**MINUTES OF A MEETING OF THE COMMUNITY & OLDER PEOPLE POLICY AND SCRUTINY COMMITTEE HELD AT COUNTY HALL, CHELMSFORD AT 10.00 AM ON 9 FEBRUARY 2012**

Membership

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| * | W J C Dick (Chairman) | * | S Hillier |
| | L Barton | * | R A Pearson |
| | R Chambers | * | Mrs J Reeves (Vice-Chairman) |
| * | P Channer | * | C Riley |
| | J Dornan | | Mrs E Webster |
| | M Garnett | * | Mrs M J Webster |
| * | C Griffiths | * | Mrs J H Whitehouse (Vice-Chairman) |
| * | E Hart | * | B Wood |
| * | T Higgins (as Substitute) | | |

* Present

The following also were in attendance:

Also in attendance were Councillors A Brown (Deputy Cabinet Member) and G Butland, and P Coleing and M Montgomery of the Essex Older People's Planning Group.

**9. Attendance, Apologies and Substitute Notices**

The Committee Officer reported apologies had been received from County Councillors L Barton (for whom Councillor T Higgins substituted), R Chambers, M Garnett, and Mrs E Webster.

**10. Declarations of Interest**

Councillor Higgins declared a personal interest for Item 12 as she was a member of the Colchester Borough Council Planning Committee. Mr P Coleing declared a personal interest for Item 13 as he had been nominated to serve on HealthWatch. No other interests were declared.

**11. Minutes of last meeting**

The Minutes of the Committee held on 12 January 2012 were approved as a correct record and signed by the Chairman of the meeting.

**12. Extra Care Housing (ECH)**

The Committee received the following reports:

COP/05/12 - from Susannah Westwood, Commissioning Manager, Strategic Planning and Commissioning, on Extra Care in Essex.

COP/06/12 - comprising the Executive Summary of 'Establishing the Extra in Extra Care, *perspectives from three Extra Care Housing Providers' authored* by Dr Dylan Kneale, International Longevity Centre UK.
Both Susannah Westwood and Dr Kneale were present to introduce and supplement their respective reports and to answer questions.

(a) Current ECH provision in Essex

There were currently 305 ECH units in the county with a possibility of approximately 430 units identified to be provided in new developments. A further table of information had used the Department of Health recommendation of estimating need for ECH at 25 places per 1,000 people aged over 75 and, based on the estimated 2010 population, the current variance between supply and demand in Essex was estimated to be 2,749 places. With the projected growth in the older population by 2015, it was estimated that there would be a need for 3,453 ECH places in the county by then. Whilst the Tendring district was shown to have the largest variance at 475 places, it was suggested that the demographics of the area combined with migration of retirees from outside Essex could mean that the variance would significantly grow over time.

(b) 'Establishing the extra in Extra Care'

Dr Dylan Kneale outlined some of the key findings from his report. The report had been compiled from observations of 12,000 residents in ECH from 1995. In particular, the median stay for residents in ECH in the study was six and a half years with about eight per cent of residents entering institutional accommodation from ECH after five years of residence. Compared to those living in the community in receipt of domiciliary care, those in ECH were less likely to enter institutional accommodation. Among a matched population aged eighty plus, the report predicted that about 19 per cent of those living in the community and in receipt of domiciliary care would enter institutional accommodation, compared to just 10 per cent of those living in ECH.

(c) Private sector provision

It was suggested that owner occupiers formed the majority of homes in most areas of Essex. With such a large owner occupier population, the only way for ECC to bridge the gap between demand and supply was to work with private developers to develop housing with care models, particularly focussing on local demand and needs. Borough and district councils were also working with developers as part of developing older people strategies and, in some instances, had identified sites (including some that had previously been sheltered housing accommodation) that could be adapted into ECH.

There was increased focus on accommodation being more easily adaptable as personal needs changed. McCarthy and Stone, the largest developer of retirement accommodation in the country, had adapted their ECH models accordingly to meet the needs of frailer older people. There were also mixed tenure models offered by the private sector across the country which varied

according to local demand, a new development in Basildon had fifteen units for sale out of a total of 61, whereas Suffolk County Council was now considering whether to support a higher ratio of units for sale in new developments.

