Nottinghamshire County Council

Adult Social Care and Public Health Committee

Monday, 08 July 2019 at 10:30

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

11	Work Programme	127 - 130

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Sara Allmond (Tel. 0115 977 3794) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting	ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE
Date	10 June 2019 (commencing at 10.30 am)

Membership
Persons absent are marked with an 'A'

COUNCILLORS

Tony Harper (Chairman)
Boyd Elliott (Vice-Chairman)
Francis Purdue-Horan (Vice-Chairman)

Joyce Bosnjak
Sybil Fielding
David Martin
Mike Quigley MBE
Andy Sissons
Steve Vickers
Muriel Weisz
Yvonne Woodhead

OTHER MEMBERS PRESENT

Councillor John Longdon

OFFICERS IN ATTENDANCE

Sara Allmond, Advanced Democratic Services Officer, Chief Executive's
Sue Batty, Service Director, Adult Social Care & Health
Carl Bilbey, Team Leader, Chief Executive's
Melanie Brooks, Corporate Director, Adult Social Care & Health
Paul Johnson, Service Director, Adult Social Care & Health
Jennie Kennington, Senior Executive Officer, Adult Social Care & Health
Philippa Milbourne, Business Support Administrator, Adult Social Care & Health
Kath Sargent, Senior Finance Business Partner, Chief Executive's
Halima Wilson, Commissioning Officer, Adult Social Care & Health

1. CHAIRMAN AND VICE-CHAIRMEN

The appointment by the County Council on 16 May 2019 of Councillor Tony Harper as Chairman of the Committee and Councillors Boyd Elliott and Francis Purdue-Horan as Vice-Chairmen was noted.

2. COMMITTEE MEMBERSHIP

The membership of the Committee for the 2019-20 municipal year as Councillors Joyce Bosnjak, Boyd Elliott, Sybil Fielding, Tony Harper, David Martin, Francis Purdue-Horan, Mike Quigley MBE, Andy Sissons, Steve Vickers, Muriel Weisz, Yvonne Woodhead was noted.

3. MINUTES OF THE LAST MEETING

The minutes of the meeting of Adult Social Care and Public Health Committee held on 13 May 2019 were confirmed and signed by the Chair.

4. APOLOGIES FOR ABSENCE

None

5. DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None

6. ADULT SOCIAL CARE AND PUBLIC HEALTH PERFORMANCE AND PROGRESS UPDATE FOR QUARTER 4

Councillor Tony Harper and Melanie Brooks introduced the report and responded to questions.

RESOLVED 2019/045

That there were no actions arising from the report.

7. PROGRESS REPORT ON BUDGET, SAVINGS AND IMPROVING LIVES PORTFOLIO

Councillor Boyd Elliott and Jane North introduced the report and responded to questions.

RESOLVED 2019/046

That there were no actions arising from the report.

8. ADULT SOCIAL CARE MARKET POSITION STATEMENT 2019-2021

Councillor Boyd Elliott and Paul Johnson introduced the report and responded to questions.

RESOLVED 2019/047

That the Adult Social Care Market Position Statement for 2019-2021, attached as appendix 1 of the report, be approved.

9. REFRESHED ADULT SOCIAL CARE AND PUBLIC HEALTH DEPARTMENTAL STRATEGY

Councillor Tony Harper and Jane North introduced the report, gave a presentation and responded to questions.

RESOLVED 2019/048

That there were no actions arising from the report.

10. ADULT SOCIAL CARE AND PUBLIC HEALTH – EVENTS, ACTIVITIES AND COMMUNICATIONS

Councillor Francis Purdue-Horan and Melanie Brooks introduced the report and responded to questions.

Melanie Brooks reported that additional events were being arranged in relation to the National Co-production Week from 1st – 5th July.

RESOLVED 2019/049

That the plan of events, activities and publicity set out in the report, be approved.

11. ADULT SOCIAL CARE AND HEALTH – CHANGES TO STAFFING ESTABLISHMENT

Councillor Francis Purdue-Horan and Melanie Brooks introduced the report.

