially enable assessment of need for SADL and 'prescription' of a defined range of equipment and adaptations currently requiring occupational therapy referral.
- SADL service element to align closely with occupational therapy teams with a renewed emphasis on defined 'preventative adaptations and retail tech-based solutions'. The existing charging system for people should remain unchanged.
- Dedicated Hospital In-reach should not be recommissioned as provision within the system is now widely available. Assessments may be conducted in all settings, including hospitals in line with people's needs. However, resources will no longer be based within hospitals.
- The resettlement service should also not be recommissioned as it is poorly utilised and other such provision is available in the wider system.
- A Telecare Response service should continue to be specified as part of the service provision with a range of contribution levels from people who draw on the service for different levels of service e.g. introducing new offers such as temporary cover for carer's respite or holiday.



Service Delivery Model

Delivery will be by a single countywide Wellbeing Service. The competition phase will not preclude bids from consortia and sub-contracting models, which should maximise the level of competition and potential range of solutions.

Contract Duration

The contract term will be a period of up to 10 years, with an initial period of 5 years and opportunities to extend by up to a further 5 years. A longer duration offers greater stability for both Council and Provider, with reduced risk around market volatility and enabling stronger partnership and strategic relationships. Market engagement was supportive of this approach.

Payment Mechanism

Payment will be by way of a fixed sum (block payment) for the delivery of core service volumes. Bidders will submit costs up to but not exceeding the fixed sum confirmed by the Council prior to publication. Included as part of their pricing submission bidders will be required to submit details of the service volumes and outcomes achievable within their respective delivery solutions and pricing proposal, subject to the minimum expectations set by the Council. Unit prices for specific service elements will also be established and used as the basis for an additional payment mechanism, should demand exceed the service delivery volumes finalised during the tender process. Payment for any services beyond the

maximum available budget will be subject to prior approval by the Council's representative. The Council will reserve the right to prioritise service element streams should costs approach the available budget threshold.

Open Book Accounting Approach

The contract will be monitored as an open book arrangement. This will enable the Council to develop a full understanding of the costs of delivery for discrete elements of the service and to understand how costs link to volumes of service delivery. This will also offer visibility of any efficiencies achieved in delivery of the core service elements, which will then be apportioned via a gain share mechanism.

1.7 Budget and Cost Implications

The current contract price was set at tender for each of the initial five-year periods ranging from £3.2 to £3.3 million across the contract term. During this time the provider has absorbed significant cost of living increases, a proportion of which were planned for within a dedicated staffing contingency element of the budget and through utilising underspend accrued during the initial mobilisation of the service. The provider has also managed between 30-40% higher than projected volumes for some core service elements in recent years through service efficiencies, lower than expected volumes of activity in some elements of service and moving to a hybrid model of delivery (online, telephone and face-to-face).

The revised model does provide potential further cost efficiencies through the removal of the Hospital In-reach and resettlement service elements. However, because of the growth in service demand, projected demographic, and cost of living inflationary pressures, any efficiencies resulting from the removal of these service elements should remain within the service budget to be targeted at those highest priority components and cohorts to ensure the service delivers the greatest impact.

The effect of redesign and demand management changes on the costs of the service will need to be kept under close review, and decisions made about the balance between additional investment and demand management over the life of the contract.

In addition to the potential efficiencies, the service contains elements attracting income from people who draw on it and charges and adjustments to the Council's approach to those aspects will be further considered as the detailed model is developed.

The competitive tendering process will test the deliverability of the revised service model within the constraints of the available confirmed budget to determine the service volumes and outcomes achievable within the respective delivery solutions.

1.8 Risk and Dependencies

Accurate future demand projections are inherently challenging to predict in broad scope preventative support services. An increasing proportion of current service referrals (40% in 2022-23) are via professionals and external agencies making the service vulnerable to changes in the referring patterns of key partners.

The Integrated Care Board (ICB) social prescribing model is currently being recommissioned which may increase flow into the Wellbeing Service as practice in primary care evolves within a revised model. Maintaining flex in eligibility thresholds during a future contract term will assist with dynamic intelligence driven demand management, whilst maintaining strong strategic links with key partners will be critical to navigating service interdependencies.

Population and demand projections, coupled with high inflation may impact the future sustainability of service costs for providers within the available service budget. This will be partly mitigated by efficiencies gained from ceasing some elements and testing the deliverability of the revised service with the market. Any future integration schemes may equally attract funding from system partners.

Any significant changes in fees for Telecare Response may result in people withdrawing or transferring to other providers. Where this is the case, this may increase risk for them. Where the people involved are receiving this element of service as part or in support of a regulated care package this will impact the workload of case workers in managing the risk. Ensuring fees do not exceed the market rate should assist in mitigating this risk alongside close working with practitioners during service mobilisation to identify such cases.

1.9 Public Services Social Value Act

In January 2013 the Public Services (Social Value) Act 2013 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 incentivise the delivery of a skilled and trained workforce.

Under section 1(7) of the Public Services (Social Value) Act 2013 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 adopted elsewhere has been reviewed. This and the market consultation 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.

2. Legal Issues:

Equality Act 2010

Under section 149 of the Equality Act 2010, the Council must, in the exercise of its functions, 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 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.

The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

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 to the need to tackle prejudice and promote understanding.

Compliance with the duties in Section 149 may involve treating some persons more favourably than others.

The duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all 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.

The purpose of the service being reviewed is to address a range of needs for every person aged 18 and above who is resident in the county with certain needs. In reviewing the service, particular analysis has been undertaken to understand if the service impacts differently on any groups with protected characteristics by the eligibility, design or delivery of services.

Some of the changes proposed for the redesigned service are linked to this assessment, for example removing reference to age, other than that this being a service for all adults from access criteria, to avoid prioritisation of access on this basis alone.

The service design proposed, however, remains deeply personalised supporting all individuals with protected characteristics which require adjustments to the service offer to be supported.

A full Equality Impact Assessment can be found at Appendix A of this report.

Joint Strategic Needs Analysis (JSNA) and the Joint Health and Wellbeing Strategy (JHWS)

The Council must have regard to the JSNA and the JHWS in coming to a decision.

Lincolnshire JSNA clearly identifies the ageing population of the County as a significant challenge facing the County as a whole and the demand for health and care services. It identifies interventions which should be implemented to both prevent poor health and slow the loss of health and independence people experience as they age.

Lincolnshire JHWS aims to inform and influence decisions about health and social care services in Lincolnshire so that they are focused on the needs of the people who use them and tackle the factors that affect the population's health and wellbeing.

The themes of the Strategy are to:

- Embed prevention across all health and care services;
- Develop joined up intelligence and research opportunities to improve health and wellbeing;
- Support people working in Lincolnshire through workplace wellbeing and support them to recognise opportunities to work with others to support and improve their health and wellbeing;

- Harness digital technology to provide people with tools that will support prevention and self-care;
- Ensure safeguarding is embedded throughout the JHWS.

The Wellbeing Service is a core contributor to the addressing of the needs identified within the 'Age Well' area of the JSNA and contributes significantly to the embedding of prevention, technology-based prevention and care development and safeguarding into the Lincolnshire system.

Crime and Disorder

Under section 17 of the Crime and Disorder Act 1998, the Council must exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area (including anti-social and other behaviour adversely affecting the local environment), the misuse of drugs, alcohol and other substances in its area and re-offending in its area.

The service does not directly contribute to section 17 duties, although elements of it will certainly increase the security of people's homes and their sense of safety. This will be achieved through the installation of small aids for daily living and security, safety and alarm technology where these are identified as aiding people's independence.

3. Conclusion

The review of the current service and contract included; learning from service delivery, feedback from people who drew on the service and other stakeholders, performance against contract measures and a review of demand and utilisation overall and within discrete commissioned elements. It has concluded that the current service is working well, is valued by people who draw on it, stakeholders, and partners, and is delivering good outcomes for individuals and against performance metrics.

The proposed new model of delivery will ensure that these positive outcomes and benefits continue and in addition, through a re-focus of those most in need of the Wellbeing Services, ensure that the impact to end users is maximised, as well as improving the ability to evidence value for money.
Entry pathways and eligibility criteria redesign will enable the service provider and Council to control costs over the life of the proposed new contract. A new contract should be let by competitive tender to implement the remodelled service recommended by the review activity so that improvements are achieved as early as possible.

4. Legal Comments:

The Council has the power to commission the service and enter into the contract proposed.

The decision is consistent with the Policy Framework and within the remit of the Executive.

5. Resource Comments:

Adult Care and Community Wellbeing has a budget of £3.3m allocated for the Wellbeing Service. The increase in costs reflected in this report arising from demand and inflation are forecast to be funded through the service efficiencies also reflected in this report, specifically the removal of the Hospital in-reach and resettlement services. The expectation therefore is for the service to be delivered within the existing £3.3m budget and this is reflected in the medium-term financial plan.

6. Consultation

a) Has Local Member Been Consulted?

Not applicable.

b) Has Executive Councillor Been Consulted?

Yes.

c) Scrutiny Comments

The decision will be considered by the Adult Care and Community Wellbeing Scrutiny Committee on the 29 November 2023 and the comments of the Committee will be reported to the Executive.

d) Risks and Impact Analysis

See body of report and Appendix A Equality Impact Assessment

7. Appendices

These are listed below and attached at the back of the report:	
Appendix 1	Equality Impact Assessment

8. Background Papers

The following Background Papers under section 100D of the Local Government Act 1972 were used in the preparation of this report:

Document title	Where the document can be viewed
NHS Long Term Plan	NHS England » The NHS Long Term Plan
Integrated Care Strategy	https://lincolnshire.icb.nhs.uk/documents/strategies-and-plans/integrated-care-partnership-strategy/integrated-care-partnership-strategy-january-2023/?layout=default

This report was written by , Tony McGinty, Consultant in Public Health who can be contacted on anthony.mcginty@lincolnshire.gov.uk or 07741885115.

Appendix 1: Equality Impact Analysis
Wellbeing Service Recommissioning

Purpose

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 evolves on proposals for a:

- project
- service change
- policy
- commissioning of a service
- decommissioning of a service

You must take into account any:

- consultation feedback
- significant changes to the proposals
- data to support impacts of the 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. 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. 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 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

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 ask simple questions:

- who might be affected by this decision?
- which protected characteristics might be affected?
- how might they be affected?

These questions will help you consider the extent to which you already have evidence, information and data. It will show 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 decide where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable, then it must be clearly justified and recorded as such. An explanation must be stated 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

Details	Response
Title of the policy, project or service being considered	Wellbeing Service Recommissioning
Service area	Adult Care and Community Wellbeing- Public Health
Person or people completing the analysis	Andrea Ball, Shirlene Hodgins
Lead officer	Anthony McGinty
Who is the decision maker?	Executive
How was the Equality Impact Analysis undertaken?	An ongoing desktop exercise based on service user and stakeholder engagement
Date of meeting when decision will be made	5th December 2023
Is this a proposed change to an existing policy, service,	Proposed change to existing service

project or is it new?	
Version control	V0.1- Document Created – 15/09/2023. V0.2 – Revised to reflect feedback- 05/10/23. V0.3 – Additional information added for withdrawal of 2 elements 26/10/23. V0.4 - Revised to reflect feedback from HR and Community Engagement – 30/10/23. V0.5 - Additional information added ref the response service element 31/10/23. FINAL Version – Completed 31/10/23.
Is it LCC directly delivered, commissioned, recommissioned, or decommissioned?	LCC Recommissioned
Describe the proposed change.	<u>**Current Service Description**</u> Lincolnshire's Wellbeing Service (WBS) provides a range of component elements designed to promote adults' (aged 18+) ability to live fulfilling, active and independent lives. The WBS is a preventative service and aims to: • Improve or prevent the deterioration of individuals' health, wellbeing, and overall quality of life. • Enhance independence, improve individuals' ability to self-care and access appropriate supporting structures and community resources; • Reduce or delay escalation to statutory support services. • The service currently comprises of the following elements delivered countywide: • **Assessment** – Conducting a person-centred and strength-based assessment of need of all eligible individuals referred into the service. • **Generic support** – Providing up to a maximum of 12 weeks personalised generic support based on the individual's self-identified outcomes and needs identified through their assessment. This may include advice,

	connection and signposting to community resources, other relevant services and/or direct support to meet individual needs. • **Telecare response service** – Provision of a visit to the home of a service user, who has subscribed, and pays for this service, in response to a request from a telecare monitoring provider. For subscribed service users this is offered 24 hours, 7 days per week generally where no informal carer has been or can be identified to attend. The countywide deployment of trained responders can assess and assist with non-injury falls, provide support and reassurance in emergency situations. • **Small aids for daily living** - Rapid installation of items of preventative equipment, known as small aids to daily living (SADLs), and installing minor adaptations which are supportive to the wellbeing and independence of the service user. The costs of the equipment are met by the individual who may source these independently or through stocks held and supplied by the Provider. Installation and support to utilise them is provided by the service free of charge. • **Resettlement service** – Working with health and care partners to visit and support identified individuals returning from a hospital stay to resettle into their home. Activities might include turning on the heating, ensuring food and drink is available, unpacking belongings and medication. This service is available between the hours of 10am to 10pm daily via referrals from acute and community hospital teams countywide. • **Hospital in-reach** – Taking a supportive role in hospital discharge pathways where service users' discharge could be supported by elements of the Wellbeing Service or connection with wider services. **Proposed Changes** The key features of the revised model summarised below with the key changes in bold text: • **Continuation of the service having a low threshold for entry and eligibility criteria being worded to enable the threshold to be tightened to support demand management.** The re-commissioned service will utilise strength -based approaches at the front door (CSC). • **The wording of the eligibility criteria will be refined to better reflect the purpose and functions of the service. The wording will reflect strength-based practice** • **Enhanced digital access** including self-serve/assessment and resources to enable people to access frequently identified information and signposting advice negating the requirement for a full trusted assessment in some cases.

	• **Adoption of a full 'trusted assessor' role** to initially enable 'prescription' of a defined range of equipment and adaptations currently requiring occupational therapy referral. • **Bolstering the role and scope of generic support** to meet diverse needs. The provider will be expected to monitor referrals and support provided to ensure that they are providing the service equitably (including geographically and to all those with protected characteristics) compared to the needs of the population. If there are gaps in provision, they will be required to work with the commissioner to ensure that gaps are met. • **SADL service element to align closely with occupational therapy teams with a renewed emphasis on retail tech-based solutions**. The existing charging system for service users should remain unchanged. • **The Dedicated Hospital In-reach Service should not be recommissioned** as provision within the system is now widely available. Trusted Assessments may be conducted in all settings, including hospitals in line with service user needs, however, resources will no longer be based within hospitals. The provider of the new service will still be required to promote the service to all partners and ensure referral pathways are set up and working efficiently. • **The Resettlement Service should not be recommissioned** as it is poorly utilised and other such provision is available in the wider system. Generic support will be provided in both hospital and home settings and will cover some elements of support. It will not be provided in the same timely way as currently though. This has not been identified as a gap during engagement. • **A Telecare Response service should continue** to be specified as part of the service provision with all service users paying a **market level fee**. The maximum response time specified for the provider will change from 45 mins to 1 hour.

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, consider the impacts the proposed changes may have on people:

- without protected characteristics
- and 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:

- underage 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.

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 on the protected characteristics for our workforce on our website. Managers can obtain workforce profile data by the protected characteristics for their specific areas using Business World.

Positive impacts

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

Protected characteristic	Response
Age ***Over 65 Years***	**Refined strength-based eligibility criteria and enhanced digital access** The current service has 11 eligibility 'triggers' and individuals must meet 4 or more of these to be eligible for service. There is currently a trigger '65 or over', this trigger will be removed from the future service and there will no longer be any age specific criteria. This means that eligibility will no longer be biased towards older adults and will purely be based on need. The council will place a requirement in the new service specification to offer an equal and accessible service, which will be monitored through

	contract management. Therefore, individuals with this protected characteristic will not face barriers in accessing the service should they need it and stand to benefit from it in the same way as other eligible people without a protected characteristic. The new service will have increased accessibility as a new digital offer will be developed. Enhanced digital access including self-serve/assessment and resources to enable people to access frequently identified information and signposting advice negating the requirement for a full trusted assessment. During recent times it is proven that online services are now an essential requirement, for example, to keep in touch with each other, order shopping and health supplies, access services or information etc. *(Lincs Digital)* This offer will not limit accessibility but will increase choice. Those who cannot or do not wish to access the service digitally will be able to access using more traditional methods. The service will also work with Lincs Digital to improve individuals' ability to access and use digital technology. We do not believe that the changes will negatively impact those over 65 years old. **Adoption of a full 'trusted assessor' role and SADL service element to align closely with occupational therapy teams with a renewed emphasis on retail tech-based solutions.** Information from the service shows that the average age of a person accessing the SADLs service is 79 years old. There will be a positive impact of implementing a full trusted assessor model for people with age as a protected characteristic as it will improve service user access to minor adaptations and small aids for daily living and reduce the need for multiple assessments of need from the WBS and the Occupational Therapy Service. This will save time for the individual to receive a SADL. Individuals with this protected characteristic will not face barriers in accessing the service should they need it and stand to benefit from it in the same way as other eligible people without a protected characteristic. Evidence from stakeholder engagement highlighted the need to improve working relationships between the WBS (Wellbeing Service) and the OT Team (Occupational Therapy), particularly with more complex cases, to the benefit of individuals with this protected characteristic. The recommissioned service will offer support with retail tech-based solutions to enhance independence. This will therefore have a positive

	impact on individuals both with and without this protected characteristic. **Bolstering the role and scope of generic support** Enhancing the scope of the generic support service to meet those with more diverse needs will impact positively on individuals with this protected characteristic. The scope of generic support will cover elements of the hospital in-reach service and resettlement services that are due to be decommissioned, for example, generic support can be delivered in a hospital setting if appropriate. This will mitigate the negative impact of removing these services for individuals with this protected characteristic. A range of service delivery methods will be offered in the new service model such as a digital offer. This will be led by the needs and preferences of service users. **Dedicated Hospital In-reach should not be recommissioned** [No positive impact] **The resettlement service should also not be recommissioned** [No positive impact] **A Telecare Response service should continue with all service users paying a market level fee.** Continuing a service which was valued by people with this characteristic is positive for them, and will make this opportunity available to others who need it in future.
Disability	**Refined strength-based eligibility criteria and enhanced digital access** The current service has 11 eligibility 'triggers' and individuals must meet 4 or more of these to be eligible for service. Although eligibility will not specifically targeted at adults with disabilities it will be based on need and people with disabilities should be expected to meet the eligibility criteria and receive a service. The council will place a requirement in the new service specification to offer an equal and accessible service, which will be monitored through contract management. Therefore, individuals with this protected characteristic will not face barriers in accessing the service should they need it and stand to benefit from it in the same way as other eligible people without a protected characteristic.

	The re-commissioned service will utilise strength-based approaches at the front door (CSC) through a strength-based conversation. Strength-based approaches help individuals to realise their own strengths to address their needs. This approach is personalised and will therefore benefit all people approaching the service. A range of ways of interacting with the service will be offered, this will include making a referral, assessment and generic support. Service users will be offered support via a delivery method that suits their needs and preference. For example, workers may recommend a home visit – to enable a richer assessment of need. As stated above, during recent times it is proven that online services are now an essential requirement, for example, to keep in touch with each other, order shopping and health supplies, access services or information etc. *(Lincs Digital)* Due to the broad demographic area of Lincolnshire and most people within the service being over 65 (81%) and/or have a physical disability (43%) *WBS Engagement Survey* then the ability to access digital technology in these protected characteristics (as well as any other age/disability) is key. Enhanced digital access including self-serve/assessment and resources to enable people to access frequently identified information and signposting advice negating the requirement for a full trusted assessment will have a positive impact on individuals with this protected characteristic. It means that individuals' signposting needs will be dealt with quicker as they won't have to come into the WBS only to be signposted onto another service or have an unnecessary assessment of need. The 2021 census shows 7.8% of usual residents in Lincolnshire to be disabled under the Equality act with day-to-day activities limited a lot. Within the county, East Lindsey has the highest proportion of disabled residents with day-to-day activities limited a lot (9.9%) compared to the lowest in South Kesteven (6.6%). The re-commissioned service will be open to adults from the age of 18 following a strength-based conversation. The council will place a requirement in the service specification to offer an equal and accessible service when it is re-procured, which will be monitored through contract management. Therefore, individuals with this protected characteristic will not face barriers in accessing the service should they need it and stand to benefit from it in the same way as other eligible people without a protected characteristic.