Members were concerned that, as the trend was towards greater private sector provision, supply and demand pressures could lead to locals being priced-out of the market as affluent retirees from outside the area could migrate to certain Essex areas, particularly near the coast.

(d) Funding issues

Historically, social housing development of ECH had received significant capital grants from the Homes & Communities Agency and the Department of Health. Since 2010, the national Affordable House Building Programme had been reduced significantly, impacting on the numbers of affordable homes able to be built. Local authorities could decide to use funding from the New Homes Bonus to finance ECH provision. An ECC 'Invest to Save capital bid submitted under the Capital Programme Bids process had not been approved.

Officers acknowledged that the long-term viability of some of the smaller ECH sites had been a concern, and that the current list of recommended ECH accommodation in Essex was shorter than it had been in the past to reflect that it now only included those deemed to be sustainable.

(e) Location of ECH sites and facilities on site

Members emphasised the importance of sites being close to local amenities and not remote so as to create a 'life time neighbourhood'. There was, however, a minimum 'footprint' for a financially viable ECH site which was thought to be at least one and a half acres to accommodate at least 40 ECH units. It could be difficult to find such sites in town centre locations. Some anecdotal evidence suggested that the threshold for financial viability for ECH sites could be significantly higher than the 40 units previously thought.

Members stressed the importance of ECH sites being able to accommodate family and friends visiting residents. It was highlighted that most ECH schemes did have guest suites. In addition, some ECH units were two-bedroomed and would be able to accommodate visitors in the second bedroom. It was acknowledged that housing benefit payable to a resident might not cover the cost of occupying a two bedroom unit with anecdotal evidence suggesting that families often had to 'top up' the rent payments.

If an owner occupier of an ECH unit was subsequently transferred to residential care it was likely that their ECH unit could be leased-out and such rental income taken into account as part of the eligibility assessment for Social Care funding.

Members suggested that ECH could be a suitable platform for being able to keep residents with Alzheimer's or early dementia in the community for longer.

Reference was made to a particular ECH scheme in Colchester that had units specifically targeted for such residents.

The Homes for Older People Strategy was being updated as part of the development of an ECH Strategy. It was acknowledged that, in the past, there had been a tendency for older people housing strategy to be undertaken in isolation rather than as part of an overall care strategy. Members would be invited to participate in the development of older people housing strategy.

The Chairman thanked the witnesses for attending and they then left the meeting.

## 13. Essex Public Health Transition

The Committee received a report (COP/07/12) from Mike Gogarty, Director of Public Health, updating the Committee on the plans in place for the transition of public health responsibilities from primary care trusts to ECC. Dr Gogarty was in attendance to introduce and supplement the report and to answer questions.

(a) Introduction

The Strategic Health Authority required Primary Care Trusts (PCTs) to submit public health transition plans by the end of March 2012. A current draft of the document, drafted from an ECC perspective and on the basis of the existing PCT clusters in Essex, had been circulated to the Committee, which described the preparation and progress underway as well as describing the local context and some of the key issues that needed to be addressed by the time of the transfer to ECC in 2013.

(b) Future responsibilities

Public Health England would be responsible for the main advisory function although there was a clear mandate on local authorities to ensure that appropriate plans were in place to support that function at local level. Delivery of 'on the ground' health protection likely would remain with the community health trusts. Local authorities would be responsible for commissioning the majority of health improvement functions except those already reflected in GP contracts or already with the NHS Commissioning Board. Members were concerned that there was no senior public health representation on the National Commissioning Board. It would also be the role of the local authority to address local health inequalities and ensure that vulnerable groups were also included in an integrated approach to public health planning. It was anticipated that GPs would embrace the changes through the Clinical Commissioning groups being established.