RESOLVED 2019/050

1) That the extension of the 0.5 full time equivalent (FTE) Social Worker (Band B) post in the Learning Disability Forensic Team to the end of March 2020, with funding provided through the Transforming Care Partnership be approved.

2) That the amendment of the contract for the East Midlands Improvement Programme Manager (Band F) post to full-time from 22 hours per week and to two years from one-year duration, with funding provided from the Joint Improvement Programme be approved.

3) That the extension of 1 FTE Project Manager (Band D) post for an additional 10 months from 1st June 2019 to 31st March 2020, with funding from the Adult Social Care Transformation Team be approved.

4) That the establishment of 0.81 FTE (30 hours per week) Better Care Fund Programme Manager (Grade F) post on a permanent basis within the Adult Social Care and Health department, funded by the Better Care Fund partnership be approved.

12. WORK PROGRAMME

RESOLVED 2019/051

That the work programme be accepted with the following addition:-

- An update to include the Adult Social Care and Health Departmental Strategy Action Plan be brought to a future meeting

The meeting closed at 11.31 am.

CHAIR

Nottinghamshire County Council

Report to the Adult Social Care and Public Health Committee
8 July 2019

Agenda Item: 4

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PERFORMANCE AND QUALITY FOR CONTRACTS FUNDED WITH RING-FENCED PUBLIC HEALTH GRANT 1 JANUARY 2019 TO 31 MARCH 2019

Purpose of the Report

1. To enable Members to scrutinise the performance and quality of services commissioned by Public Health (PH)

Information

2. The Health and Social Care Act 2012 confers general duties on local authorities to improve and to protect the health of their local populations, including specific statutory duties to commission certain mandatory services for residents[1], the provision of specialist advice to the local NHS, and health protection advice to organisations across the local system.

3. In discharging these duties, the Council is currently supported by a ring-fenced grant which must be deployed to secure significant improvements in health, giving regard to the need to reduce health inequalities and to improving uptake and outcomes from drug and alcohol treatment services.

4. Services commissioned by public health contribute to a number of Council commitments (in particular, Commitment 6 – People are Healthier) and are critical for securing improved healthy life expectancy for residents.

5. Working with colleagues, the Public Health Contract and Performance Team manages the performance of providers to ensure the Authority and the residents of Nottinghamshire are receiving good outcomes, quality services and value for money.

6. Contract management is undertaken in a variety of ways including regular contract review meetings, quality assurance visits to the service and ongoing communication.

7. This report provides the Committee with an overview of performance for Public Health directly commissioned services and services funded either in whole or in part by PH grant,

[1] These mandatory services include: local implementation of the National Child Measurement Programme, assessment and conduct of health checks, open access sexual health and contraception services

in January to March 2019 against key performance indicators related to Public Health priorities, outcomes and actions within:

a). the Public Health Service Plan 2017-2018;

b). the Health and Wellbeing Strategy for Nottinghamshire 2017-21; and

c). the Authority's Commitments 2017-21.

8. A summary of the key performance measures is set out on the first page of **Appendix A**. Where performance is at 80% or greater of the target or meets the standard, it is rated green.

9. Appendix A also provides a description of each of the services and examples of the return on investment achievable from commissioning public health services.

NHS Health Checks (GPs)

10. The NHS Health Check Programme has met its targets for the year, and performance continues to improve. In the past year, GPs have identified and started treatment for 1,118 people at high risk, who were likely to have experienced a heart attack or stroke if they had not been detected early through NHS Health Checks. This is in addition to offering advice, sign-posting and treatment to all those who had a health check, a total of 22,149 in 2018/19.

11. The aim of this programme is to help prevent heart disease, diabetes, stroke, kidney disease and certain types of preventable dementia by offering a check once every five years to everyone between the ages of 40 and 74 who has not already been diagnosed with one of these conditions.