	Adoption of a full 'trusted assessor' role and SADL service element to align closely with occupational therapy teams with a renewed emphasis on retail tech-based solutions. There will be a positive impact of implementing a full trusted assessor model for people with this protected characteristic as it will improve service user access to minor adaptations and small aids for daily living and reduce the need for multiple assessments of need from the WBS and the Occupational Therapy Service. This will save time for the individual to receive a SADL. Individuals with this protected characteristic will not face barriers in accessing the service should they need it and stand to benefit from it in the same way as other eligible people without a protected characteristic. Evidence from stakeholder engagement highlighted the need to improve working relationships between the WBS and the OT Team, particularly with more complex cases, which will benefit individuals with this protected characteristic. The recommissioned service will offer support with retail tech-based solutions to enhance independence and will therefore have a positive impact on individuals both with and without this protected characteristic. **Bolstering the role and scope of generic support** Enhancing the scope of the generic support service to meet those with more diverse needs will impact positively on individuals with this protected characteristic. The scope of generic support will cover elements of the hospital in-reach service and resettlement services that are due to be decommissioned. This will mitigate the negative impact of removing these services for individuals with this protected characteristic. A range of service delivery methods will be offered in the new service model. This will be led by the needs and preferences of service users. **Dedicated Hospital In-reach should not be recommissioned** [No positive impact] **The resettlement service should also not be recommissioned** [No positive impact]

	<u>A Telecare Response service should continue with all service users paying a market level fee</u> Continuing a service which was valued by people with this characteristic is positive for them, and will make this opportunity available to others who need it in future.
Gender reassignment	No positive impact
Marriage and civil partnership	No positive impact
Pregnancy and maternity	No positive impact
Race	No positive impact
Religion or belief	No positive impact
Sex	No positive impact
Sexual orientation	No positive impact

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.

Positive impacts
<u>Unpaid Carers</u> – There are an estimated 70,391 unpaid family carers in Lincolnshire (Source: Census 2021). Given the county's ageing population, this number is predicted to increase. The Wellbeing Service can signpost any unpaid carers to Lincolnshire's Carers Service which promotes and supports health and wellbeing of carers, helping prevent, reduce, and delay escalation into formal care services of the adult or child with needs. **<u>People living in rural areas</u>** – Lincolnshire is a rural county. The Wellbeing Service will have a range of differing delivery methods available to service users depending on need or preference. An example of this is a digital offer for people with low needs. The provider will be required to monitor and evidence equitable delivery to the commissioner.

Adverse or 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'*.

Protected characteristic	Response
Age ***Over 65s***	**Withdrawal of the Resettlement Service** **Negative Impact:** All regions are projected to have a greater proportion of people aged 65 years and over by mid-2028. Lincolnshire has an ageing population and between 2023-2028 the population of over 65s is expected to increase by 10.7% (*Subnational population projections for England: 2018-based, Office for national statistics)* With the ageing population and the average age of all Wellbeing Service referrals being 69.3 over the last 5 years, *(WBS Annual Report 22-23)* then it would be fair to say there will be some negative impact for people within the older age groups when withdrawing the Resettlement Service, for example, those that are within an older age group (65+ as stipulated in the current service criteria/trigger), live alone, and who have used this service previously when returning from hospital. As stated in the WBS intelligence report, the average number of admissions to ULHT per month between 01/04/2021 and 31/03/2023 for people aged 65 and over was 6,280. In 2021/22 54.1% of admissions were patients aged 65 years and older compared to 2022/23 where 53.78% of admissions were aged 65 years and older.

The average length of stay (LoS) (Days) for patients admitted to ULHT is consistently higher in those aged 65 or over compared to those aged 18-65.

Admission Date	Under 65	Over 65
2021		
Qtr2	1.5	2.7
Qtr3	1.7	3
Qtr4	1.6	3.3
2022		
Qtr1	1.6	3.3
Qtr2	1.6	3.3
Qtr3	1.6	3
Qtr4	1.5	3.2
2023		
Qtr1	1.4	3.1

The average LoS in the over 65s has also increased from an average of 2.7 days in Quarter 2 of 2021, to 3.3 days in 2022, with a slight decrease to 3.1 days in Quarter 1 of 2023.

With the likelihood of more people over 65 being admitted to hospital and requiring support to be discharged and settled back into the home, then the impact of withdrawing this component can only be negative to that population.

For information, the percentage of people aged 65 and over who are living alone in Lincolnshire was 28.3% in 2011, which was lower than the England rate of 31.5%. Notably the 2021 census reported there were 48,155 one-person households in Lincolnshire for people aged 66 years and over, and 41,938 single family households where all residents were aged 66 years and over.

Older people living alone. ***Public health profiles - OHID (phe.org.uk)***

Mitigating Factors:

The Resettlement service has generally been underutilised and has seen a lower volume of activity than expected when the service was developed, receiving just 10% of the expected volume in 2022/23.

The table below outlines the volume of referrals for each year of the contract:

Year	Number of referrals
2018 – 2019	60
2019 – 2020	92
2020 – 2021	25
2021 – 2022	174

2022 - 2023	131

Notably, the volume of people referred to the resettlement service decreased from 2021/22 to 2022/23 by 25%.

It should be noted that the lack of referrals is not considered to be due to a lack of awareness of the service or issues with the referral process. The current service provider has undertaken considerable work, in partnership with LCC, to try to increase uptake of the service.

Another service that is available to Lincolnshire residents is 'The Discharge Buddies and Home Support Buddies Resettlement Service' delivered by Age UK. This service supports people with enabling them to be discharged from hospital quickly and safely back into their own home (a very similar service to the current wellbeing resettlement service).

Trained and experienced staff can collect patients from hospital and ensure they are settled back into their home and that their surroundings are comfortable, they have food available, and the heating is on. Shopping, prescriptions, and pensions can be collected as part of this support and resettlement service.

Having this service in place across the county will mean there is still a service out there for the older population who require support when leaving hospital and settling back into the home.

The withdrawal of the wellbeing resettlement should not impact massively, and the Age UK service should be able to meet the extra demand as it will be minimal. The remaining services will be available to support resettlement into home following assessment of need such as SADLs, generic support and telecare products and monitoring.

Withdrawal of the 'dedicated' hospital In Reach service.

Negative Impact:

The current hospital in reach component is designed to assist with the development of referral pathways into the service and assist with integration of the service into health and care settings.

Based within the hospital setting, part of the role within this component is to also assist patients with discharge planning, working with current commissioned and volunteer transport services to support the timely discharge of patients, as well as work with transport services to facilitate access to the resettlement component of the service. The additional Hospital Housing Link Workers are also part of the in-reach service where they are

based within the hospital setting to support patients on the wards immediately in readiness for discharge.

As referenced above in the resettlement element and in the WBS intelligence report, the average number of admissions to ULHT per month between 01/04/2021 and 31/03/2023 for people aged 65 and over was 6,280. In 2021/22 54.1% of admissions were patients aged 65 years and older compared to 2022/23 where 53.78% of admissions were aged 65 years and older.

The average length of stay (LoS) (Days) for patients admitted to ULHT is consistently higher in those aged 65 or over compared to those aged 18-65.

Admission Date	Under 65	Over 65
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Qtr2	1.5	2.7
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Qtr4	1.6	3.3
2022		
Qtr1	1.6	3.3
Qtr2	1.6	3.3
Qtr3	1.6	3
Qtr4	1.5	3.2
2023		
Qtr1	1.4	3.1

The average LoS in the over 65s has also increased from an average of 2.7 days in qtr. 2 of 2021, to 3.3 days in 2022, with a slight decrease to 3.1 days in qtr. 1 of 2023. These numbers are also likely to influence this age population within the hospital in reach element too.

With the likelihood of more people over 65 being admitted to hospital and requiring support to be discharged and settled back into the home, then the impact of withdrawing this component can only be negative to that population.

Mitigating Factors:

The Hospital In-reach function has struggled to evidence impact and was then severely hampered by the Coronavirus pandemic. The integration of the Hospital Housing Link Workers has received positive feedback; however, case volumes are small, and if needed, this work would be the duty of the District Housing authority as required by the Homelessness Reduction act 2017. Staff report a 'crowded' space to establish and maintain service awareness and engagement.

Another service that is available and delivered by Age UK is the Hospital Avoidance Response Team (HART). Receiving referrals 24 hours a day, 365 days a year, the HART offer a flexible approach to delivering short-term care and support. This is often to assist patient hospital discharges, reduce delayed transfers of care and prevent avoidable hospital admissions, whilst at

the same time enabling people to regain and retain independence, making it almost a duplication of the work done by the hospital in reach service within the Wellbeing Service.

The Discharge Buddies and Home Support Buddies Resettlement Service (which is a separate service) and described above is also delivered by Age UK and can support people in hospital to be discharged safely home with the right support.

There are other services available within what has been described as a crowded space, meaning withdrawing the Wellbeing Service Hospital In reach element making little impact to this arena.

A Telecare Response service should continue with all service users paying a market level fee.

As of June 2023, there were 1,224 service users signed up to the Telecare Response Service. We have assumed that a high proportion of these service users will be over the age of 65. Service data shows that Telecare Response has experienced volumes above those originally projected for the past three contract years. Attending non-injury falls has consistently been the most common call-out tasking; representing 44% of all attendances in 2022-23, supporting on over 1,100 incidences. No response telecare activations account for 38% of all attendances over the last five years supporting risk mitigation and assisting in further instances of falls on arrival.

Falls are the most frequent type of accident in people over 65. The number of injuries caused by falls increases with age. Most injuries resulting from falls are minor, however, 10% of falls result in fractures which are a major cause of mortality and morbidity amongst those aged over 65 years. For those over 75, falls are also the most common cause of death from injury (Source: Age UK).

Telecare response currently costs service users £2.50 per week. This price was capped during the initial contract term and has remained unchanged to date. Research suggests that other response service providers operating across Lincolnshire charge £12 per month (£144 per year, an average of £2.77 per week) in addition to the cost of a telecare service which also needs to be in place. Therefore, individuals subscribed to the telecare response service will see an increase in price of around 27 pence per week.

The price increase of telecare response may mean that some individuals do not continue to pay for the service and choose not to have the response service in place. This would have a negative impact on those with this protected characteristic and may mean that people do not have crucial

	support in place at the time they most need it, affecting their ability to continue to live independently in their own home. It could also have a negative impact on family members of the service user who rely on this service to support their loved one. Initial data review suggests there are currently 7 people who have telecare response fully funded by LCC and 108 who have telecare funded by LCC and who self-fund the response service. This means, for some, it is likely to be part of their care package. These numbers refer to those who have telecare provided by NRS. LCC will continue to fund this. The current response time as set out in the contract/spec is within 45 mins. Increasing this time to an hour could have a negative impact on the customer, however, evidence suggests that responding within an hour can still have a positive outcome. NHS evidence is that an hour is sufficient. The NHS England Going further for winter: Community Based Falls response 2022 report Emergency admissions for falls in people aged 65 have increased year on year – from 185,000 in 2010/11 to 234,000 in 2019/20. The impact of falling is significant – falls can negatively affect functional independence and quality of life, and falls resulting in a lie of **over** one hour in length, are also strongly associated with serious injuries, admission to hospital, and subsequent moves into long term care. As stated in the WBS data Response times.xlsx our current service averages 30 mins response time across the county which is within the 45-minute target. If we were to extend this to an hour, the response time is potentially still likely to be met well within the new target. The mapping of hubs and staffing structure would be reviewed to ensure the new response time works well across the county and is still as efficient as the current service. The WBS would still be offering the quickest response time in the County (Age UK has a 2hr response window) which mitigates the risk of increasing the time to an hour.
Disability	**A Telecare Response service should continue with all service users paying a market level fee.** The term disability covers a wide range of impairments. The term 'physical impairment' refers to one or more conditions or limitations which may be congenital or acquired at any age, be temporary, long-term, or fluctuating. People with physical impairments may often have unique and multi-dimensional requirements. ***(Source: Lincolnshire JSNA, accessed 05/10/23)***

The term ‘sensory impairment’ encompasses visual impairment (including those who are blind or partially sighted), hearing impairment (including those who are profoundly deaf, deafened or hard of hearing) or with dual sensory impairment (deaf blindness). These impairments can be congenital or acquired at any age. Prevalence increases with age, often, alongside additional sensory, or other, impairments. ***(Source: Lincolnshire JSNA, accessed 05/10/23)***

As of June 2023, there were 1,224 service users signed up to the Telecare Response Service. Service data shows that Telecare Response has experienced volumes above those originally projected for the past three contract years. Attending non-injury falls has consistently been the most common call-out tasking; representing 44% of all attendances in 2022-23, supporting on over 1,100 incidences. No response telecare activations account for 38% of all attendances over the last five years supporting risk mitigation and assisting in further instances of falls on arrival.

Research shows that individuals with a visual impairment are at greater risk of falling. 3.8 per cent of falls that result in hospital admissions could be directly attributed to visual impairment and cost 10 per cent of the local NHS cost of treating accidental falls ***(Source: Thomas Pocklington Trust).***

The impact of a price increase for individuals subscribed to telecare response may mean that some do not continue to pay for the service and choose not to have the response service in place. This would have a negative impact on those with this protected characteristic and may mean that people do not have crucial support in place at the time they most need it, affecting their ability to continue to live independently in their own home. It could also have a negative impact on family members of the service user who rely on this service to support their loved one.

Telecare response currently costs service users £2.50 per week. This price was capped during the initial contract term and has remained unchanged to date. Research suggests that other response service providers operating across Lincolnshire charge £12 per month (£144 per year, an average of £2.77 per week) in addition to the cost of a telecare service which also needs to be in place. Individuals subscribed to the telecare response service will see an increase in price of around 27 pence per week.

Initial data review suggests there are currently 7 people who have telecare response fully funded by LCC and 108 who have telecare funded by LCC and who self-fund the response service. This means, for some, it is likely to be part of their care package. These numbers refer to those who have telecare provided by NRS. LCC will continue to fund this.

Gender reassignment	No perceived adverse impact
Marriage and civil partnership	No perceived adverse impact
Pregnancy and maternity	No perceived adverse impact
Race	No perceived adverse impact
Religion or belief	No perceived adverse impact
Sex	No perceived adverse impact
Sexual orientation	No perceived adverse impact

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.

Negative impacts
A Telecare Response service should continue with all service users paying a market level fee Carers – This demographic may rely on the telecare response service and should any price increase stop service users from having the service, this group would be negatively impacted. **Enhanced digital access** Digitally Excluded Service users who are not online, for example those in very rural areas, older people or those in poverty and without access to broadband or a device could potentially be excluded from support if it is primarily available online. Services will continue to offer an alternative, such as written correspondence, telephone interview or face to face meetings to ensure they are not further excluded. The service will also have a focus on digital inclusion to ensure, where possible, barriers to accessing online support are addressed.

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
- 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. You can contact them at engagement@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place. Include:

- who you involved when compiling this EIA under the protected characteristics
- any organisations you invited and organisations who attended
- the date(s) any organisation was involved and method of involvement such as:
  - EIA 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 or engaged with.

Objective(s) of the EIA consultation or engagement activity
A range of engagement has taken place with service users, non-service users, staff, and stakeholders to: • Assess the quality of the Wellbeing Service • Assess whether services are meeting the needs of the residents of Lincolnshire • Understand how aware local people are of the Wellbeing Service • Understand how services are accessed, including preferences and barriers to accessing services • Identify opportunities to innovate and improve services • Identify key priorities for the future of the Wellbeing Service • Inform the development future service specifications Ask about protected characteristics in relation to service delivery.

Who was involved in the EIA consultation or engagement activity?

Detail any findings identified by the protected characteristic.

<table>
<tr><th>Protected characteristic</th><th>Response</th></tr>
<tr><td>Age</td><td>Information from the WBS engagement survey Report:

Which age group do you belong to?

<table>
<tr><td>Prefer not to say</td><td>3 of 333 (0.9%)</td></tr>
<tr><td>16-19</td><td>1 of 333 (0.3%)</td></tr>
<tr><td>20-24</td><td>3 of 333 (0.9%)</td></tr>
<tr><td>25-34</td><td>11 of 333 (3.3%)</td></tr>
<tr><td>35-44</td><td>13 of 333 (3.9%)</td></tr>
<tr><td>45-54</td><td>33 of 333 (9.9%)</td></tr>
<tr><td>55-64</td><td>70 of 333 (21%)</td></tr>
<tr><td>65-74</td><td>57 of 333 (17.1%)</td></tr>
<tr><td>75-84</td><td>78 of 333 (23.4%)</td></tr>
<tr><td>85+</td><td>64 of 333 (19.2%)</td></tr>
</table>
</td></tr>
<tr><td>Disability</td><td>Do you consider yourself to have a disability?

<table>
<tr><td>Yes</td><td>235 of 324 (72.5%)</td></tr>
<tr><td>No</td><td>77 of 324 (23.8%)</td></tr>
<tr><td>Prefer not to say</td><td>12 of 324 (3.7%)</td></tr>
</table>

Please state which of the following best describes your disability?

<table>
<tr><td>Physical</td><td>99 of 232 (42.7%)</td></tr>
<tr><td>Emotional / Mental Health</td><td>25 of 232 (10.8%)</td></tr>
<tr><td>Other – the vast majority of those that had selected this option had listed more than one disability that was available to select from the options but as the question only allowed you to select your main disability they’d chosen to enter in other instead. However,</td><td>81 of 232 (34.9%)</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td><table><tr><td>some that weren't included that were listed was: ADHD, Dementia, Autism and Epilepsy.</td><td></td></tr><tr><td>Learning</td><td>11 of 232 (4.7%)</td></tr><tr><td>Visually Impaired / Blind</td><td>9 of 232 (3.9%)</td></tr><tr><td>Hearing Impaired / Deaf</td><td>7 of 232 (3%)</td></tr></table></td></tr>
<tr><td>Gender reassignment</td><td>Not asked</td></tr>
<tr><td>Marriage and civil partnership</td><td>Not asked</td></tr>
<tr><td>Pregnancy and maternity</td><td>Not asked</td></tr>
<tr><td>Race</td><td>To which of these ethnic groups do you belong?<table><tr><td>White</td><td>324 of 336 (96.4%)</td></tr><tr><td>Black</td><td>3 of 336 (0.9%)</td></tr><tr><td>Asian</td><td>2 of 336 (0.6)</td></tr><tr><td>Mixed</td><td>1 of 336 (0.3%)</td></tr><tr><td>Chinese</td><td>1 of 336 (0.3%)</td></tr><tr><td>Other – Anglo-Indian</td><td>1 of 336 (0.3%)</td></tr><tr><td>Prefer not to say</td><td>4 of 336 (1.2%)</td></tr></table></td></tr>
<tr><td>Religion or belief</td><td>Not asked</td></tr>
<tr><td>Sex</td><td>Which of the following options best described how you think of yourself?<table><tr><td>Female</td><td>182 of 325 (56%)</td></tr><tr><td>Male</td><td>137 of 325 (42.2%)</td></tr><tr><td>Prefer not to say</td><td>6 of 325 (1.8%)</td></tr></table></td></tr>
<tr><td>Sexual orientation</td><td></td></tr>
<tr><td>Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been</td><td></td></tr>
</table>

involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	
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?	Through service user engagement conducted by the provider which will be built into the contract.

Further details

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

Actions required	Action	Lead officer	Timescale
Include any actions identified in this analysis for on-going monitoring of impacts.	N/A	N/A	N/A

Version	Description	Created or amended by	Date created or amended	Approved by	Date approved
V0.3	Wellbeing Service Recommissioning EIA	Shirlene Hodgins	26/10/23		

Agenda Item 6

Open Report on behalf of Martin Samuels, Executive Director - Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**29 November 2023**
Subject:	**Service Level Performance against the Corporate Performance Framework 2023-24 Quarter 2**

Summary:

This report summarises the Service Level Performance against the Success Framework 2023-24 for Quarter 2. All performance that can be reported in Quarter 2 is included in this report.

Full service level reporting to all scrutiny committees can be found here: Corporate plan – Performance data - Lincolnshire County Council

Actions Required:

To consider and comment on the Adult Care and Community Wellbeing Service Level Performance for 2023- 24 Quarter 2.

1. Background

This report details the Service Level Performance measures for the Adults and Community Wellbeing Scrutiny Committee that can reported in Quarter 2.