Local government was already responsible for some of the wider determinants of public health so it was suggested that there was significant logic in it also taking on overall responsibility for public health. However, although

acknowledging that the current structure was fragmented, Members suggested that the proposed new structure would be no different in that respect.

(c) Restructuring

Both the North and South Essex PCT Clusters had undergone reorganisations and revised structures had been included in the draft transition report submitted to Members. It was stressed that it was important that a joined-up approach was adopted to span the two PCT cluster areas. The North Cluster had developed a single team with a strong locality focus. The South Cluster, needing also to serve the Southend and Thurrock Unitary authority areas, had developed two teams based around the South East and South West PCT structures. Within that structure, some posts would have a responsibility for the population of the ECC administrative area, and some for the populations of the Southend and Thurrock Unitary areas.

The re-organised North Cluster team would be co-located with appropriate ECC locations from April 2012 and would be structured in line with the evolving Target Operating Model for ECC. The entire South East Essex public health team would initially be co-located with Southend-on Sea Borough Council, whilst the South West Essex public health staff identified for the Thurrock locality would be co-located with Thurrock Council from April 2012. Agreement would be reached with ECC on the co-location of South Essex public health staff supporting Basildon, Brentwood, Castle Point and Rochford. The pace of progress had been slower in the south of the county and it was acknowledged that certain functions may need to be provided across the three administrative areas (ECC, Southend and Thurrock) to achieve economies of scale.

(d) Size and cost efficiency of the public health function

Members suggested that, if the organisation responsible for providing public health was going to be primarily a commissioning organisation, they had expected to see a smaller organisational structure than the one detailed in the transition plan. It was confirmed that the organisation was already now approximately 30% smaller than previous, reflecting an ongoing reduction in scale and staffing levels. The running cost of the public health function was estimated to be £3 per head of population compared to £22 per head of population across the wider PCT sector. It was expected that further savings in service delivery would be achievable once the transition was complete. However, there would be significant challenges to be addressed during the transition, including IT issues and system compatibility.

Initial indications for the levels of funding to be received per capita basis for public health had seemed to be low compared to the national average and would be reviewed further. The current formula was based on current PCT spending levels rather than a needs-based assessment, nor did it seem to relate to past performance.

Historically, there had been a clear distinction between commissioning and provider services but it was expected that this distinction may not be so clear within the organisation in future. There was the opportunity for the public health teams, whilst working with local authority colleagues, to bring public health commissioning skills to social care commissioning.

(e) Director of Public Health

Public Health England had established the criteria for the Director of Public Health appointments to be made by each local authority. In Essex, three appointments would be made, one in each of the Southend, Thurrock and ECC administrative areas.

(f) Joint Strategic Needs Assessment (JSNA)

As the JSNA comprised a wide suite of documents it was widely owned by a number of different partner organisations and it was important that contributors felt that there was added value through their contribution to it. In future, added value could be achieved by including public health strategy in the ongoing development of the JSNA. It was acknowledged that the JSNA had started as an evidence based document which now needed to evolve into a qualitative document and include greater involvement from user groups and Members.

There were various officer project teams established to start the transition of public health responsibilities to ECC. Whilst Members were concerned that there were no elected representatives on these groups, it was stressed that, at present, they were low level development groups who were not managing key issues. Notwithstanding that, Members remained concerned that exclusion at any level meant that Members would not be properly informed and officers acknowledged this and promised further Member involvement (initially through an ECC Member Development session). Borough and district Members would also need to be briefed. A particular concern expressed by Members was that the project teams could be determining where some public health staff were going to be located and whether the future service followed a centralised or devolved model. It was acknowledged that such key issues would need to be agreed by Members.

## 14. Essex Assist and Adult Social Care ICT Strategy

The Committee received a report (COP/08/12) on Essex Assist from Will Patten, Commercial Director, AH&CW, who was also in attendance, together with Andrew Ellingham, Senior Project Manager, Transformation Support Unit, to introduce and supplement the report and to answer questions.