12. The proportion of people taking up their invitation for a health check this year is 69.5%, which is considerably better than last year's national average of 47.9%. Over the full year, 31,890 people were invited in total, which meets the annual target set. Quarter 4 of 2018/19 shows positive performance, with 9,458 people being invited to attend a health check, above the quarterly target of 8,218. In terms of health checks undertaken, during quarter 4 there were 6,296 checks, resulting in a total for the year of 22,149 (against a target of 21,697).

Integrated Sexual Health Services (ISHS)

13. The ISHS (Nottingham University Hospitals (NUH), Sherwood Forest Hospital Foundation Trust (SFHFT) and Doncaster and Bassetlaw Hospitals (DBH)) provides a testing and treatment service for sexually transmitted infections (STIs) and contraception. A similar number of filled appointments 47,172 in 2018/19 compared with 47,330 in 2017/18 took place across the three ISHS NHS Trusts.

60% of new users accepting HIV test

14. All three ISHS providers have met or exceeded this target for the year 2018/19. This is an important positive achievement as it helps services to identify individuals with HIV who would otherwise not be tested and miss out on early treatment advice and support. Previously reported low performance was investigated and found to be due to a data reporting error. The Authority is now confident both that the data is being accurately reported, and that the ISHS are performing at or above expectation for this target.

75% of 15-24 year olds accepting a chlamydia test.

15. Chlamydia is one of the most common STIs and although often symptomless it can cause long-term health problems including infertility if left untreated.

16. Historically, Nottinghamshire performance on chlamydia testing has been poorer than the England average. However the most recent national data show sustained increases in numbers accepting a test, and the proportion of tests where chlamydia is detected has significantly improved. Chlamydia detection is now similar to the national average, and in areas where the service need is highest, such as Mansfield and Bassetlaw, performance is significantly better than average. This means the Authority can be positively reassured that more young people are being tested, that the testing approach is effective as more people with chlamydia are being diagnosed and treated, and the targeting of the test is appropriate, as geographical areas where we would expect to see highest levels of chlamydia are achieving higher detection rates.

17. Within the ISHS service, performance on this standard varies between providers. SFHFT has exceeded the quality standard. DBH performance is below target (70% against target of 75%), which shows an improvement on previous year, with more young people taking up the offer of the test compared to 2017/18. NUH are below the quality standard reporting 67% against target of 75%. However, the service assures us that all those young people that are clinically appropriate are offered a test.

30% of women aged 16-24 receiving contraception accept LARC

18. Long-acting reversible contraceptive (LARC) methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. Take up of LARC across all ages of women of reproductive age should contribute to reducing unintended pregnancies. This 30% measure is routinely surpassed by all three ISHS providers and this has been the case for 2018/19.

Young People's Sexual Health Service- C Card (In-house)

19. The C-card scheme is a free and confidential advice and condom service for young people living in Nottinghamshire. The service is below target for new registrations mainly due to a very slow first quarter, quarters two and three have seen an increase in activity. Compared

to the same period last year the reduction in registrations is 1%. Achieving the stretch target has been a challenge and an action plan has been developed which aims to increase new registrations and the number of active sites across the scheme. The action plan includes: new promotional materials distributed to all existing sites and to the new sites; information distributed to GP's and Pharmacies to promote the scheme; and inactive sites are being targeted for refresher training. The C Card Technical Specialist has also attended County College Freshers Fairs to promote the scheme to young people. An evaluation of the scheme is in progress including engagement with service users, the results of this evaluation will drive further actions to increase usage and continue to ensure quality of delivery.

Alcohol and Drug Misuse Services (Change Grow Live)

20. Change, Grow, Live (CGL) is the substance misuse treatment and recovery service in Nottinghamshire. The service has supported more people to successfully complete treatment in 2018/19 than in the previous year, and demonstrates strong and effective performance, meeting or exceeding all of its service targets in 2018/19.

21. CGL works proactively across the county to ensure residents get free from their substance misuse. Successful completion data from CGL for non-opiates such as cannabis, amphetamines, steroids, cocaine and crack cocaine and Novel Psychoactive Substances (or what were formerly known as 'legal highs'), show that for the year 2018/2019, there was an average completion rate of 24.9% which is well above the target of 15%.