- 4 measures that exceeded their target ☆
- 13 measures that achieved their target ✓
- 1 measures did not meet their target ✗
- 1 measure that does not have a target (contextual)

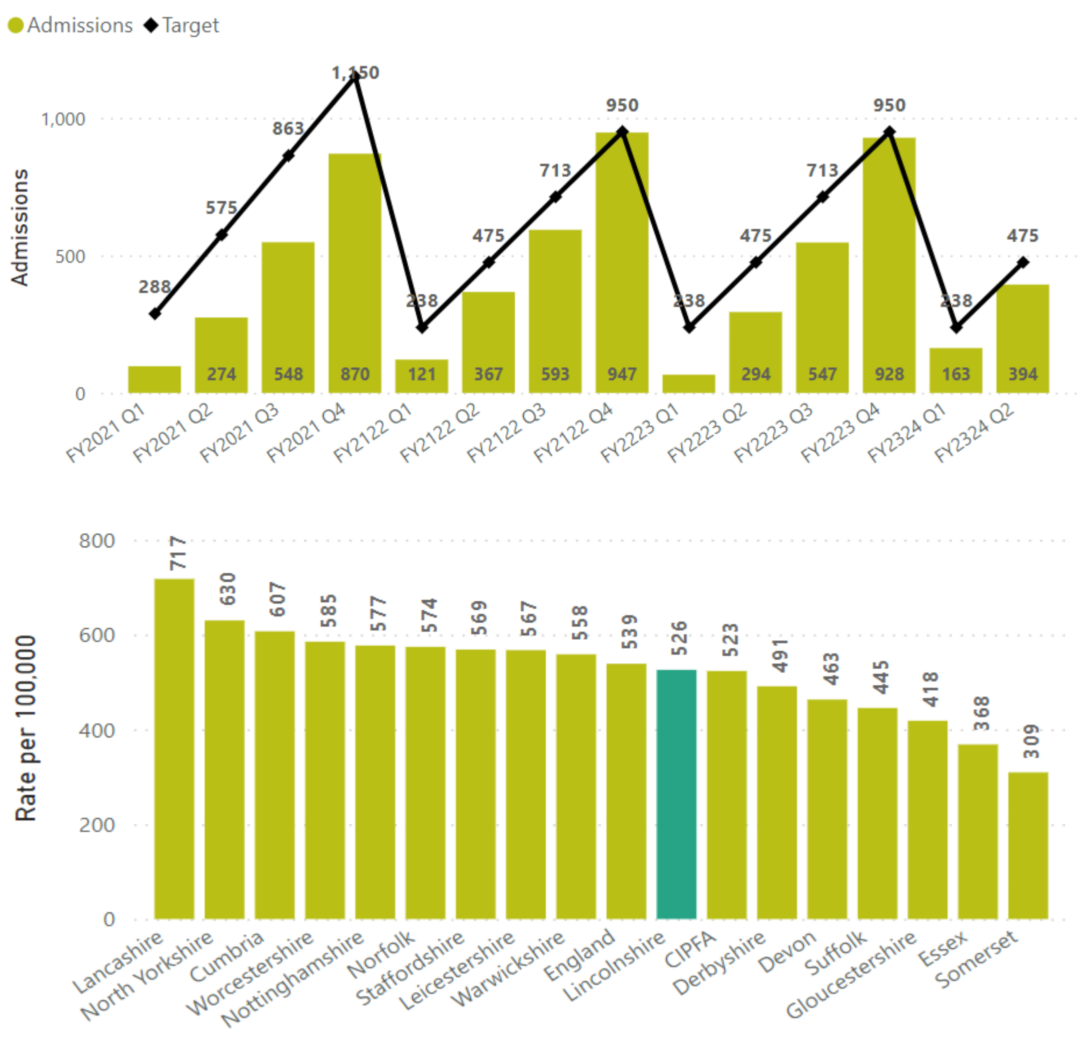
1.1 Adult Care

1.1.1 Measures that exceeded their target

PI 60 Permanent admissions to residential and nursing care homes aged 65+ ☆
April 2023- September 2023

Actual: 394
Target: 475

There have been 394 permanent admissions to residential care up to the end of Quarter 2. It should be noted that the actual number will be slightly higher as there is a known delay in entering information into the system. This is a positive picture given the demographic of Lincolnshire means there is an increasing number of people aged 65+ in the county.
84% of the new admissions have a physical support need as their primary need. 25% are aged 90+. Clients living in south Lincolnshire have seen the largest increase of admissions to residential (128).



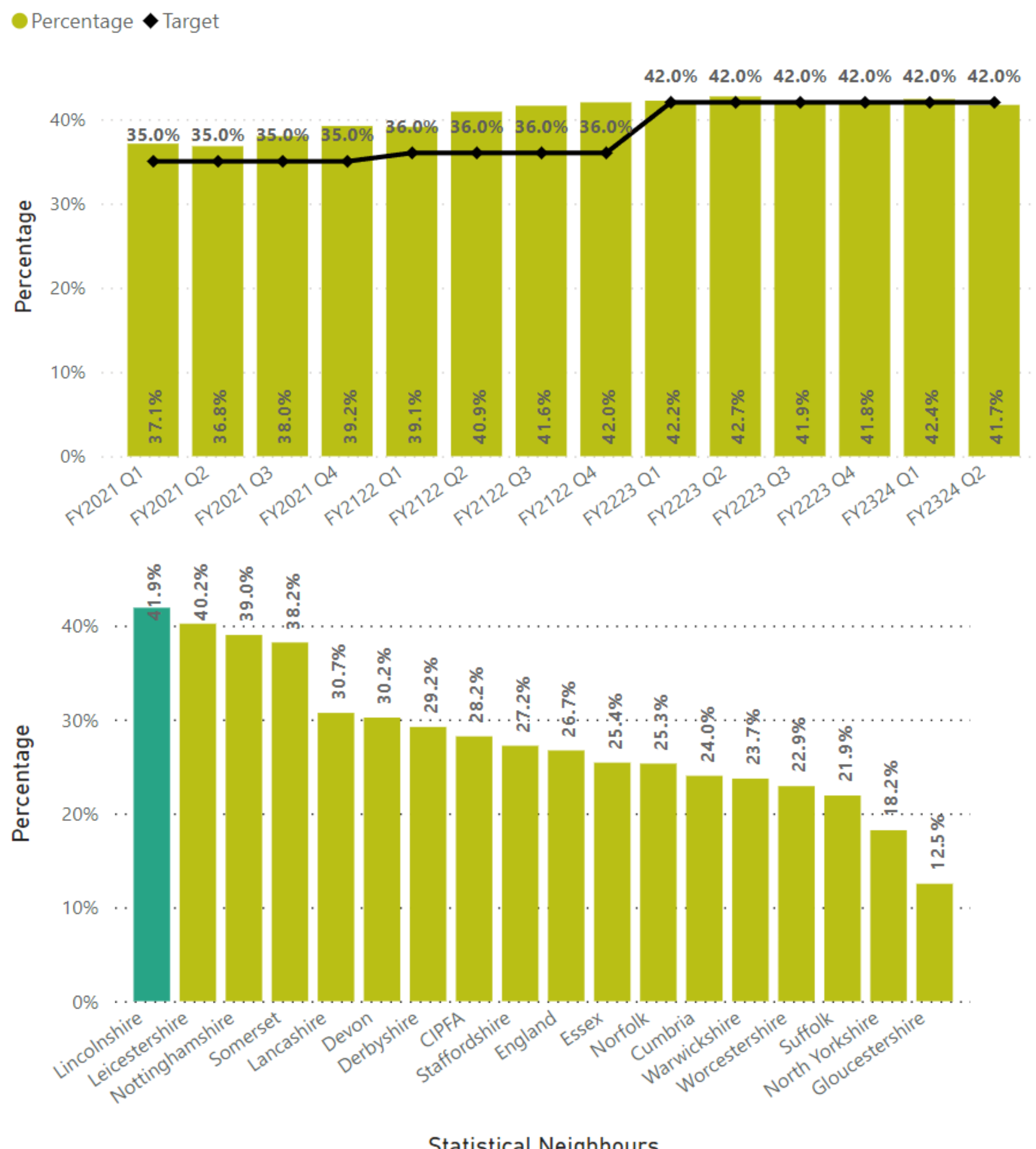
Benchmarking period April 2021 – March 2022

1.1.2 Measures that achieved their target

PI 63 Adults who receive a direct payment ✓
As at September 2023

Actual: 41.7
Target: 42

We continue to provide a consistent number of clients with a direct payment which enables them to have more control over how their own care and support is provided and gives more freedom of choice over the care they need. End of Quarter 2 performance (41.7%) is slightly lower than at the end of Quarter 1 and is within target tolerance. This is due to a slight increase in the overall Adult Frailty & Long Term Conditions (AFLTC) 65+ year old cohort number at the end of Quarter 2. However, performance against this measure is usually well-above the national average.

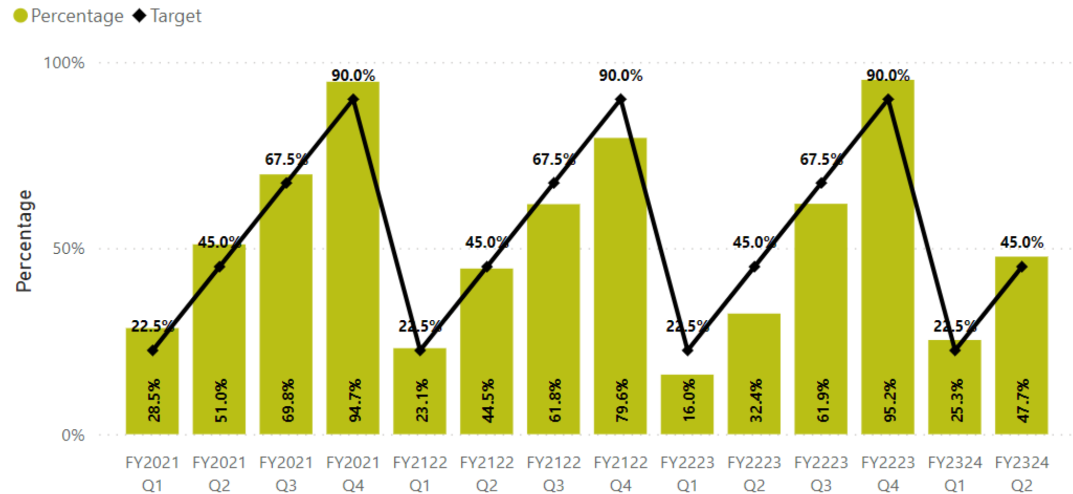


Benchmarking as at March 2022

PI 65 People in receipt of long term support who have been reviewed ✓
April 2023 – September 2023

Actual: 47.7
Target: 45

All teams across Specialist Adults Services and Adult Frailty & Long Term Conditions (AFLTC) teams have achieved the target for Quarter 2 and are on-track to achieve the annual target. As well as ensuring that planned reviews are completed, our monitoring of quality practice standards also tells us that our assessment and care management practice is of good quality. During the autumn and winter period there is a focus from the AFLTC teams on review completion, and progress is monitored every 2 weeks.



Benchmarking data has been removed as we use a different cohort definition which does not match the national definition. However, our definition will change in 2023-24 to match the national definition and benchmarking information will be available in future reports.

PI 113 Emergency and urgent deliveries and collections completed on time ✓
As at September 2023

Actual: 97.5
Target: 98

The figures that comprise the numerator and denominator, for this performance indicator, are lines of activity. Therefore, if one delivery or collection has 8 items in it then it would count as 8 as opposed to 1. This means larger packages of equipment being delivered have a disproportionate effect on the overall percentage but reporting it by line as opposed to activity holds the provider to a higher standard. This reporting method also prevents the provider favouring smaller activities over larger ones as the larger more complex suites of equipment that these activities represent are for the service user with the most serious conditions.

One of the urgent service levels is a 4-hour delivery, if the delivery is completed even one minute later than the original 4-hour window from the order being placed by a clinician,

then the order is deemed to have failed. All of the 4-hour urgent deliveries were completed within 5 hours during the last Quarter. However, as they were completed slightly later than the initial window, they bring the completion percentage down.

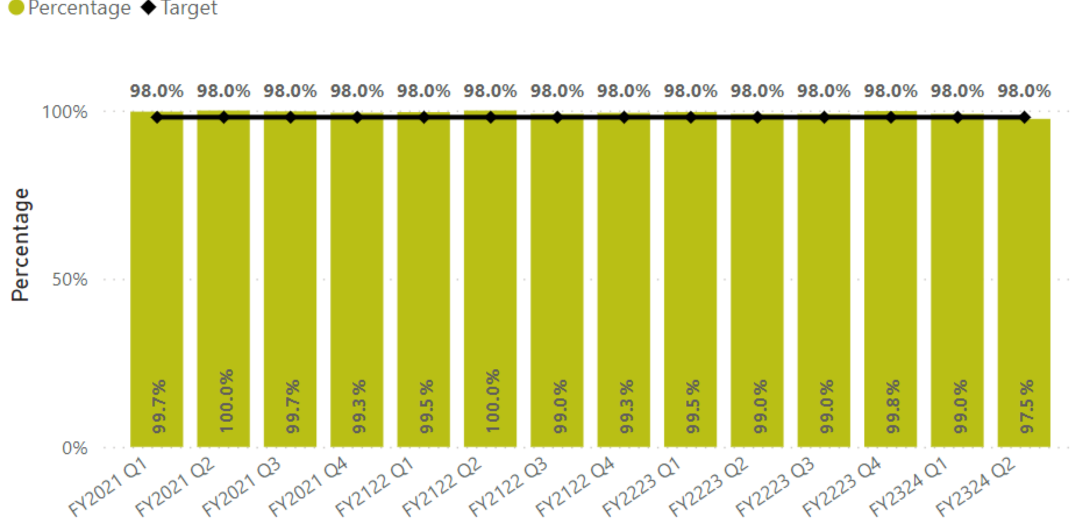
Urgent activities can be for any number and combination of 300+ pieces of equipment which prevent the provider from holding a store of equipment on each of their vehicles as they complete their routes through the county.

The greatest strain on the provider is the increased number of deliveries that need more than one technician to attend, in order to safely move and assemble some pieces of equipment. This equipment is chiefly bariatric (the branch of medicine that deals with the causes, prevention, and treatment of obesity) and with the changing demographics in Lincolnshire the demand for bariatric equipment continues to increase as does the urgency of its demand.

Due to the geographic nature of Lincolnshire, and the distribution of its population, the urgent deliveries for bariatric equipment absorb a lot of the available resource for the provider. A sudden spike in 4-hour bariatric activities can lead to the failure of other urgent activities. The east coast is the primary area for bariatric equipment. Considering its population density it is disproportionally represented in this type of activity. The long transit time for the east coast also limits the available resources for other urgent activities which further compounds the issue.

This performance indicator has been achieved, although it did not achieve the 98% target (by 0.52%) this Quarter, it was within tolerance. The slight reduction was caused by a singular month during the Quarter where a combination of the above factors, employee sickness, and changes in personnel, affected the success rate of the urgent activities.

The provider is actively working to mitigate this impact going forward, and to ensure that this performance indicator continues to achieve its target.

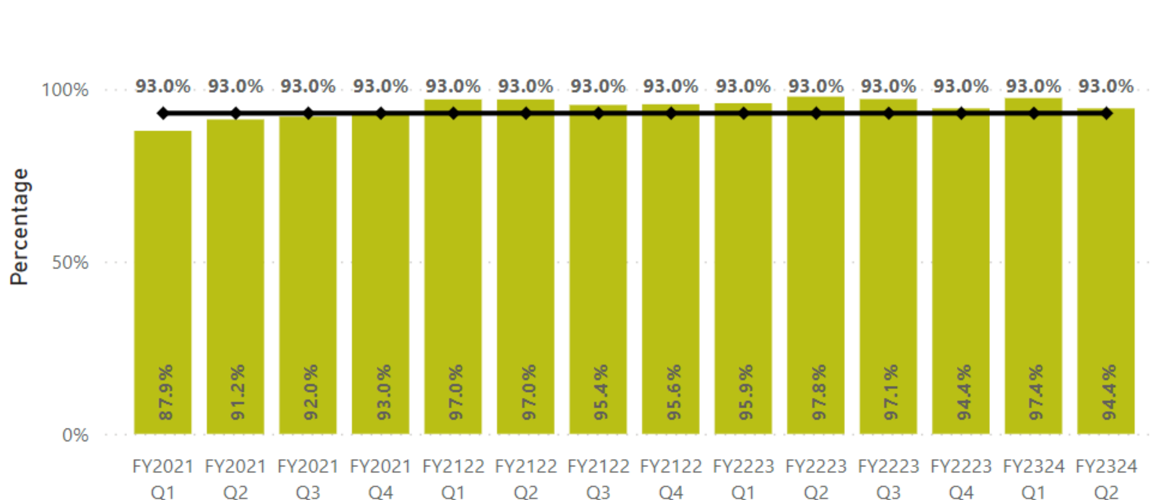


This performance indicator is a local measure so benchmarking data is not available.

PI 122 Requests for support for new clients aged 65+, where the outcome was no support or support of a lower level ✓
April 2023 – September 2023

Actual: 94.4
Target: 93

This performance indicator has achieved its target. This measure reflects the proportion of those new clients who received short-term services during the Quarter, where no further request was made for ongoing support. Since short-term services aim to reable people and promote their independence, this measure provides evidence of a good outcome in delaying dependency or supporting recovery and short-term support that results in no further need for service. We usually perform well above national and the region.



This PI is a local measure for the 65+ age group, so benchmarking data is not available. Benchmarking information is available for the 18+ age group.

PI 124 Completed episodes of Reablement, where the outcome was no support or support of a lower level ✓
April 2023 - September 2023

Actual: 93.8
Target: 95

The reablement service Libertas continues to provide care and support that allows clients up to a maximum of 6 weeks reablement care in their own home. Due to the care and support these clients are receiving 93.8% (1372 out of 1463) of all episodes of reablement have resulted in clients not going on to receiving a long-term adult care service, which is within target tolerance but is slightly below the Quarter 1 figure. The reason for the slight decrease compared to at the end of Quarter 1 is due to the number of people discharged from hospital into reablement who then went into long-term support, 68 people in Quarter 2 compared to 12 in Quarter 1. All but 1 of the 68 people are accessing support

within a community setting due to a range of needs and it's the most appropriate care for them. The 93.8% figure should be viewed within the context of the 2021/22 regional performance of 84.5% and England performance of 77.6%.

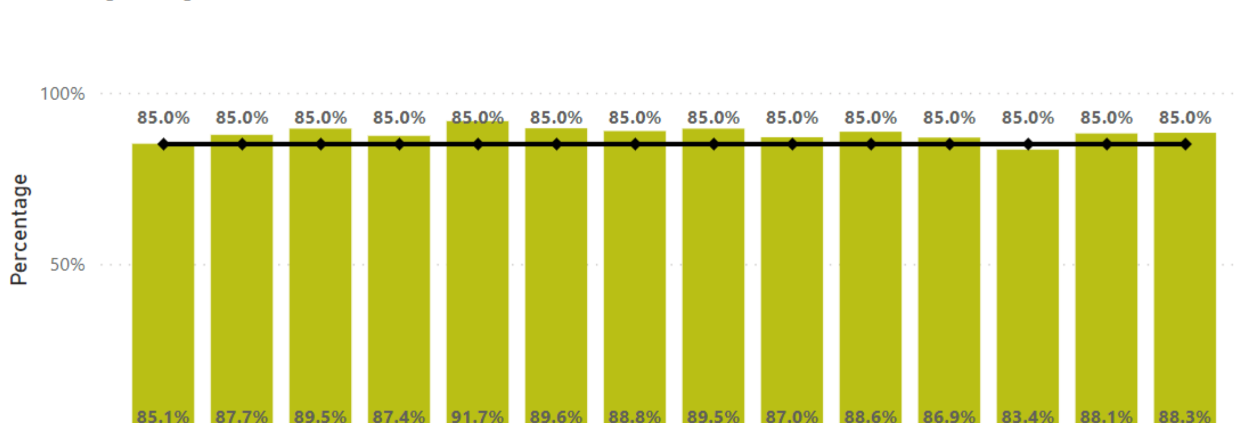
Benchmarking period April 2021 – March 2022

PI 158 For adults discharged from hospital, the percentage who remain at home 91 days after discharge ✓

As at September 2023

Actual: 88.3
Target: 85

The target has been achieved which is positive, evidencing that people have received an appropriate assessment of their needs to ensure they remain at home following discharge from hospital. Of the 1,469 discharges that are at home after 91 days, 304 of these are at home receiving a long-term support service (e.g. home care). Of the 195 clients not at home on the 91st day, 114 of these are now in Long Term residential care.



Benchmarking data is not available as we use a local definition (which is different to the national comparator).