The primary purpose of Essex Assist was to provide basic information on the care home market to end users, provide advice, support and a marketing platform for providers and to provide functionality to enable end users to compare care options. The information would be broadly targeted to meet the requirements of approximately 10,000 citizens in the self funding sector, with requirements ascertained via the telephone or website (to be developed)

through a series of simple questions. Information would then be provided direct to end users free of charge via telephone, an 'off the shelf' web-site or a paper based care directory. Essex Assist was also looking to see if the information could be made available via applications on a mobile telephone but this would not be in the initial launch.

Initially, the focus would be on information for residential care services but other service information could be added at a later date. There would be links to other appropriate partner organisations such as 'Age Concern'. Information on all residential providers in Essex would be included, whilst further thought was being given as to how to overlay that with any available ECC qualitative information on the providers.

Officers would check to see if the 'Friends and Family' advice leaflet on private provision of residential care services was still being distributed and, if so, how this would complement the Essex Assist service in future.

Officers outlined the benefits to Essex citizens, to ECC and to partner organisations. In particular, it would ensure that citizens had access to high quality information to enable better decision-making whilst providers would benefit from more effective and targeted marketing.

Members requested that the ICT Strategy should return to Committee as a Part II item prior to Cabinet Decision.

## 15. Home Care Provider Services

The Committee received a report (COP/09/12) from James Wilson, Senior Manager, Adult Social Care. The report outlined the review of commercial arrangements for the Home Support Service contract with respect to monitoring and the option of using electronic monitoring of visits. Will Patten, Commercial Director, AH&CW, and Julius Olu, Senior Account Manager, were in attendance to introduce and supplement the report and to answer questions.

New contracting arrangements had been implemented to support the move away from the 'time and task' traditional timetabled individual visits, towards a simple allocation of total weekly hours using one flexible diary. This 'one diary' approach saved time for key workers, and managers at care validation stage and also ensured greater flexibility for the service user giving them more choice and control over how their care needs were met.

ECC encouraged the timing and duration of the majority of individual visits to be agreed and arranged flexibly between the service user and care provider on the basis of meeting the assessed needs. Monitoring could only take the form of checking total hour and not individual visits. There was a process for service users and their families to report incidents to their social worker (or to the finance department when receiving an invoice for their contribution to their care needs) where the care provider turned up late or did not stay for the agreed time. Valid complaints, which also could come from referrals from other

ECC officers, would be referred to the Commercial Team to investigate and to seek to remedy any concerns with the care provider and to identify any underlying trends. The Commercial Team could refer issues to the Quality Improvement and Safeguarding Teams and issue breach notices to the care provider where necessary. Ultimately a new provider could be arranged for the service user or the service user offered a personal budget as a cash payment in lieu of services to give them more choice and control over planning and managing their support.
To give some context, it was reported that there had been 19 complaints in the previous six months whilst there had been 2.5 million visits. However, it was acknowledged that further investigation was necessary to ascertain if all complaints were being recorded and whether there was any service user reluctance to report issues. Officers would be reconciling these monitoring arrangements with those provided for children receiving domiciliary care.

**16. Intention to award a contract under the Older People Residential Care Agreement**

Members were updated on the Cabinet Member intention to award a contract under the Older People Residential Care Agreement, which had been published earlier in the week. A tender exercise had been completed for a service that in future would move away from block contracts and guaranteed hours (where there had been little incentive to improve quality) and, instead, link quality and cost together. It was highlighted that smaller residential home providers had been well represented in the tender process and had seemed to be able to compete with the larger providers. Providers had submitted bids on an open competitive basis.

**17. Forward Look**

The Committee received and **noted** a report (COP/04/12) from the Governance Officer outlining the Forward Look for the Committee and the items currently scheduled for meetings through to July 2012 and other issues that had arisen which might require scrutiny in the future.

**18. Date of next meeting.**

It was noted that the next meeting would be held at 10am on Thursday 8 March 2012 in Committee Room 1. A schedule of proposed meeting dates through to April 2013 had been circulated and was noted. The proposed June date to be re-arranged.

The meeting closed at 12.18 pm

**Chairman**
**8 March 2012**