22. Re-presentations and unplanned discharges from the service have been consistently low through the year. From a total of 13,168 unique individuals who have presented to service, only 664 (5%) were discharged in an unplanned way with only 64 re-presentations within the 12 month period.

23. Overall improvements in the wider outcomes derived from the service are all above target for the year. These outcomes are: Employment, training and education: target 25%; performance 52%. Mental wellbeing: target 60%; performance 81%. Housing improvements (where housing was identified as an issue at entrance into the service: target 70%; performance 96%.

24. In Nottinghamshire harder targets are set for the service than is nationally expected, with the aim being to ensure all service users with any substance misuse issues are helped to recovery and not just those who require a clinical intervention. Therefore the performance of the service in meeting these targets is particularly positive, and demonstrates the effectiveness of the treatment and recovery system in Nottinghamshire.

Young People's Substance Misuse Service (Change, Grow, Live)

25. CGL took over the young people's substance misuse service on 1st October 2018. CGL have initiated new ways of working across the county with an emphasis on preventing young people starting to misuse substances as well as providing support for those who are misusing. Since October, 104 young people have been referred into the service, 22 for

structured treatment, 14 for brief intervention (1 off session) and 44 for extended brief intervention (4 sessions) and the remainder either have declined support, have an assessment pending or were an inappropriate referral. The majority of referrals for the service have derived from Youth Justice followed by social care and supported housing. After consultation with the service users, the new service has been renamed' Let's Grow' as one young person stated 'It's the grow part of Change Grow Live and it's about us growing as young people.'

Smoking Cessation (Solutions 4 Health)

26. The service in Nottinghamshire (SmokefreeLifeNotts) was recently restructured to deliver a new model for smoking cessation. The new model offers a more flexible, individualised approach with increased access to telephone and online support as well as the more traditional groups and one to one sessions.

27. Albeit small, there has been an improvement in the numbers of successful quitters. In 2015/16, the final year of the previous contract there were only 2257 quitters. In this last year the provider managed 2,996 quitters. It is expected with all the changes made by the service and extra support from public health that this upward trajectory is set to continue.

28. SmokefreeLifeNotts staff are now on the wards in King's Mill Hospital, offering support at the bedside to patients who smoke, either with quitting or temporary abstinence during their hospital stay. "Stop Before the Op" support is also offered to outpatients waiting for elective surgery. This will complement the ongoing work that continues to take place with pregnant women at King's Mill Hospital and the wellbeing coordinators that are now in post. There are around 300 patients admitted every week to Sherwood Forest Hospital Foundation Trust and 800 staff smoke so the potential to make a real impact is possible with this targeted work.

29. SmokefreeLifeNotts staff are also now on the wards at Nottingham University Hospitals (NUH) to enable them to adopt the same ward-based approach to support County patients who attend the hospital as inpatients and outpatients, with the same potential for impact.

30. Due to the cyclical nature of smoking cessation (more people quit at New Year, following Stoptober and Stop Smoking Day in March), referrals and therefore quitters are expected to rise in line with these key campaigns.

Illicit Tobacco Services (In-house)

31. Trading Standards Officers continue to apprehend those individuals who sell and distribute illicit tobacco products within the County. The dedicated Illicit Tobacco Team, which includes a Nottinghamshire Police Officer, share intelligence with other agencies and authorities as well as Public Health colleagues. This intelligence picture is crucial and allows Trading Standards to share resources and costs when working with these colleagues.

32. A warrant was executed at a residential address in Mansfield in November 2018 where 1,500 packs of counterfeit cigarettes and 61 pouches of counterfeit hand rolling tobacco

were seized, with a retail value of £15,890. 2 males were arrested and interviewed. An investigation continues into the individuals.

33. During October, November and December 2018 a total of 2,537 packs of illicit tobacco were seized along with 93 pouches of hand rolling tobacco, with a total retail value of £27,700. Enquiries and legal processes continue on several premises and individuals.