1.1.3 Measures that did not meet their target

None in Quarter 2

1.2 Specialist Adult Services

1.2.1 Measures that exceeded their target

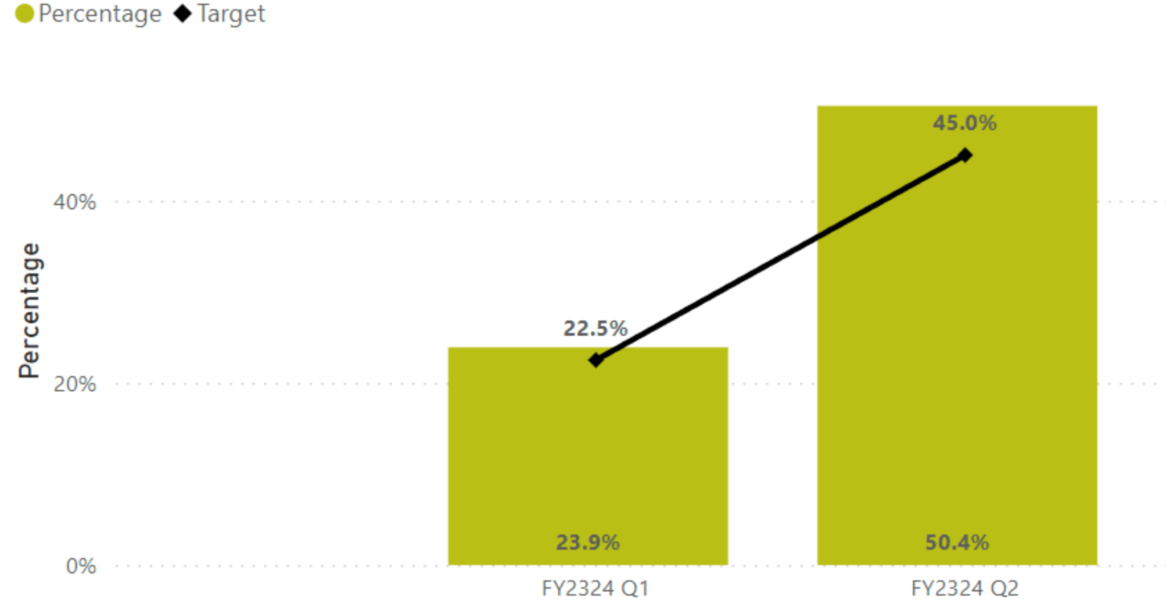
PI 174 Proportion of adults with a learning disability or a mental health need in receipt of long-term support who have been reviewed ☆

April 2023- September 2023

Actual: 50.4
Target: 45

Specialist Adults Services review performance covering adults with a mental health need or a learning disability is above the Quarter 2 target and on-track to achieve the end-of-year target of 90%. As well as ensuring that planned reviews are completed, our monitoring of quality practice standards also tells us that our assessment and care management practice is of good quality. No benchmarking information is made available by National Health

System (NHS) England to allow comparisons with other Councils for Mental Health and Learning Disability Teams.



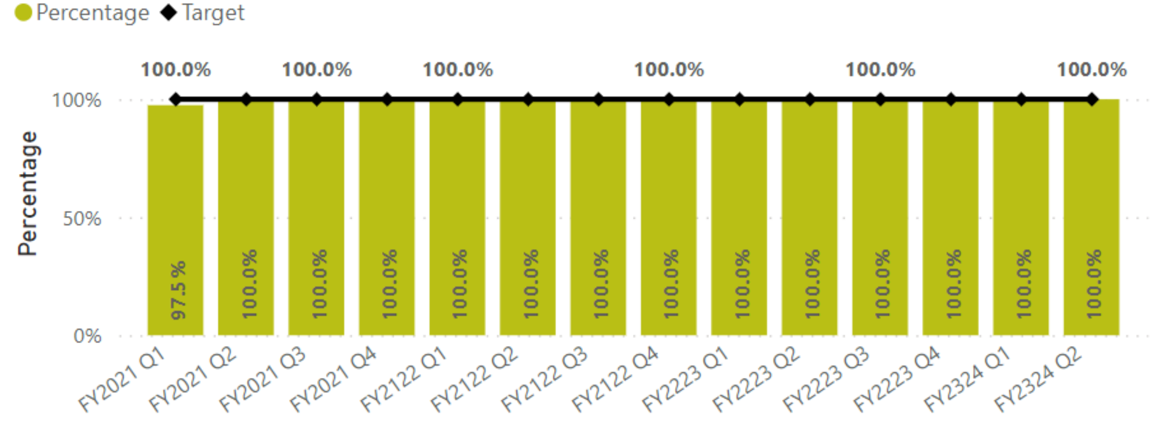
No benchmarking information is made available by NHS England to allow comparisons with other Councils.

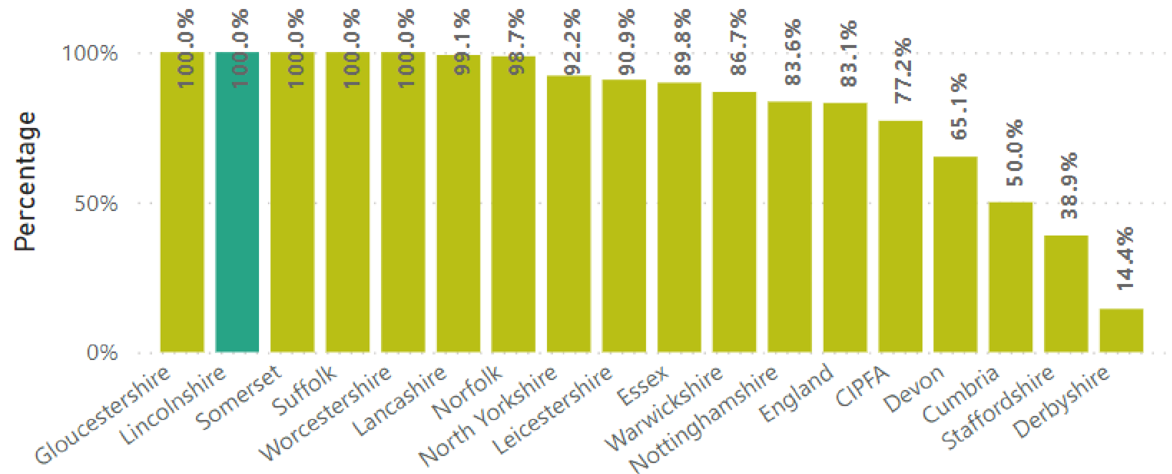
1.2.2 Measures that achieved their target

PI 28 Safeguarding cases supported by an advocate (where appropriate) ✓
April 2023 – September 2023

Actual: 100
Target: 100

This measure is consistently met and demonstrates that individuals are provided with the necessary support to share their views and wishes.



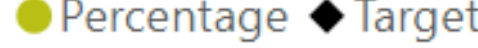


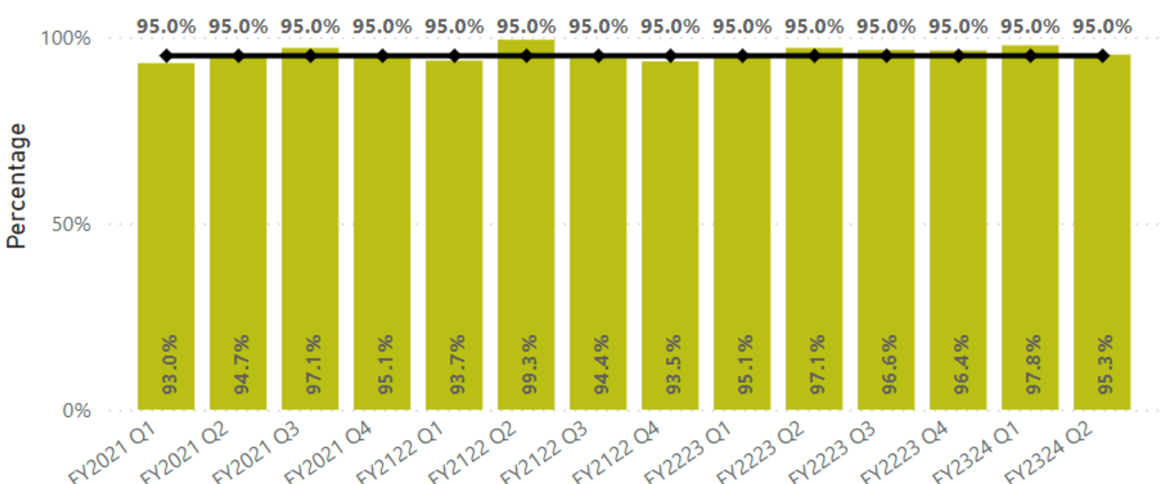
Benchmarking period April 2022 – March 2023

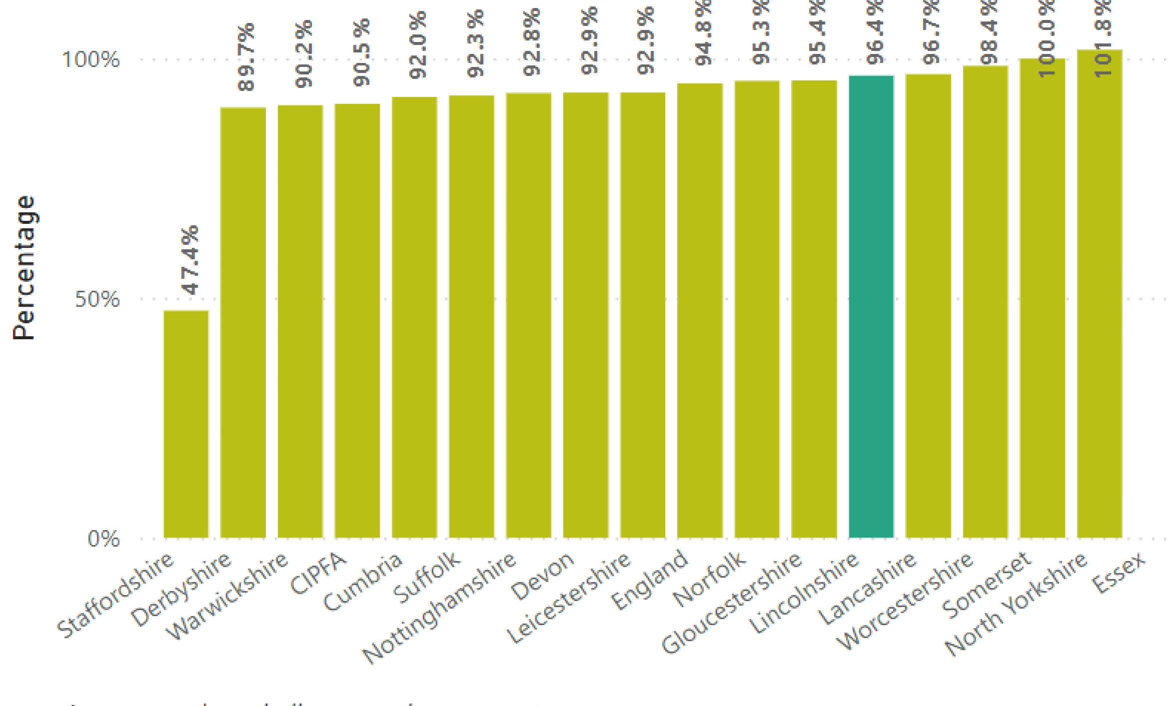
PI 116 Concluded safeguarding enquiries where the desired outcomes were achieved ✓
April 2023 – September 2023

Actual: 95.3
Target: 95

This target provides continued assurance that the adult concerned is always at the centre of adult safeguarding, that their wishes and views are sought and that a person-centred and outcome focused approach is taken.



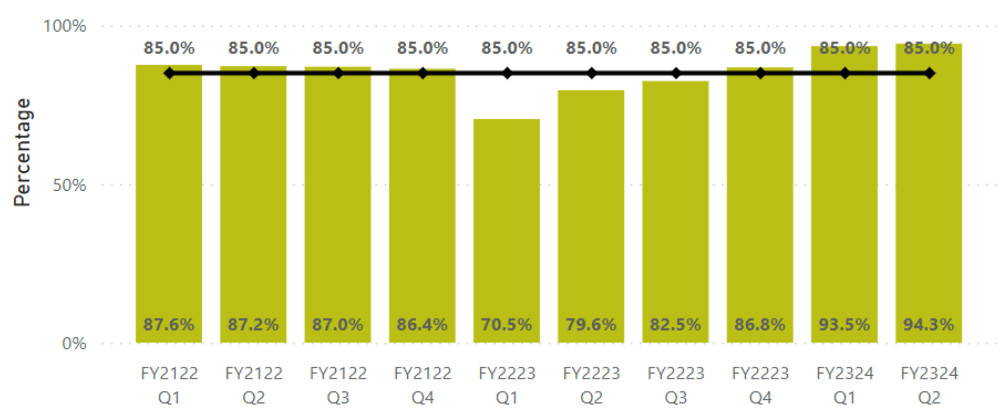


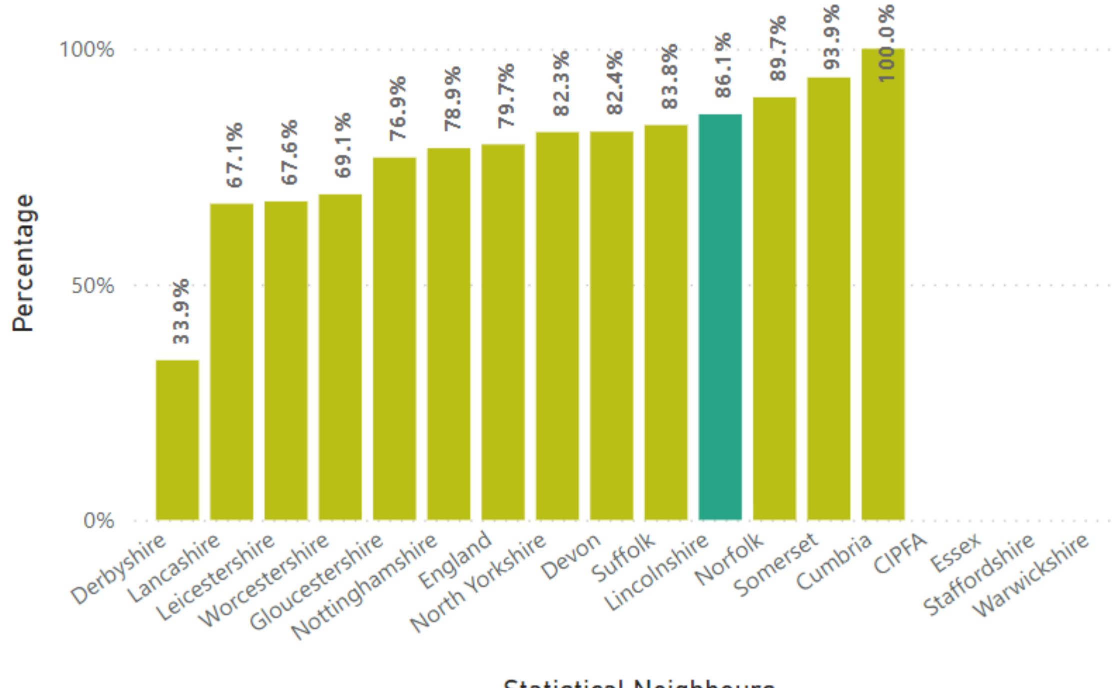


Benchmarking period April 2022 – March 2023

PI 163 Percentage of people who were asked what outcomes they wanted to achieve during an Adult Safeguarding enquiry ✓
April 2023 – September 2023

Actual: 94.3
Target: 85
Making Safeguarding Personal is a key priority for the Lincolnshire Safeguarding Adults Board (LSAB) Prevention strategy 2023-2026. Work is on-going across the partnership to ensure that the adult concerned is spoken to at the earliest opportunity and is supported to express what outcomes they would like to achieve. Continuous improvement against this measure shows the positive impact of this activity.





Benchmarking period April 2021 – March 2022

1.2.3 Measures that did not meet their target

None in Quarter 2

1.2.4 Measure that does not have a target (contextual)

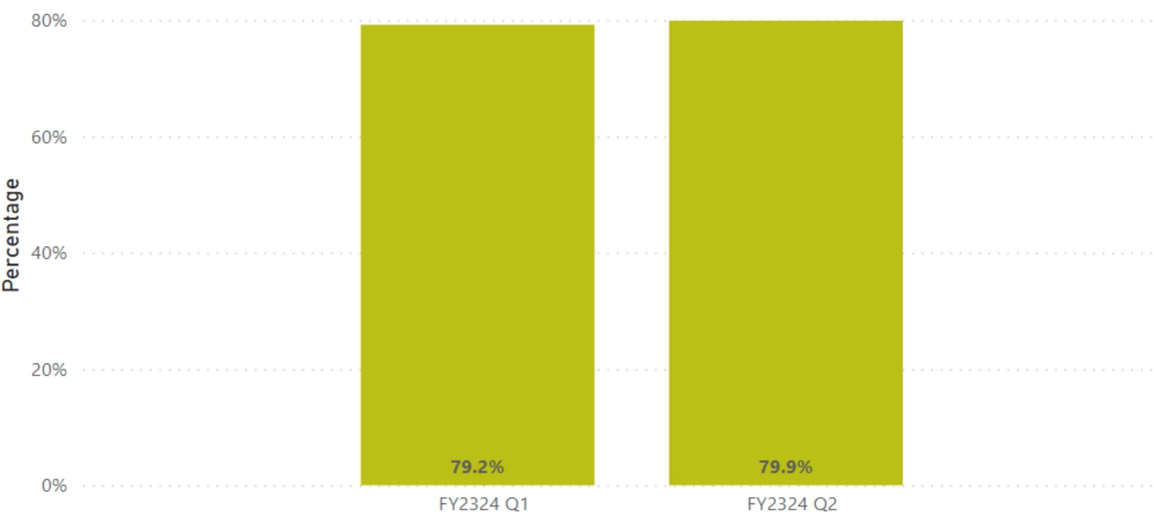
PI 173 Proportion of adults with a learning disability who live in their own home or with their family
As at September 2023

Actual: 79.9
Target: n/a

This measure is intended to improve outcomes for adults with a learning disability by demonstrating the proportion in stable and appropriate accommodation. The nature of accommodation for adults with a learning disability has a strong impact on their wellbeing, safety and overall quality of life including reduced risk of social exclusion.

At the end of Quarter 2, 79.9% live in their own home, with their family or informal carers. This is a slight increase from Quarter 1 and compares to the 2021/22 national figure of 78.8% and the statistical neighbours figure of 75.8%. A lot of work is done by the Learning

Disability Team to support adults with a learning disability to move into their own home, remain living with their family or informal carers.



Benchmarking data will be updated in Quarter 3 and it will then be considered if it is appropriate to set a target for this measure.

1.3 Public Health and Community Wellbeing

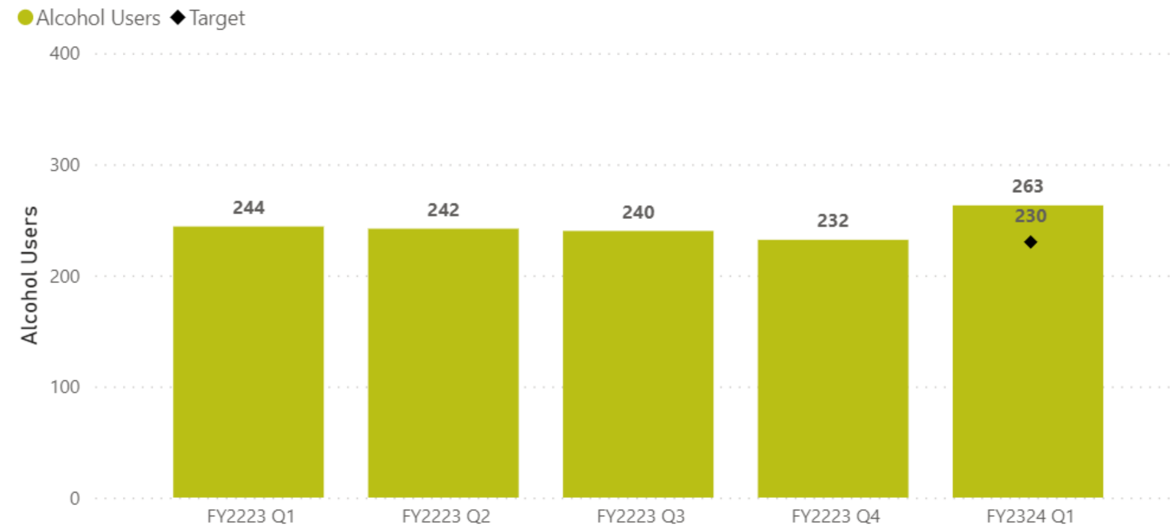
1.3.1 Measures that exceeded their target

PI 31 Number of alcohol users that left specialist treatment successfully ☆
July 22 – June 23

Actual: 263
Target: 230

The definition for this indicator has been revised in Quarter 2 2023/24 to align more closely with service activity and to reflect performance more accurately to the National Drug Treatment Monitoring System (NDTMS). This measure tracks the number of clients in treatment in the latest 12 months who successfully completed treatment. Data is reported with a 3-month (1 Quarter) lag, hence this data reflects performance in Quarter 1 2023/24.

The service has seen improved performance with 263 successful completions compared to 232 in the previous report period which reflects the continued positive work with the provider and the Improvement Plan in place for this indicator. Regular performance monitoring continues with the provider for this indicator with agreed target deliverables and outcomes. The service is currently in a recommissioning phase, and the provider will be supported to minimise any disruption to service delivery during the upcoming transition to new arrangements in April 2024.



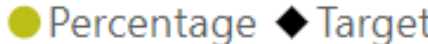
This performance indicator is a local measure so benchmarking data is not available.

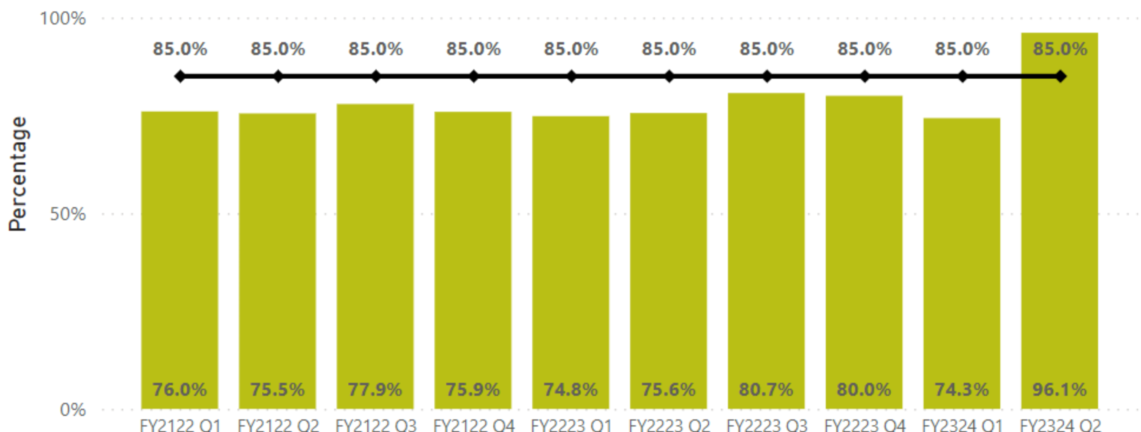
PI 121 Carers who have received a review of their needs ☆
October 2022 - September 2023

Actual: 96.1
Target: 85

The end of Quarter 2 figure is 96.1% (497 out of 517) which exceeds the target and evidences the effective work of the Carer's Service. It should be noted that the definition for this measure has changed since it was last reported at the end of Quarter 1 to ensure it accurately reflects the performance of the service. The measure takes all unpaid carers who receive a personal budget (a direct payment) and seeks to understand if their personal budget has been reviewed.

The definition used in previous reporting comprised data from 2 groups of carers;
1) reviews of carers who receive direct payments and
2) reviews of the cared-for person where they receive an ongoing direct payment for respite care.
Reviews undertaken for a cared-for-person are outside the remit and therefore control of the Carer's Service, so this group has now been removed from the measure. The definition for Quarter 2 onwards is now revised to include group one only - carers who receive a direct payment and reflects the performance of the Carer's Service.





This PI is a local measure so benchmarking data is not available.

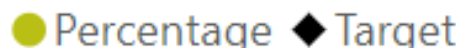
1.3.2 Measures that achieved their target

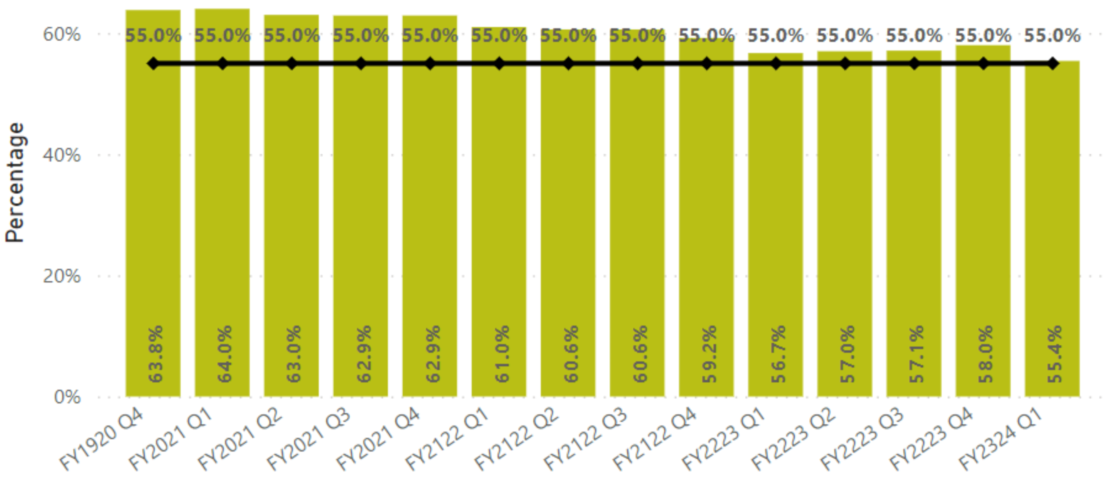
PI 33 Percentage of people aged 40 to 74 offered and received an NHS health check ✓
As at June 2023

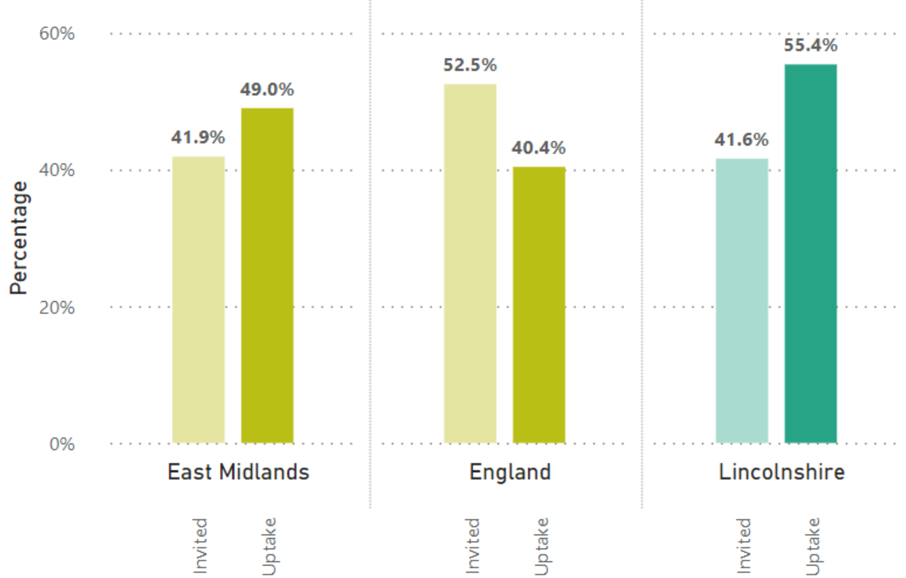
Actual: 55.4
Target: 55

This indicator reflects the latest Office for Health Improvement and Disparities (OHID) published data for the period Quarter 1 2019/20 to Quarter 1 2023/24 and is reported as a rolling five-year measure. During this period in Lincolnshire 94,678 people were invited for a National Health Service (NHS) Health Check and 52,475 people took up the invitation leading to a 55.4% overall uptake. Lincolnshire remains the highest amongst its 'CIPFA nearest neighbours' (Chartered Institute of Public Finance and Accountancy) with the East Midlands overall percentage at 49% and the England average at 40.4% in the same time period.

It should be noted that performance in this indicator will decrease as the rolling average starts to include the period when NHS Health Checks were severely impacted and then halted during the pandemic. The recorded outcomes for the first six months of 2023 post completed NHS Health Checks shows over 2,000 people were identified as having high risk indicators following their check. This includes 480 instances of Hypertension and 97 cases of Diabetes.







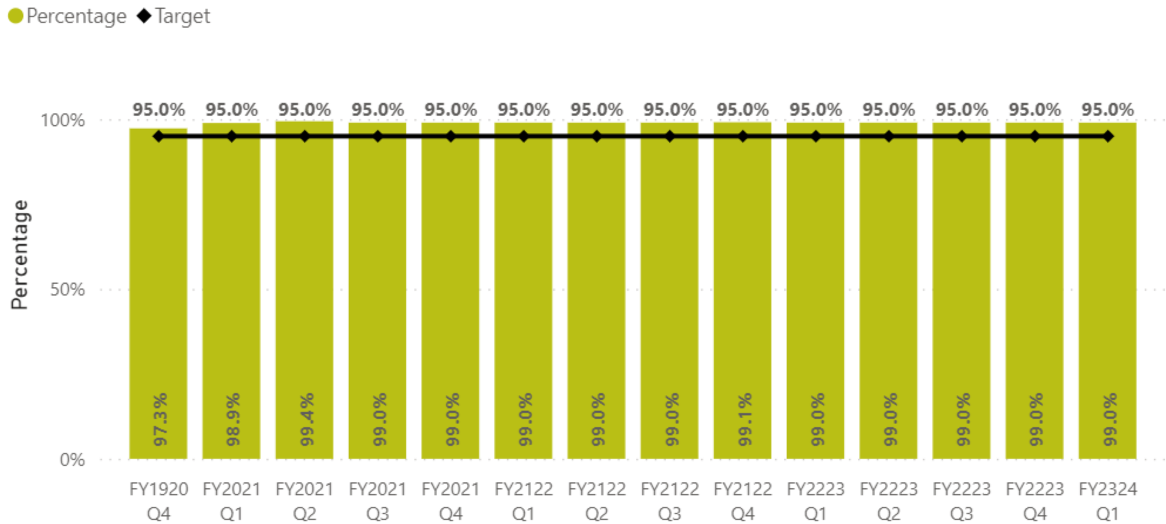
Benchmarking period April 2019 – June 2023

PI 110 Percentage of people supported to improve their outcomes following Wellbeing intervention ✓
As at June 2023

Actual: 99
Target: 95

Due to the time delay on this measure to account for the up to 12 weeks of support interventions available, this data is for Quarter 1 2023-24. The service continues to maintain its consistently strong performance in this self-determined outcome measure indicating 99% of individuals made improvements in their overall outcomes following service intervention.

Service demand has slowed from the unprecedented peak seen in Quarter 4 2022/23, however the service still completed an average of 720 assessments per month in the reporting period. Support with independence and managing money continued to be the highest outcome areas individuals are seeking service interventions to improve.



This performance indicator is a local measure so benchmarking data is not available.

PI 111 People supported to successfully quit smoking ✓
April 2023 – June 2023

Actual: 696
Target: 669

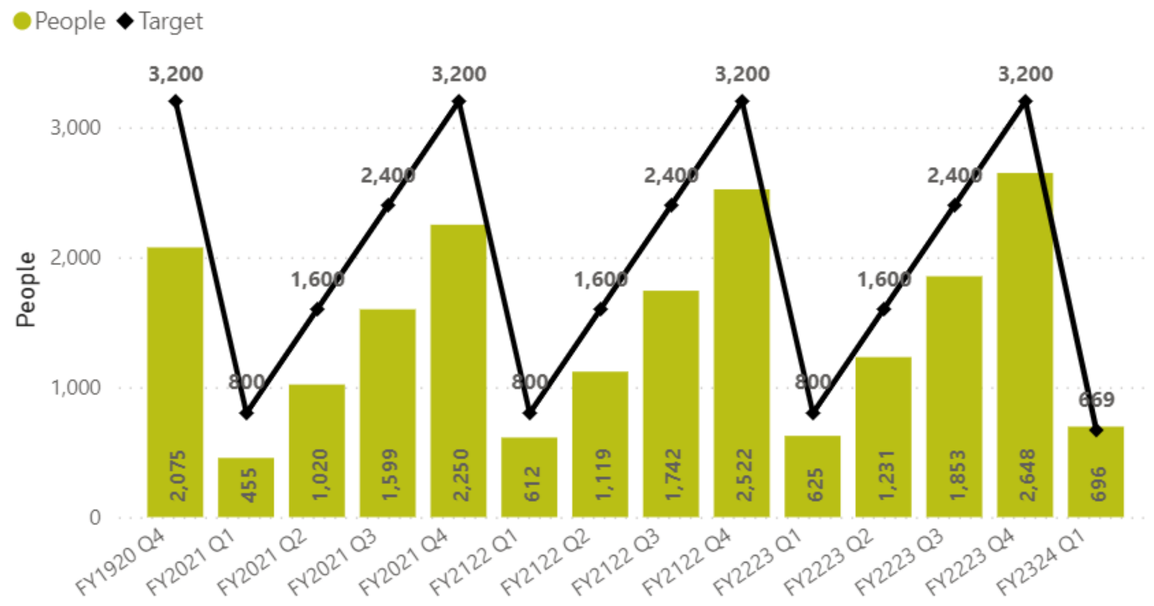
Data for Quarter 2 relates to April to June 2023 due to 12-week data lag. The quit rate for Quarter 2 is 63%, which is above national targets (and higher than the same time last year which was 54%). The effectiveness of e-cigarettes has been outlined in a report to Lincolnshire County Council (LCC), demonstrating that quit rates are equitable to the use of traditional Nicotine Replacement Therapy (NRT) and are a cost-effective option to the service. Client feedback and case studies are also positive.

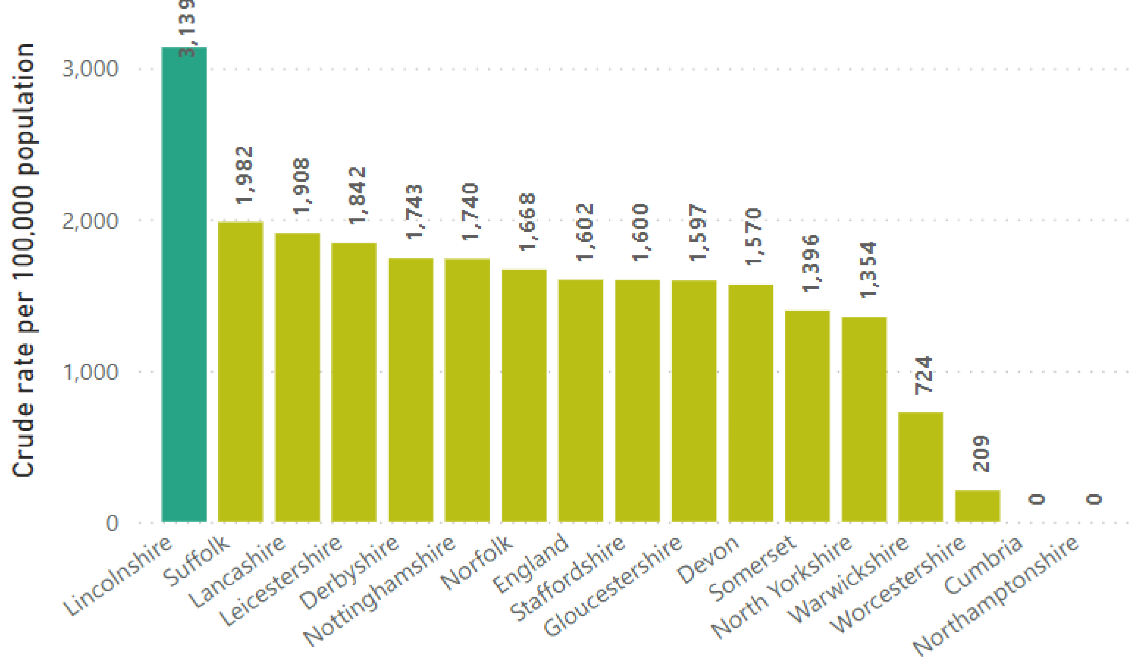
The Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) document has been updated, and the service will support roll-out of e-cigarettes across sub-contracted General Practitioners (GPs) and Pharmacies resulting in an equitable smoking cessation offer across the county. The service is bidding for the Government 'Swap to Stop' scheme, which will result in additional vape starter kits becoming available within Lincolnshire.

Face-to-face appointments continue to increase, with more clinics in community settings, including Centrepoint Outreach in Boston and in Washingborough GP surgery. Centrepoint is a support centre for homeless people in the Boston area, so a weekly face-to-face clinic can offer stop smoking support in a familiar and accessible setting to the homeless

community. It also removes the need for a permanent address as NRT/e-cigarettes are supplied directly to the client.

Maternity smoking cessation services will fully move to the National Health Service (NHS) in October, which may have a small impact on numbers in the core service (approximately 150 per year). However, the new referral route for mental health inpatients is live which should improve the transition into community support for this cohort.





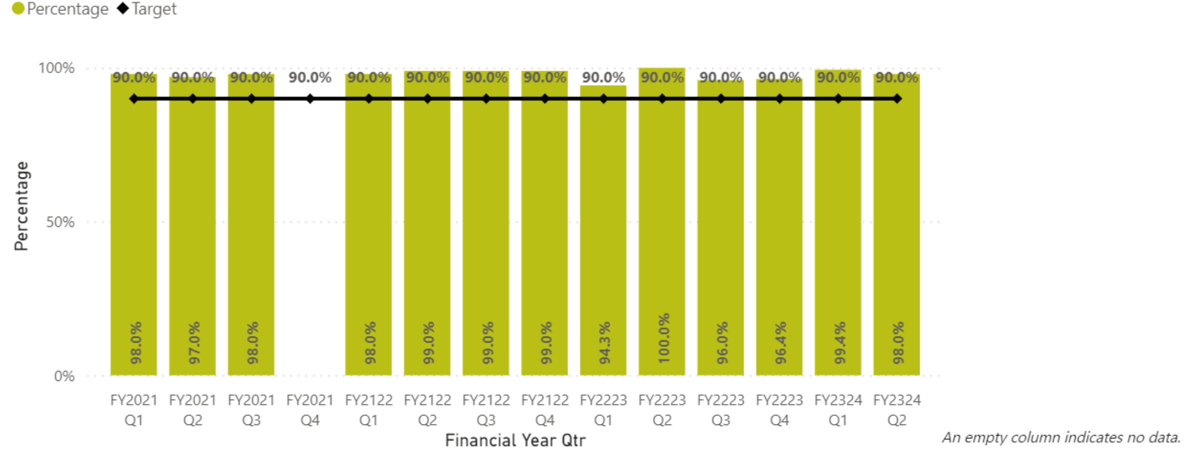
Benchmarking period April 2022 – March 2023

PI 112 People supported to maintain their accommodation via Housing Related Support Service (HRSS) ✓
As at September 2023

Actual: 98
Target: 90

The service has achieved the target this Quarter for both accommodation and floating support, evidencing the provider continues to support service users to achieve their outcomes. Areas of focus have been on managing throughput of the service and supporting service users to move on. Partnership working continues with the provider and other partners to ensure a multi-disciplinary approach to successful outcomes.

Please note a correction to the Quarter 1 2023/24 performance to 99.4% (previously reported as 100%) due to an error in the inclusion of all individuals captured in this indicator, this has now been rectified moving forwards.



This performance indicator is a local measure so benchmarking data is not available.

1.3.3 Measures that did not meet their target

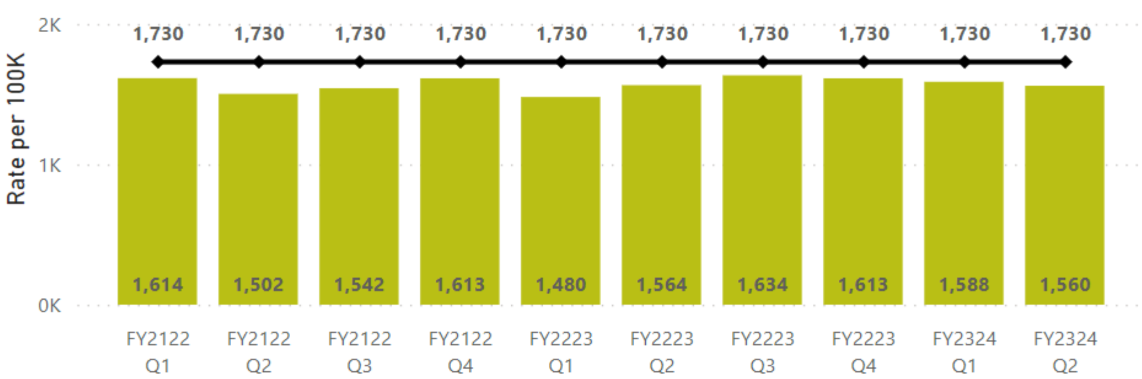
PI 59 Carers supported in the last 12 months ✗
October 2022 - September 2023

Actual: 1560
Target: 1730

While the target has not been met, 11,859 unpaid carers were supported over the last 12 months, this comprised 9,221 adult carers of adults and 2,638 young carers. Of the 9,221 adult carers supported; 785 received a direct payment and 7,934 were offered information and advice as part of the Carer's Service. Outside of the service, 502 cared for persons received respite, providing indirect support to unpaid carers. The rate for Quarter 2 is lower

than in Quarter 1. This was to be expected based on historical tends during the summer holidays, when there is less activity in this service.

The 1,730 per 100,000 population target for this measure was set several years ago and it is intended that this will be changed in Quarter 3 2023/24 to take into account the new Carer's Service model which went live on 1 October 2022. This would provide a realistic target which reflects the work of the Carer's Service in the context of other council services which support carers and are also included in this indicator.



This performance indicator is a local measure and no national benchmarking data is available.

Update regarding **PI 111 People supported to successfully quit smokin**g 2023-24 target, which was 'TBC' in Appendix A in 2022-23 Quarter 4 report. 2023-24 target is 2,675 people supported, although due to the 1 quarter lag, this will not be reported until Q1 2024-25.

2. Conclusion

The Adults and Community Wellbeing Scrutiny Committee is requested to consider and comment on the report.

3. 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 Caroline Jackson, who can be contacted on Caroline.Jackson@lincolnshire.gov.uk

Open Report on behalf of Andrew Crookham, Deputy Chief Executive and Executive Director - Resources

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**29 November 2023**
Subject:	**Adults and Community Wellbeing Scrutiny Committee - Work Programme**

Summary:

The Committee's forward work programme is set out in this report. The report also includes the relevant extracts from latest version of the forward plan of key decisions due to be taken from 1 December 2023. The Committee is requested to consider whether it wishes to make any suggestions for items to be added to its work programme.

Actions Requested:

To review the Committee's forward work programme, as set out in the report.

1. Current and Planned Items

The Committee's programme is set out below: -

A. Items to be Programmed

(1) Day Services Update – *NO EARLIER THAN SEPTEMBER 2024* – This was requested on 6 September 2023.

(2) Workforce Development, Recruitment and Retention within Adult Social Care – *NO EARLIER THAN OCTOBER 2024* – This was requested on 18 October 2023.

(3) Care Quality Commission State of Care - Annual Assessment of Health Care and Social Care in England – This was requested on 18 October 2023 and will be considered as part of the item on the Care Quality Commission's Assessment of Lincolnshire County Council on 17 January 2024.

B. Items Programmed

29 November 2023 – 10.00 am			
Item		*Contributor(s)*	*Notes*
1	Recommissioning of the Lincolnshire Wellbeing Service	Derek Ward, Director of Public Health Tony McGinty, Public Health Consultant	To consider proposals for re-commissioning of the wellbeing service, on which a decision is due to be made by the Executive on 5 December 2023
2	Service Level Performance Reporting Against the Success Framework 2023-24 Quarter 2	Caroline Jackson, Head of Corporate Performance	This is the quarterly performance report.
3	Care Quality Commission (CQC) Pilot Assessment of Lincolnshire County Council – Adult Social Care	Martin Samuels, Executive Director, Adult Care and Community Wellbeing	In advance of more detailed consideration of this pilot assessment on 17 January 2024, this item reports the findings of the CQC's pilot assessment.

17 January 2024 – 10.00 am			
Item		*Contributor(s)*	*Notes*
1	Adult Care and Community Wellbeing Budget Proposals 2024-25	Pam Clipson, Head of Finance, Adult Care and Community Wellbeing	Each year the Committee considers and prepares a statement on the budget proposals for Adult Care and Community Wellbeing
2	Director of Public Health Annual Report 2023	Derek Ward, Director of Public Health	Each year the Director of Public is required to prepare a report on a health issue impacting on the people of Lincolnshire.
3	Introduction to the Lincolnshire Carers Service	Anne-Marie Scott, Assistant Director, Assistant Director, Prevention & Early Intervention Public Health	To receive a presentation on support to unpaid family carers, including an introduction to the new support service provider.

17 January 2024 – 10.00 am			
Item		*Contributor(s)*	*Notes*
4	Care Quality Commission (CQC) Pilot Assessment of Lincolnshire County Council – Adult Social Care	Martin Samuels, Executive Director, Adult Care and Community Wellbeing	This report discusses the outcomes of the pilot assessment by the CQC in July 2023 of adult social care.
5	Overview of Care Provider Contract Management	Alina Hackney, Head of Commercial Services	This report provides an overview of the contract management process across Lincolnshire in care provision settings.

6 March 2024 – 10.00 am			
Item		*Contributor(s)*	*Notes*
1	Service Level Performance Reporting Against the Success Framework 2023-24 Quarter 3	Caroline Jackson, Head of Corporate Performance	This is the quarterly performance report.
2			

24 April 2024 – 10.00 am			
Item		*Contributor(s)*	*Notes*
1			
2			

5 June 2024 – 10.00 am			
Item		*Contributor(s)*	*Notes*
1	Service Level Performance Reporting Against the Success Framework 2023-24 Quarter 4 / Year End	Caroline Jackson, Head of Corporate Performance	This is the quarterly performance report.

5 June 2024 – 10.00 am			
Item		*Contributor(s)*	*Notes*
2			

24 July 2024 – 10.00 am			
Item		*Contributor(s)*	*Notes*
1			
2			

The forward plan of planned key decisions on items within the remit of the Committee is attached as Appendix A.

2. Previously Considered Topics

Attached at Appendix B is a table of items previously considered by the Committee since the beginning of the Council's term in May 2021.

3. Conclusion

The Committee is invited to consider its work programme.

4. Appendices

These are listed below and attached at the end of the report.

Appendix A	Forward Plan of Key Decisions within the Remit of the Adults and Community Wellbeing Scrutiny Committee from 1 December 2023
Appendix B	Adults and Community Wellbeing Scrutiny Committee - Schedule of Previously Considered Topics

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 Simon Evans, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

FORWARD PLAN OF KEY DECISIONS WITHIN THE REMIT OF THE ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE

From 1 December 2023

MATTER FOR DECISION	DATE OF DECISION	DECISION MAKER	PEOPLE/GROUPS CONSULTED PRIOR TO DECISION	OFFICERS FROM WHOM FURTHER INFORMATION CAN BE OBTAINED AND REPRESENTATIONS MADE	DIVISIONS AFFECTED
Wellbeing Service Recommissioning	5 Dec 2023	Executive	Adults and Community Wellbeing Scrutiny Committee	Programme Manager Sean.Johnson@lincolnshire.gov.uk	All

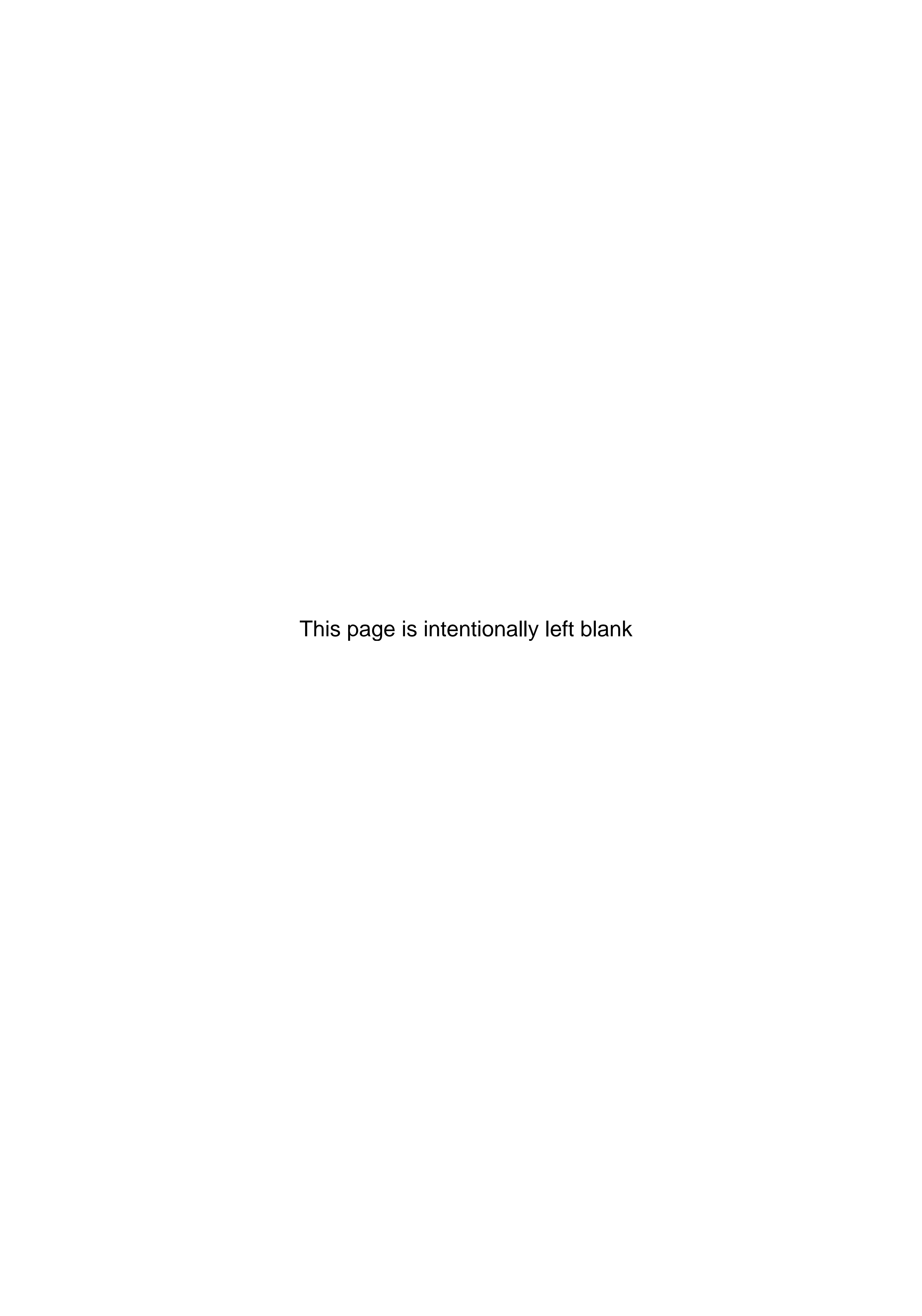
APPENDIX B

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE
SCHEDULE OF PREVIOUSLY CONSIDERED TOPICS

Key	
Y	Previous Item
D	Previous Pre-Decision Scrutiny Item
G	Future Item
G-D	Future Pre-Decision Scrutiny Item

	2021					2022									2023								2024		
	29 Jun	14 Jul	8 Sept	20 Oct	1 Dec	12 Jan	23 Feb	6 Apr	25 May	6 Jul	7 Sept	28 Sept	19 Oct	30 Nov	11 Jan	22 Feb	5 Apr	24 May	28 Jun	6 Sept	18 Oct	29 Nov	17 Jan	6 Mar	24 Apr
Meeting Length – Hours : Minutes	1:47	2:15	3:30	2:50	3:13	2:59	3:55	3:01	3:00	1:58	2:51	2:26	1:39	2:36	2:59	3:08	1:50	2:57	2:47	2:36	1:52				
Active Recovery Beds														D				D							
Acute Hospitals – Admission to Discharge Pathway																	Y			Y					
Adult Frailty and Long Term Conditions - Overview						Y																			
Adult Mental Health Services - Overview					Y																				
Adult Social Care Reform – Government Plans																		Y							
Ancaster Day Centre Refurbishment																		D							
Better Care Fund														Y											
Budget Reports		Y		Y		D				Y			Y		D				Y				G-D		
Carers Support Service							D																G		
Care Quality Commission Assessment of County Council																						G	G		
Care Quality Commission Update				Y									Y								Y				
Community Equipment Service					Y			D																	
Community Supported Living																D	D								
Contract Management Overview																							G		
Day Services			D											Y						Y					
Digital Initiatives Supporting Services																		Y							
Director of Public Health Role / Annual Report			Y			Y									Y								G		
Disabled Facilities Grants					Y									Y											
Extra Care Housing - Boston																		D							
Extra Care Housing - Lincoln															Y										
Extra Care Housing - Welton				D																					
Fair Cost of Care / Charging for Social Care									Y			D		Y		D									
Grange Farm, Market Rasen Working Age Adult Accommodation																	D								
Greater Lincolnshire Public Health						D					Y														
'Gross' v 'Net' – Ombudsman Report			D																						
Improvement and Development Programme								Y																	
Integrated Care Systems											Y							Y							
Integration of Health and Social Care									Y																
Introduction to Services	Y																								
Learning Disability – Section 75 Agreement							D																		
Market Sustainability, Fair Cost of Care												D													
Obesity											Y														
Occupational Therapy					Y																				
Ombudsman Reports		D	D																						
Performance Reports		Y	Y		Y		Y			Y	Y			Y		Y			Y	Y		G		G	
Prevention Services - Overview			Y																						
Residential and Nursing Care Usual Costs							D									D									
Respite Care Ombudsman Report		D																							
Safeguarding Adults Board		Y			Y					Y										Y					
Safeguarding Services				Y				Y											Y						

	2021					2022									2023								2024		
	29 Jun	14 Jul	8 Sept	20 Oct	1 Dec	12 Jan	23 Feb	6 Apr	25 May	6 Jul	7 Sept	28 Sept	19 Oct	30 Nov	11 Jan	22 Feb	5 Apr	24 May	28 Jun	6 Sept	18 Oct	29 Nov	17 Jan	6 Mar	24 Apr
Meeting Length – Hours : Minutes	1:47	2:15	3:30	2:50	3:13	2:59	3:55	3:01	3:00	1:58	2:51	2:26	1:39	2:36	2:59	3:08	1:50	2:57	2:47	2:36	1:52				
Sensory Services			D																						
Sexual Health Services												D					D								
Social Connections																									
Specialist Adults Accommodation – Market Rasen																	D								
Specialist Adult Services - Overview																									
Strategic Market Support Services			D																						
Substance Misuse Treatment Services												D				D			D						
Wellbeing Service																						D			
Workforce – Capacity and Development																									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Open Report on behalf of Martin Samuels,
Executive Director - Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**29 November 2023**
Subject:	**Care Quality Commission (CQC) Pilot Assessment of Lincolnshire County Council - Adult Social Care**

Summary:

In July 2023, Lincolnshire County Council (LCC) was the first local authority in the country to work with the Care Quality Commission to pilot their new process for assessing councils' performance in the delivery of adult social care functions as required by the Care Act. This report gives an overview of that assessment process and presents a copy of the outcome report produced by CQC regarding LCC, which has very recently been published.

Actions Required:

The Committee is recommended to note the report and the assessment of LCC's performance in delivering its Care Act duties, and note that a further report, setting the findings in the context of the national pilot with a total of five local authorities and presenting the LCC action plan in response to the local findings, will be presented to the next meeting of the Committee on 17 January 2024.

1. Background

Following 2010, the Government ended the system of external inspection of local authority adult social care functions in favour of a process of sector-led improvement. Through the Health & Care Act 2022 (s.163), the Government took new powers for the Care Quality Commission (CQC), which has long regulated the provision of heath and social care services to also provide an independent assessment of adult social care at local authority level. This programme will also inform a wider programme of assessments of Integrated Care Systems (ICS). For adult social care, the CQC decided to test the approach by undertaking a limited number of pilot assessments, ultimately covering five local authorities. The pilot assessments would help the CQC to test the new assurance framework, how the process might best work in practice and the time required to deliver an assessment, before formal assessments (inspections) were commenced nationally.

In Lincolnshire, we have always been on the front foot in wanting to shape local and national improvement and therefore we agreed to be part of the CQC assurance pilot. The other four councils in the pilot were Nottingham City Council, Birmingham City Council, North Lincolnshire Council and Suffolk County Council.

Pilot Process

Lincolnshire County Council (LCC) were the first of the five councils to pilot the new assurance arrangements, with CQC starting their on-site visit at County Offices, on Monday, 3 July 2023. CQC were on site for three full days and then followed up that information-gathering activity with a number of on-line interviews. Over 94 different colleagues from LCC Adult Care staff teams and from our partners, including Portfolio Holders and members of the Adult Care and Community Wellbeing senior leadership team, were interviewed by the CQC inspectors.

In addition to these staff interviews, a broad range of feedback from people who access adult care and wellbeing services, unpaid carers and wider key stakeholders was considered by CQC to help them understand how we measured up against the nine CQC Quality Statements. The CQC assurance process also considered various national outcome measures to help them understand how we perform in comparisons with other councils.

Following the assurance process, CQC shared a draft letter with LCC on a confidential basis. This set out high level feedback of what they had found and offered us opportunity to challenge the accuracy of their findings and to provide additional information for CQC to consider. Detailed feedback was provided to CQC and additional evidence was supplied to confirm areas of practice that we believe are performing to a high standard.

In October 2023, the CQC shared with LCC a second draft of the assurance feedback letter, which had accepted some of our additional points. That letter then went through a process of national calibration by CQC, alongside the findings from the other four pilot sites. No changes were made to the Lincolnshire letter as a result of that process. Provided with this covering report is a copy of Lincolnshire’s calibrated and final public facing assurance report. In order to assist Members in contextualising this report, a copy of the CQC interim assessment guidance for local authorities is also attached.

In terms of scoring, the assurance process provides a rating from 1 to 4 for each of the nine CQC Quality Statements. These translate into the now-standard ratings of 1 = ‘Inadequate’, 2 = ‘Requires improvement’, 3 = ‘Good’ and 4 = ‘Outstanding’. Lincolnshire was rates as ’Good’ against all nine quality standards. The report summarises a number of areas that CQC were particularly pleased with and also provides a small number of points for further consideration. That LCC has secured such a positive rating from the CQC, especially through a process that is very new for everyone concerned, is very welcome and represents a significant endorsement by an independent and respected authority regarding the quality of service provided by Adult Care for the people of Lincolnshire.

Next Steps

Although the LCC assessment was undertaken during the summer, the CQC were keen to ensure that they considered the results of all five pilots as a single group. The resulting assurance pilot reports were therefore only made publicly available once all five assessments had been fully completed and calibrated. As a consequence, the LCC report (along with the other four) was only published earlier this month and therefore there has not been an opportunity for the pilot sites to compare findings or share details of their differing experiences of the process – it should be noted that initial conversations between the five local authorities suggests that there were quite considerable differences in the approach adopted by the CQC in conducting the assessments, as that organisation tested a range of ideas and sought to learn as each pilot assessment was delivered. We believe there will be many benefits from sharing our experiences which will add to the richness of learning. LCC will therefore be talking to the other pilot sites before we determine specific recommendations on next steps.

We also want to take the opportunity to speak to key local stakeholders about the CQC findings before we fix the details of the resulting improvement actions. This includes experts by experience, our own staff teams and, partners. We are therefore arranging a number of opportunities to discuss the feedback letter to have input to actions for continuous improvement we will consider.

It is the intention to complete a second report to Adults and Community Wellbeing Scrutiny Committee early in the new calander year 2024 with further findings from our discussions with the other four pilot sites and our local stakeholders. This is likely to include detail on actions that we believe will enhance outcomes for local people even further and will also respond to the areas identified by CQC for further consideration.

At this time, CQC have not confirmed when they intend to complete a formal (non-pilot) inspection of LCC. This is something that we are seeking further clarification on in relation to CQC's plans for the roll out of formal inspections nationally. It is understood that Ministers have tasked the CQC with assessing all 153 local authorities within two years, and that organisation is therefore intending to deliver batches of around 20 assessments every quarter, with the first batch due to be notified very shortly. Given that the CQC will also be undertaking a new process of assessment of the 42 ICSs to a similar timescale, and will also need to provide regular monitoring visits for those local authorities that are judged to be 'Inadequate', it seems likely that their capacity will be at full stretch for some time.

2. Conclusion

The Committee is recommended to note the report and the assessment of LCC's performance in delivering its Care Act duties, and note that a further report, setting out the findings in the context of the national pilot with a total of five local authorities and presenting the LCC action plan in response to the local findings, will be presented to the next meeting of the Committee, in January 2024.

3. Consultation

a) Risks and Impact Analysis

Analysis of risks and impact will be included in the follow-up report in January 2024.

The assessment report represents the findings of the CQC, as the statutory regulator, which were developed through an extensive process of engagement and data collection. There is no requirement for consultation.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	CQC Interim Guidance for Local Authority Assessments
Appendix B	CQC Final Report on Lincolnshire County Council

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 Martin Samuels, who can be contacted on martin.samuels@lincolnshire.gov.uk.

Interim guidance on our approach to local authority assessments

Assessing how local authorities discharge their duties under Part 1 of The Care Act (2014)

Note: We will expand and update this interim guidance in collaboration with stakeholders as we develop our model and transition to ongoing assessment.

February 2023

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Context and overview

1. Introduction and strategic context

Assessing local systems is a core ambition in our current strategy. It will enable us to provide independent assurance to the public of the quality of care in their area. Our aim is to understand how the care provided in a local area is improving outcomes for people and reducing inequalities in their access to care, their experiences and outcomes from care. This means looking at how services are working together within an integrated system, as well as how systems are performing overall.

We are also committed to protecting human rights through our regulation. The Health and Care Act 2022 gives us new regulatory powers that allow us to offer a meaningful and independent assessment of care at a local authority level.

Our assessments will be based on our new single assessment framework. We will use this to assess all types of services in all health and care sectors at all levels. It will apply when registering new providers through to how we look at local authorities.

Providing assurance at local authority level:

Our assessments will focus on how local authorities discharge their duties under Part 1 of The Care Act (2014). This will focus on 4 themes:

1. How local authorities work with people
2. How local authorities provide support
3. How local authorities ensure safety within the system
4. Leadership

This interim guidance has been approved by the Secretary of State for Health and Social Care as required by the Health and Care Act 2022. Its aim is to help local authorities understand more about our approach during the pilot phase.

We will expand and update this interim guidance in collaboration with stakeholders as we develop our model over the coming months and transition to ongoing assessment. It will form the basis for the more detailed guidance about the process later in the year.

2. Key points

Applying our single assessment framework to local authority assessments

- We will use our new regulatory model and single assessment framework across all our work. This includes our new role in providing meaningful and independent assessment of care in a local authority area.
- The single assessment framework applies to all types of services in all health and care sectors and at all levels, including local authority level.
- The quality statements in the single assessment framework are based on people's experiences and the standards of care they expect. We will be using a subset of the quality statements in assessments of local authorities.
- These assessments will build on what we already know from regulating health and care providers and other existing sources of evidence. We will use the information we receive from a range of sources to make assessments flexibly, without being tied to set dates. This ensures we have an up-to-date view of quality.
- Continued collaboration with our strategic partners nationally and at local level is an essential part of our approach.
- We are introducing 6 evidence categories to make our judgements structured and consistent.
- We will carry out initial assessments for all local authorities to achieve a baseline understanding of quality before starting our longer-term approach for ongoing assessment.
- We will award ratings for all local authorities after the initial baselining period. Ratings will be produced on a similar basis to providers – based on building up scores from quality statements to a rating.
- Rather than rate all 5 key questions, we will structure the assessment and rating approach specifically around the context, aims and roles of local authorities.
- Our teams can see all the data and insight they need on one digital platform, helping them to make better decisions about what they need to focus on, both in terms of risks and areas of improvement.
- Reports and outputs will have a shorter and simpler format making them easier to read. They will be clear about when we last assessed evidence and when ratings were updated.

People's experiences of health and care

Our new single assessment framework focuses on what matters to people who use local health and social care services and their families. We want to encourage people who use services, and organisations who represent them or act on their behalf, to share their experiences at any time.

We are using the term ‘people’s experiences’ throughout our assessment framework and the associated guidance about our methods for this approach. We define people’s experiences as “a person’s needs, expectations, lived experience and satisfaction with their care, support and treatment, including equity of experience, access to and transfers between services”. Our key principles for using people’s experiences are:

- People using services, their families, friends and advocates are the best sources of evidence about lived experiences of care and their perspective of how good it is.
- People’s experiences is a required evidence category for all quality statements when assessing local authorities.
- We value people’s experiences as highly as other sources of evidence and weight them equally with other required evidence categories. We also consider the context, impact and equity of people’s experiences in our analysis.
- If we receive feedback that people have poor experiences of care, this is always identified as a concern, even if other evidence sources have not indicated any issues. In these cases, we will need to review further and gather more evidence.
- We increase our scrutiny of, and support for, how providers, local authorities and integrated care systems encourage, enable and act on feedback, including from people who face communication barriers, and how they work with them to improve services.

We recognise that people’s experiences are a diverse and complex source of evidence – ranging from a rating on a review website to a complex narrative. So, we are developing an effective approach to analysing these sources to inform our decision making. We will use a range of data characteristics such as data on demographics, inequalities and frequency of use for care services. We are committed to ensuring we consider the experiences of people most likely to have poor access, experiences or outcomes from care.

We are also thinking innovatively about the relationship between our assessment activity at both the provider and system level (both local authority and integrated care system) and how we can use this to maximise improvement and reflect people’s lived experience of care in a way that people can understand.

To achieve this, the assessment framework:

- sets out clearly what people should expect a good service to look like
- places people’s experiences of care at the heart of our judgements
- ensures that gathering and responding to feedback is central to our expectations of providers, local authorities and integrated acre systems.

The way we record and analyse people’s feedback is changing so that we can make better use of the evidence. This includes quickly identifying changes in the quality of care and analysing qualitative information to better understand a picture over time, as well as responding to urgent individual incidents separately.

The key components of our regulatory approach

3. Our new assessment frameworks

Single assessment framework

Our new single assessment framework is based on a set of quality statements. They are arranged under topic areas and describe what good care looks like.

To develop the quality statements, we reviewed our existing assessment frameworks as well as using aspects of the Making It Real framework. Making It Real was co-produced by Think Local Act Personal (TLAP) with a range of partners and people with lived experience of using health and care services. It is a framework for how to provide personalised care and support aimed at people working in health, care, housing, and people who use services. It contains a jargon-free set of personalised principles that focus on what matters to people.

Quality statements are written in the style of 'We' statements from a provider, local authority and integrated care system perspective, to help them understand what we expect of them. They are the commitments that providers, commissioners and system leaders should live up to in order to deliver truly person-centred care and support. They also help to provide a benchmark of what good care looks like by linking to the relevant best practice standards and guidance.

Our assessment framework will also help people understand what a good experience of care looks and feels like by linking it with 'I statements' from TLAP's Making It Real framework. We will use these statements to support us in gathering and assessing evidence under the People's Experience evidence category.

Making people's voices prominent in our single assessment framework helps to focus the whole health and social care system on people as we increasingly work across the boundaries of health and care, at local authority, integrated care system and national system levels.

Safety through learning is a key theme in our strategy so we have reflected this in the quality statements to set our expectations for how services and providers need to work together, and within systems, to plan and deliver safe, person-centred care. We will assess the extent to which people can influence the planning and prioritisation of safe care and be truly involved as equal partners to transform safety and to ensure that human rights are upheld. We will also assess how leaders foster a culture of openness and learning to improve safety for people.

Driving improvement is also a key theme in our strategy. Our assessments of systems will transform how we bring together a view of quality across a local area, putting people at the centre and helping to drive improvement in health and care.

Assessment framework for local authorities

We will use a subset of the quality statements from the overall assessment framework. This is because local authorities are being assessed against a different set of statutory duties to registered providers.

The Secretary of State for Health and Social Care will publish objectives and priorities for our assessments. These priorities are likely to change and evolve over time. They will be addressed as part of a wider assessment of the quality statements in the assessment framework.

To assess how well local authorities are performing against their duties under Part 1 of the Care Act 2014 we will assess the following 9 quality statements across the 4 themes.

- **Quality statements are what local authorities must commit to.**
- **I statements are what people expect.**

Theme 1: How local authorities work with people

I statements:

- I have care and support that is co-ordinated, and everyone works well together and with me.
- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.
- I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.
- I am supported to plan ahead for important changes in my life that I can anticipate
- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals

Quality statements:

- **Assessing needs:** We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
- **Supporting people to lead healthier lives:** We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

- **Equity in experience and outcomes:** We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response.

Theme 2: How local authorities provide support

I statements:

- I have care and support that is co-ordinated, and everyone works well together and with me
- Leaders work proactively to support staff and collaborate with partners to deliver safe, integrated, person-centred and sustainable care and to reduce inequalities.

Quality statements:

- **Care provision, integration and continuity:** We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
- **Partnerships and communities:** We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Theme 3: How local authorities ensure safety within the system

I statements

- When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.
- I feel safe and am supported to understand and manage any risks.
- I feel safe and am supported to understand and manage any risks.

Quality statements:

- **Safe systems, pathways and transitions:** We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
- **Safeguarding:** We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Theme 4: Leadership

Quality statements

- **Governance, management and sustainability:** We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
- **Learning, improvement and innovation:** We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Types of evidence we will use

Six evidence categories signal the types of evidence we use to understand the quality of care being delivered against each quality statement. The evidence categories required to assess each quality statement vary according to what is being assessed.

The following are the 6 evidence categories and some illustrative examples:

1. **People's experience** as set out in our experience principles and framework. This category covers all types of evidence where the source is from people who have experience relating to a specific health or care service, or a pathway across services. It also includes evidence from families, carers and advocates for people who use services. Examples include interviews with people, Give Feedback on care forms, survey results, feedback from representative groups and case tracking.
2. **Feedback from staff and leaders** including for example, from direct interviews, compliments and concerns raised with us, and surveys. Evidence from self-assessments.
3. **Feedback from partners** including for example, commissioners, providers, professional regulators, accreditation bodies, royal colleges, multi-agency bodies. This will include partners involved in the wider determinants of health and wellbeing such as housing, licensing, or environment services.
4. **Observation.** This category will not be used as part of our assessments of local authorities as it does not apply to the specific context of a local authority.
5. **Processes** are the series of steps, or activities that are carried out to deliver care and support that is safe and meets people's needs. We will focus on the effectiveness of the processes rather than simply the fact they exist. This category includes metrics such as waiting times, audits, policies and strategies.
6. **Outcomes** are focused on the impact of processes on individuals and communities, and cover how care has affected people's physical, functional or psychological status. Evidence includes information on the quality of a provider, clinically relevant measures, quality of life assessments and population data.

The quality statements and evidence categories remain relatively static, but the specific evidence sources we will look at to assess quality will change more frequently, in line with the most up-to-date best practice standards, guidance and information.

4. The assessment process

Initial baseline assessments of local authorities

Assessing local authorities is a new duty for CQC. Before we can move to our new assessment model of ongoing assessment, we need to establish a 'baseline' of completed initial assessments for all local authorities.

The baselining period will take a phased approach to these initial assessments. In the first phase, our work will focus on:

- further developing and embedding our assessment approach through a series of pilot assessments
- gathering evidence
- developing our understanding of relative performance across local authorities
- building relationships within each of the areas.

We will explore opportunities for themed reporting at national level, during this first 6 months.

The second phase involves formal assessment. We will gather all required evidence for each local authority, report on our findings and award ratings. The aim of the second phase is to complete the initial assessments and award ratings for all local authorities. We aim to award ratings in this phase within 2 years.

For the initial assessment, we will start by assessing evidence that we **have**, followed by evidence we need to **request** and finally evidence that we need to actively **collect**. We will only actively collect information that we can't get through other means.

Examples of evidence that we **have** include:

- Outcomes evidence for all local authorities. We will begin to benchmark and assess this against each quality statement for each local authority. In some cases, we will also have partial evidence from some of our other evidence categories. For example, we will have insight from our regulation of providers (Feedback from partners evidence category) and data on the effectiveness of some processes (Processes evidence category).

Examples of evidence that we will **request** include:

- specific policies and strategies (Processes evidence category)
- any survey information that local authorities hold (People's experience, and Feedback from staff and leaders evidence categories)
- the self-assessment from local authorities on their current performance (Feedback from staff and leaders evidence category).
- information from peer reviews (Feedback from partners evidence category)

Evidence that we actively **collect** includes:

- people's experiences (for example, through case tracking and focus groups), more focused engagement with partners and conversations with staff and leaders.

In this way, we will be gathering evidence across all local authorities throughout the baseline period. This will enable us to provide or publish national insights on progress and share information that supports improvement. This approach will also help us develop our longer-term regulatory intention of ongoing assessment.

We will continue to learn and evolve our approach during piloting, initial baselining assessments and once we move to the third phase of our ongoing assessment model.

Collecting evidence on site and off site

We will use the best options to collect evidence, which may be either on site or off site. This will depend on the type of required evidence for a quality statement.

Other types of evidence can be collected either on site or off site or a combination of the two, for example people's experiences or feedback from staff and leaders. There are circumstances where face-to-face contact is the most effective and appropriate way to communicate and understand experiences, for example:

- where people have communication needs that would make telephone or video conversations challenging (or not suitable at all)
- where the nature of inquiry is sensitive, such as following a death or serious incident
- in establishing a rapport with a new lead contact
- where there are concerns around confidentiality (for example, if other people are in the same room, or potentially trying to influence the person we're talking to)
- when we want to corroborate what we see and what we hear in real time.

We will use the expertise of our Experts by Experience and specialist advisors to inform our assessment activity. This ensures that our judgements maintain credibility. Assessment teams can get quick access to specialists for support in:

- understanding which evidence to collect
- corroborating and analysing evidence
- interviewing key staff

Experts by Experience support us to understand people's experiences, both on and off site. They can reach out to people, families and carers using telephone and video calls and engage continuously with communities whose voices are seldom heard. This means that we may not always need to cross the threshold to gather this evidence and update our ratings.

5. Working with national and local partners

We will work with key national and local partners to share data and to gather evidence. Examples of partners include:

- health and care providers
- professional regulators (for example, Social Work England)
- national and local Healthwatch
- community groups, especially those involving people more likely to have poorer access, experiences or outcomes from care
- the Local Government and Social Care Ombudsman.

6. How we will determine ratings

A scoring framework to support consistent judgements

To support the transparency and consistency of our judgements, we intend to introduce scoring into our assessment process for local authorities. This approach will be consistent with our assessments of registered providers.

For each quality statement in the assessment framework, we will assess the 'required evidence' in the evidence categories and assign a score to the quality statement.

The scoring framework to support decisions is:

1 = Evidence shows significant shortfalls in the standard of care.

2 = Evidence shows some shortfalls in the standard of care.

3 = Evidence shows a good standard of care.

4 = Evidence shows an exceptional standard of care

Developing scores and ratings

When we assess evidence, we assign a score to the relevant quality statement. The scores for the quality statements aggregate to ultimately produce the ratings, and an overall score. All evidence categories and quality statements are weighted equally.

The overall rating will use our four-point rating scale. The score will indicate a more detailed position within the rating scale. For example, if a local authority was rated as good, the score will tell us if this is in the upper threshold of good, nearing outstanding. Similarly, if a local authority was rated as requires improvement, the score would tell us if it was at the lower or higher threshold, so nearer to inadequate or good.

We will work with the local authorities, the Department of Health and Social Care, Local Government Association and the Association of Directors of Adult Social Services on the best way to publish our findings.

7. Reporting and sharing information

What our reporting will look like

When we have gathered enough required evidence across the quality statements, we will start to publish assessment reports for local authorities.

There will be a short period between assessment and publication to provide an opportunity for the organisations to carry out a factual accuracy check.

We will publish our reports on our website. Our current thinking is that our reports will include a short summary of the key features of the local authority and will focus on people's experiences of care. We will publish our most up-to-date findings against the themes and for each quality statement. We will include information on what people have said about their experience and how we used it in our assessments.

We will provide narrative on areas that require improvement, areas of strength and report on the direction of travel of the local authority.

We will carry out engagement to clearly understand what different audiences need from our reports and this will influence their design.

Publishing ratings under the assessment process

We will begin publishing scores and ratings for local authorities once we have sufficient evidence. We will be gathering evidence and building relationships overtime rather than on a single inspection.

When we publish ratings, we will publish the following information:

- the overall rating
- the score for each quality statement.

The scores will indicate where a local authority sits within a rating, showing whether it is nearer the upper or lower threshold.

We quality assure our processes and reports to check that our view of quality is reliable. If we identify anomalies, we will update our approach accordingly.

A rating may not be changed on our website every time we review and update a score at quality statement level. But we will indicate that we have reviewed the quality statement score and make clear when this has happened. We will always update our website when a rating moves from one level to another (for example, from requires improvement to good at either quality statement or overall rating level).

Local Authority Assessment

Appendix B

Name of Local Authority: Lincolnshire County Council

Date of publication:

Assessing how local authorities meet their duties under Part 1 of the Care Act (2014) is a new responsibility for CQC. We have been piloting our approach to these new assessments in five local authorities who volunteered to participate. Our assessment of Birmingham City Council was part of the pilots. We will be incorporating any learning from the pilots and evaluation into our formal assessment approach.

Demographics

The population is currently 755,833 with approximately 30% of people over the age of 65 and a projection for the trend towards an increase in older people set to continue.

Lincolnshire County Council area covers 7 districts and is the fourth most rural county in England.

The Index of Multiple Deprivation (IMD) for the overall area is 4 (10 is the most deprived). There are variations in deprivation across the area.

There are 9 'communities of interest' identified as the groups of people most at risk of health and social care inequalities.

Financial facts

- The LA estimated that in 2022/23, its total budget would be £895,817,000. Its actual spend for that year was £917,896,000, which was £22,079,000 more than estimated.
- The LA estimated that it would spend £230,464,000 of its total budget on adult social care in 2022/23 Its actual spend was £234,568,000, which is £4,104,000 more than estimated.
- In 2022/2023, 26% of the budget was spent on adult social care.
- The LA has raised the full ASC precept for 2022/23 and 2023/24. Please note that the amount raised through ASC precept varies from LA to LA.
- Approximately 10,495 people were accessing long-term ASC support, and approximately 2,350 people were accessing short-term ASC support in 2022/23. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

LA Indicative Rating:

Good = Evidence shows a good standard.

Summary of strengths, areas for development and next steps

Strengths
There was a real focus on prevention, independence and maintaining and developing people's own skills to prevent and delay the need for more formalised care and support. There was a range of services on offer to people with the aim of supporting people's wellbeing. The front-line teams used a strengths-based approach to assessment and support planning which enabled them to consider people's strengths as well as areas of their life where they may need some support. This approach was being rolled out to partner organisations to ensure a consistent approach.

The focus on partnership working and collaboration was strongly embedded with staff supporting this approach. The expectation of staff to build relationships and work effectively with partner organisations, even in the teams which were not fully integrated, was clearly understood.

There was clear leadership with effective governance and risk management systems in place. Staff morale was high, with staff confirming they had good opportunities for learning and development. Investment has taken place to develop the workforce internally as well as in partnership with regulated providers to try to address some of the workforce challenges in the area. The local authority had a commitment to commissioning other organisations to provide services where it was felt that they had the skills and experience to do so to a high standard.

There was a good understanding by all staff and leaders about the inequalities within the area and the challenges of the geography. These priorities were clearly identified in formal strategies.

People who required an initial assessment or further support did not have to wait long; the waiting lists were low with a risk-based approach to managing them with action taken if risk increased.

Areas for development and next steps
There have been issues with the arrangements for financial assessments to be carried out for direct payments and delays in the actual payment of these. The local authority was already aware of these issues and had started to take action to address these.

The pathway for autistic people was not entirely clear, with no social work team identified specifically to support them. They were allocated to either the learning disability team, the mental health team or the adult frailty and long term conditions team. The local authority is a key partner in the Autism Partnership Board, and it is expected that further work will be developed in respect of the support offer for autistic people.

The reprovision of the homecare contracts has led to clear benefits in terms of the reduction of missed calls and 'hand back' of contracts. There are processes in place to offer an alternative provider if a person doesn't wish to use the identified provider for that area or they can choose to have direct payments. The local authority is due to carry out another survey of people receiving homecare and so will be able to review how effective the new commissioning model is, including people's views regarding choice.

Whilst the local authority are meeting their Care Act duties with regard to the management of safeguarding concerns there were still times when partner organisations did not understand the criteria for a s42 enquiry or what action was being taken if a formal

investigation did not take place. The local authority needs to continue with the ongoing communication they have with partner organisations about safeguarding.

The pathway for young people in transition to adult services was not always clear with some young people moving to social work teams without dedicated transitions staff.

Summary of people's experiences

The majority of people with lived experience had positive experiences. They spoke about the assessment process and the subsequent support planning which mostly had led to positive outcomes for them, including for unpaid carers. The main challenge for people who had a less positive experience was the lack of a clear pathway for autistic people and for young people transitioning to adult services.

Some people did not find the website easy to navigate and found that it was not always clear to understand who provided the Wellbeing services, whilst others found it a helpful resource.

The local authorities' own surveys and our own discussions found that people spoke highly of the individual members of staff and of the time they took to fully understand their needs. People told us about the opportunities for them to be involved in co-production and their confidence that action would be taken in response to the gathering of their views.

Theme 1: How the local authority works with people

Assessing needs Indicative Score: 3

Evidence shows a good standard.

What people expect:
I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment:
We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this Quality Statement

The implementation of the strengths-based approach to assessment to ascertain people's abilities, needs and wishes had been rolled out across the local authority following work with an external organisation who supported this process. The principal social worker now leads on this work to ensure that it is fully embedded as well as leading on the quality assurance of this approach. Frontline teams were positive about this approach and gave examples of how this had improved outcomes for people as well as increasing the staff satisfaction with the way they were working.

The local authority worked with partners in a collaborative way. Where these organisations were involved in the assessment and review of people's needs, they also had received the strengths-based approach training so that there was a consistent way in which people have conversations with staff about their abilities and needs. This includes the partner organisation who provide the Customer Service Centre and health staff who worked in the integrated teams.

The local authority data shows that waiting lists were low with currently no-one waiting for an assessment from the social work teams supporting people with a learning disability or a mental health need. The waiting list for people waiting for an initial assessment through the other teams was less than 100 and a risk-based approach was taken so that any urgent situations received contact within 24 hours. Staff told us that all assessments took place within the planned 28 days and that they had the staffing resource to do this.

National data shows that the local authority achieved a higher than national average completion of reviews, planned and unplanned, for those receiving long term support. An internal survey, the 'Needs Assessment Pathway' survey, had recently been carried out and from the 102 respondents there was an overall satisfaction level of 7.83 (highest score being 10). The key themes that had been identified were that people felt there was a positive impact for them from the support they were receiving, they were satisfied with their support and that the staff were helpful and informative. The areas for improvement were

that some people felt that it had taken too long for their support to start following assessment.

People we spoke with were mostly positive about the process for obtaining an initial assessment from the local authority. We received positive feedback about the communication with the frontline teams and people confirmed that they were kept informed about the plans for their support. The involvement of someone from the carers team in the Customer Service Centre meant that people were able to be referred quickly to that team when the contact staff identified that someone was an unpaid carer.

Carers had mixed views about whether annual reviews of their needs took place with some saying the social workers initiated the review and others saying that they had to chase the team to have a review carried out. The carers team are currently working with the primary care networks regarding the provision of information about the definition of an unpaid carer and the support available to them. This was one of the ways of trying to reach unpaid carers as the local authority know that there are high numbers of unpaid carers who do not have contact with them.

There was a much higher than national average take up of direct payments. The financial assessments were carried out by a partner organisation and the local authority have identified that there have been some issues with delays in assessment as well as delays in the direct payments being paid. There was a clear plan in place to address this. We received positive feedback from people who have direct payments about the flexibility which enables them to have more choice about where and how they access support. There was an independent organisation available to support people with issues such as recruitment and paying staff.

The local authority was one of the first in the country to implement the Trusted Assessor process which enabled people other than social workers to receive training prior to carrying out assessments of people's needs. They are currently running a pilot with a small number of homecare providers carrying out the initial assessments of people's needs as part of plans to prevent delays in people receiving a service. This is yet to be fully evaluated.

Supporting people to lead healthier lives: Indicative Score: 3

Evidence shows a good standard.

What people expect:
I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment:
We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this Quality Statement

Independence and prevention are key themes within the Joint Strategic Needs Assessment and other strategies that are developed from that, including the Joint Health and Wellbeing Strategy and Better Lives Integrated Care Partnerships Strategy. The aims of the strategies and the focus on independence and prevention were well understood by staff and leaders.

The Lincolnshire County Council website provides information about the services provided and about the various ways in which people can contact the local authority. There are links to the Wellbeing service which is provided by a partner organisation. There are also links to the Carers service. We had mixed feedback from some people about how easy it was to find information when first using the website and that one of the main difficulties was a lack of clarity about which organisation was providing the different levels of support and how they linked with the local authority. Work is currently being undertaken with people with lived experience to review the accessibility of the website. The local authority had carried out an engagement exercise with people using the Wellbeing service where positive responses were receive in terms of how the service enabled increased independence for people.

The strengths-based approach adopted by the front-line assessment and social work teams had a real focus on what the person was able to do for themselves, what their strengths were and what their current support networks were. This formed the basis of the conversation about where their need for support was. This was confirmed in our discussions with staff who were all positive about the focus on independence and wellbeing and gave examples of positive outcomes for people.

Front line teams all spoke about working closely with other teams within the local authority as well as with partner agencies regarding the sharing of information about what services, including voluntary and community services, were available to people to support them to maintain their independence and delay or prevent their need for formal services.

There was a joined-up approach across public health, district councils, health partners and the local authority in looking at housing based on a recognition of the effect that poor housing has on a person's wellbeing and ability to retain their independence. The need for additional Extra Care housing schemes as well as bespoke options for people with complex needs has been identified as areas for development.

The reablement service provided to people discharged from hospital was provided by a partner organisation. Data shows that there had been a positive impact for people in terms of gaining back their independence following a stay in hospital. For example, 57% of people did not need any service following a period of reablement and 90% of people who did require a further service were more independent than at the point of discharge.

There was a real focus on enabling people who required support and unpaid carers to take up the option of receiving direct payments if that is what they wished to do. The take up of direct payments was 41.95% which was above the national average. People gave us examples of how the use of direct payments had enabled them to retain more control over their support as they were able to make their own decisions about who provided that support and in what way.

Equity in experience and outcomes Indicative Score: 3

Evidence shows a good standard.

What people expect:
I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals

The local authority commitment:
We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this Quality Statement:

There was a consistent understanding from everyone we spoke with, from senior leaders to front line staff, about the inequalities within the county and the particular challenges of the geography. These priorities were clearly identified in the formal strategies, with plans in place to address them. For example, the Communities of Interest document provides additional information about the 9 identified communities in the area who were at risk of health and social care inequalities. This was supported with leadership from the Director of Public Health and through partnership working with health colleagues.

The Public Health report 2022 clearly identifies the challenges that each of the four identified geographical areas experiences across Lincolnshire. The four areas identified are – Urban Centre, Urban Industrial, Rural and Market town, Coastal communities. The report is clear about the demographics of each area and the challenges and opportunities that each area presents. There are clear recommendations for further consideration at the end of the report for the local authority to consider in partnership with the rest of the health and social care system in Lincolnshire.

People with lived experience told us that there were opportunities for them to get involved in co-production in relation to the accessibility of the information provided by the local authority. For example, people with a learning disability had been involved in developing easy read formats and some staff have had training in the use of alternative communication methods so that they were able to gather views from more people.

The local authority website had information on it about how to change some of the accessibility options so that users can change their preference, including a voice activation option. The local authority were committed to improving the accessibility and there was a function on the website for people to make suggestions for improvements. Staff told us that they were able to request information in alternative languages and that they did not have any problems in obtaining interpreters when needed.

The frontline staff teams told us that they were encouraged to be creative and flexible in their approach to engaging with people, in general, but with particular focus when supporting those people who were part of communities who were at higher risk of health and social care inequality. There was joint working with partners from housing and the voluntary and community sector to work towards improving the access to support those communities.

For example, the local authority had been influential in the development of a multi-agency approach to supporting people with complex needs who needed longer term support with a focus on prevention. One of the criteria for support from this team was that the person was from a community considered to be at particular risk of inequality.

The recently revised commissioning for homecare was carried out partly in response to the challenges of providing homecare to people living in rural areas and the previously high number of people waiting for homecare in those areas. The revised commissioning has meant that there were very few delays in obtaining homecare and there have been no occasions when providers have said that they are not able to provide care to people at short notice.

Theme 2 – Providing support

Care provision, integration and continuity Indicative Score: 3

Evidence shows a good standard.

What people expect:
I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment:
We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this Quality Statement:

The set up of the frontline social work teams is that there are teams based on three identified primary support needs– learning disability, mental health and adult frailty and long term conditions. There are plans in place to create a social work team specifically for people with a physical disability. Most people gave us positive feedback from people about their experiences of contact with the local authority teams and the support arranged for them. This was consistent with the feedback that the local authority had gathered from people using their service.

The staff teams were committed to partnership working, both with colleagues internally and with partner organisations. This approach was clear within the integrated teams as well as those teams who were not formally integrated.

Where complaints had been received about the provision of support, action had been taken to address these. For example, a review of complaints in 2022/2023 identified some concerns about communication and the length of time in between initial contact and further contact. The local authority reviewed this issue with the teams involved and made changes so that the contact service were supported to be able to answer more generic queries directly. This meant that the social work teams were able to focus on other work. Staff involved told us that this had been a positive change.

We received some less positive feedback about the pathway for autistic people who did not also have a learning disability. There was no team specifically to support autistic people and therefore they could be supported by any of the teams, depending on the person's specific needs. The local authority are a key partner in the Integrated Care Partnership development of the Autism Partnership Board which oversees the Lincolnshire All Age Autism Strategy.

There were effective systems in place to ensure that the local authority gathered feedback from people who used services, staff, and partner organisations so that they were able to identify where there were gaps in the provision of services. There was a real focus on partnership working to address issues. The relationship with the registered providers of homecare, residential and nursing homes was very positive and there was joint working with them with regards to shaping the market to ensure that appropriate services are developed to meet people's needs.

There were times currently when local people with complex needs may have to access more specialist services in a neighbouring county due to the lack of local available services. There was joint working taking place with health partners regarding developing services for people with a learning disability and for those with mental health needs to prevent admission to hospital and to be able to discharge people when they were ready for discharge from long stay hospital admissions.

Some of the geographical challenges relate to the rurality of the area and the difficulties that this can bring regarding workforce, transport and lack of local services. This had led to long delays in obtaining homecare in some areas and homecare providers handing back packages of care as they were not able to fulfil them. The revised commissioning for homecare had addressed many of those issues that had previously been present in the provision of home care. In addition, it reduced the number of packages of care that were handed back and missed visits. The new commissioning process has identified a small number of providers who cover specific geographical areas. They are able to subcontract with another provider which does provide a limited choice if the person does not want to use the preferred provider identified for the area in which they live. There is also the opportunity for the local authority to spot purchase a different provider or for the person to have direct payments which enables them to have more control over who provides their homecare.

The local authority are currently working with service users and staff to agree actions following a recent survey of people using day services. One of these issues was the inflexibility of times when people could attend as they were reliant on transport which was not always available at the times that they wished to use it.

We received mixed views about the transitions service for young people transitioning to adult services. Young people were allocated to an adult's team in the year prior to them becoming 18 and the involvement of adult social work teams with the children's team prior to this was variable. Currently the only specific transitions social workers are within the learning disability team. There were plans in place to appoint a transitions worker within the adult frailty and long-term conditions team who will specifically work with young people with a physical disability prior to the planned development of a social work team specifically for people with a physical disability. This means that there were other young people with differing needs who will be allocated to a generic social worker rather than a social worker with additional skills and knowledge with regards to transition.

Partnerships and communities: Indicative Score: 3

Evidence shows a good standard.

What people expect:

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment:

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this Quality Statement:

Partnership working was one of the real strengths of the local authority. High level strategies were co-produced with partner organisations where appropriate and have a focus on partnership working. The commissioning strategies were focused on partnership working with appropriate governance systems in place to oversee the quality of the service. There were examples of pooled budgets with the local health system and integrated teams, for example, the hospital discharge teams. The local authority was seen as an equal partner by those in the health system.

The feedback was very positive from all of the partner organisations who we spoke with, including health, voluntary and community sector, service user led organisations and providers of homecare and residential/nursing care. They all spoke very highly of the commitment of the local authority to working in this way. They spoke positively about the quality of the relationships between the local authority and themselves with the shared view that despite the occasional challenges in working in this way the local authority was committed to it.

There was a shared aim of achieving improved outcomes for people through joint working, whether this was through formal partnership agreements or through less formal relationship building with other teams and organisations to best be able to meet someone's needs.

We received mixed views from people about how smoothly their move between services was with most people satisfied with the communication and support when they moved between services. However, some reported that they felt that communication could have been improved. The local authority had already identified areas where improvements were needed and some of the more recent service developments, such as the integrated hospital discharge teams, had been as a result of that.

There are s75 agreements in place with health providers which enables the local authority to commission health providers to commission and provide social care. These are in place for services for people with a learning disability as well as people with a mental health need. We heard about positive outcomes for individuals because of the health and social care teams working in this way. This included people having involvement with one

professional rather than several which had been their experience previously. This enabled them to build more effective relationships with them and meant that they did not have to keep repeating their story.

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Theme 3: How the local authority ensures safety within the system

Safe pathways, systems and transitions Indicative Score: 3

Evidence shows a good standard.

What people expect:
When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment:

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this Quality Statement

The commitment to partnership working and to the provision of personalised care had led to improved outcomes for people when they were moving between services. One of the challenges for integrated working was the issue of information sharing via the computer systems. The local authority are working with health partners regarding this and so far, have achieved read only access for staff in the integrated teams.

A fully integrated hospital discharge team started working together a year ago and are achieving positive outcomes for people being discharged from hospital. The team worked closely with the other services available for people who required varying levels of support when discharged from hospital. This varied from a voluntary service providing transport and shopping to the reablement team providing longer term support. The local authority's data, as well as national data, showed that the support had enabled increased numbers of people to return home and remain at home rather than requiring longer term support such as residential care.

The local authority were one of the first in the country to implement the Trusted Assessor system with some regulated providers carrying out the assessments for people waiting for discharge from hospital. This, along with the development of other services, such as the Community Connectors scheme, some with partner organisations, has led to improved pathways for people ready to be discharged from hospital. There were additional plans in place which could be quickly implemented to support at times of pressure, such as during the winter, when there are likely to be higher than usual admissions to hospital.

The contracts team had a risk management system in place for providers of homecare and residential/nursing homes. This ensured that support was provided to those where there were concerns about the quality of the service being provided. The providers spoke highly of the relationships with the contracts and commissioning teams and about the positive

partnership working that took place, even when dealing with challenging issues. This meant that the providers had a good understanding of the services that are going to be needed in the future and felt part of the discussions and planning for this. The providers also found that due to the positive relationships they had they were more likely to speak to the local authority teams for advice and therefore any issues could be dealt with at an early stage.

The pathway for people in transition from children's to adult's services was not always as seamless for families as it could be. The local authority are currently planning for additional front line social workers to take a lead on transitions within the social work teams.

Risk assessment was a core aspect of the assessment of people's needs alongside the focus on personalised care and support. Social work staff who we spoke with were aware of the legal frameworks in which they worked as well as the importance of respecting individuals' choice. Staff told us that they were able to obtain the service of an advocate when people required one. The advocacy provider confirmed this and that they were able to provide advocates for support with Care Act assessments in a timely way.

The development of the multi-agency Team Around the Adult service aimed to provide additional support to those people who have complex needs and require that support to maintain their safety and wellbeing. This meant that the most vulnerable people received the support from the most appropriate professional at any specific time and we heard examples of positive outcomes for people.

Safeguarding Indicative Score: 3

Evidence shows a good standard.

What people expect:

I feel safe and am supported to understand and manage any risks.

The local authority commitment:

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this Quality Statement

The Safeguarding Adults Board Strategy clearly set out the identified risks for the area and had work streams which were monitored to ensure action was being taken to address the risks effectively.

Information about safeguarding and how to make a referral to the safeguarding team was available on the local authority website, including specific information for unpaid carers. All the front-line staff who we spoke with had a focus on safeguarding and ensuring that risks for people were reduced in line with their right to make their own decisions. All staff were confident in the safeguarding policies and processes.

National data shows that the local authority is in line with the national average in the numbers of people who received a service, and unpaid carers reporting that the service they received makes them feel safe.

The local authority was clear in its adherence to the Care Act definition of safeguarding and s42 enquiries. A s42 enquiry is where the local authority believes that someone is at risk of harm or abuse and therefore further enquiries need to be carried out. Their own audits of safeguarding referrals and subsequent action taken show that they had met their Care Act responsibilities in terms of safeguarding. The most recent internal audit also showed that 96% of people who were subject to a safeguarding enquiry reported their satisfaction with the way in which it was carried out and the outcomes.

All safeguarding referrals went to the safeguarding team where they were triaged. Decisions were made at that point as to whether the referral would proceed to a s42 enquiry and if so, who should carry that out. If it did not meet the criteria for the enquiry, then a decision was made as to who should be responsible for further discussion about the issue. The out of hours duty team consists of Approved Mental Health Professionals (AMHPs) and they were responsible for reviewing the s42 responses carried out by regulated providers. The overall oversight of these enquiries remained with the safeguarding officer.

There was guidance available for partner agencies regarding what the Care Act criteria was for a safeguarding referral and s42 enquiry and the local authority had carried out learning sessions with partner organisations. However, these were not well understood by all partner organisations which could lead to differences of opinion about whether safeguarding concerns had been dealt with appropriately.

Learning from safeguarding enquiries as well as Safeguarding Adult Reviews was collated and shared with front line teams.

Theme 4: Leadership

Governance, management and sustainability Indicative Score: 3

Evidence shows a good standard.

The local authority commitment:

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this Quality Statement

The leadership of the local authority was stable which enabled longer term plans to be put into place with time to embed. Monitoring activity took place to ensure the effectiveness of new ways of working which enabled the management team to make decisions about whether further improvement was needed.

The governance arrangements were effective in providing oversight of the provision of assessment, ongoing care and support to people. This included effective challenge at the Scrutiny Committee by councillors. For example, the Quality and Safeguarding Board were responsible for overseeing safeguarding, quality of services, complaints, and market risk. There were clear lines of accountability and reporting to the senior leadership team. Front line teams told us that the DASS and Assistant Directors regularly spoke to them about their views and that they were confident that they were listened to as they could see that action was taken to address issues.

There were effective working relationships between the leadership team and partner organisations which had led to the development of a high number of partnership ways of working.

Feedback from partner organisations, as well as internally within the local authority, was that the Director of Adult Social Services (DASS) has excellent communication skills with a real focus on developing partnerships in order to meet people's individual needs. They were all positive about the culture of the local authority being set by the DASS and that culture being embraced throughout the teams. Front line staff teams told us that they felt well supported by the management teams and able to discuss challenges and issues with them.

Whilst we did not speak with many people with lived experience about the leadership of the local authority, we did hear from one person who assured us that they were able to contact the DASS. They told us they had done this and were very happy that they had been listened to.

An audit of the local authority's risk management processes had recently been carried out by an external organisation and the outcome was that there were comprehensive and effective risk management processes in place with clear leadership from the senior leadership team.

The local authority had invested in developing its own workforce and that of partner organisations involved in providing services as a way of maintaining sustainability. In recent years, the ratio of qualified staff in front line teams compared to non-qualified staff had increased. There were processes in place to enable staff to be trained through apprenticeship and other schemes to become qualified social workers. This had helped with staff recruitment and retention. Whilst there were some vacancies across the teams these were not in high numbers and the majority were in the process of being recruited to.

Work had taken place with the provider forum who had been supported financially to take on the role of rolling out training to the providers of homecare and residential/nursing care homes to assist with their recruitment and retention of staff. There were also processes in place to ensure that the risk to people using services was minimised if a regulated service failed. There were procedures in place to deal with interruptions to service and learning from the pandemic had been taken forward in plans to deal with any future similar situations.

The local authority was proactive in seeking out the views of people with lived experience to gain their views about the care and support they were receiving. In addition, they involved people in the co-production of strategies for how services could be developed. Work is currently taking place to review the co-production that is taking place by the local authority and partner organisations against national guidance relating to co-production best practice.

Learning, improvement and innovation Indicative Score: 3

Evidence shows a good standard.

The local authority commitment:
We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this Quality Statement

There was a real focus on staff development and learning. Front line staff all confirmed that they were given opportunities for mandatory training as well as any specific training that would enable them to be able to carry out their roles more effectively. There were opportunities for a number of unqualified staff to commence social work training each year. The programme of training about strengths-based practice had been rolled out across the local authority over the last year and the approach was clearly embedded in practice.

There were clear systems in place to ensure that learning from complaints, Safeguarding Adults Reviews (SAR) and any internal audits were shared. This was done in a variety of ways including staff learning events, through managers at team meetings and through written updates. The shared learning from a SAR led to the development of the Team Around the Adult as teams took action to address the learning points. Where the need for improvement had been identified the required actions had been completed or were in the process of being implemented.

The senior leadership promoted a culture of openness and transparency with surveys being commissioned to be carried out by the internal quality monitoring team as well as external organisations such as Healthwatch. There was ongoing work with the local university to carry out research on behalf of the local authority and to evaluate new systems of work to ensure they were effective.

The Continuous Improvement Plan recorded areas where improvement was needed and was monitored by senior leaders to ensure progress. One of the areas was the further development of technology enabled care (TEC). Whilst many examples of TEC were provided the local authority and staff have received training to ensure it is considered as part of assessments. Further development is planned.

We heard examples from front line staff and people with lived experience about the focus on being creative about how people's support is provided, particularly for those in situations where support may be more challenging to provide. The very real commitment to partnership working and seeking out the organisations with expertise in particular areas had led to more effective ways of ensuring that people's individuals needs were met.