Obesity Prevention and Weight Management (Everyone Health)

34. The Obesity Prevention and Weight Management service supports children and adults through a variety of targeted community prevention, healthy eating and physical activity initiatives and weight management support. The service has delivered on its commitment to increasing the number of people it reaches in Nottinghamshire, with substantial improvements across all service elements. A total of 2,843 people were supported with 12 weeks weight management offer, and all performance targets have been achieved for 2018/19.

35. The public health team and the provider developed improvement plans in 2017 and 2018 to increase uptake of the weight management offer for overweight children and their families and women who are obese during pregnancy as these targets were not being met. The measures have resulted in the service achieving their targets for numbers of clients supported in 2018/19 and more than double the number of service users than the previous two years.

36. As we enter the final year of the contract, the focus is on maintaining this level of service provision and uptake and focusing on improving uptake in parts of the county which have been lacking. The public health team is also focused on capturing the learning from commissioning and provision of this service over the last four years to feed into the mobilisation of the Integrated Wellbeing Service from April 2020.

Domestic Abuse Services (Notts Women's Aid and Womens Aid Integrated Services)

37. The Domestic Abuse service provides information, advice, safety planning and support (including support through the courts) to women, men, teenagers, children and young people. The service does not have targets but the public health team monitors the outputs and outcomes of the service. The service is facing increasingly complex and difficult cases. Quality Assurance visits further evidence that the services provided are robust, well received by service users and provide good value for money.

38. Figures show an increase in numbers of adults, children and young people supported compared with last year. The number of high-risk adult referrals is increasing, and this is beginning to impact on the capacity of the multi-agency risk assessment conferences (MARACs) where information is shared across partner agencies to ensure safety.

39. Over 50% of children on Child Protection Plans live in a household with domestic abuse and to this end the providers work closely with Children's Services and have workers based with the Family Service.

Seasonal Mortality (Nottingham Energy Partnership)

40. This service protects and improves the health of residents in the county, by facilitating insulation and heating improvements and preventative adaptations in private sector homes, providing energy efficiency advice and reducing fuel poverty. The service targets the most deprived private sector households, with a specific emphasis on support to residents over 60 and a smaller provision for families with children under 5 and pregnant women. The service achieved the 2018/19 targets.

41. The service has exceeded the annual target of 259 and provided 499 people with comprehensive energy efficiency advice and/or help and advice to switch energy supplier or get on the cheapest tariff. The service also trained 219 against an annual target 187 individuals to deliver Energy Efficiency Brief Interventions to improve awareness of the links between cold-homes, fuel poverty and ill health and to generate appropriate referrals to the service.

Social Exclusion (The Friary)

42. The Friary provides a “one-stop” approach on three mornings a week from a single location in West Bridgford to individuals in crisis situations, including homeless people. It delivers one to one assessment of need, specialist advice and practical support regarding housing, benefits, debts and health needs (including signposting to other services that operate within the Friary e.g. GP clinic, substance misuse services) The service offered support to 349 individuals in Quarter 4. There were 1,131 more interviews provided over this last year from the previous year.

43. The service is now decommissioned and the provider was thanked for all their work.

Public Health Services for Children and Young People aged 0-19 (Nottinghamshire Healthcare Trust)

44. The service is in its second year of delivery and the Healthy Families Programme is now embedding across the County as a fully integrated universal service for children, young people and their families.

45. The Authority has had to set very ambitious targets in line with national requirements, for the provider and whilst some of these targets have yet to be met, the service overall is performing well with Nottinghamshire data for mandated reviews in 2018/19 being similar to, or better than the England average. As an example, 99% of 2-2½ year developmental reviews completed, were undertaken using ASQ-3 (Ages and Stages Questionnaire). The use of this evidence-based tool enables the Healthy Families Team to make an informed assessment of a child’s readiness to start school, and therefore offer targeted interventions for children when concerns are identified.

46. Staffing and recruitment challenges experienced by the service due to retirement, maternity leave, and sick leave are resolving. The Trust is working pro-actively to recruit

and retain the workforce and a picture of increased workforce stability is emerging. This is being reflected in improved performance against the key performance indicators.

Oral Health Promotion Services (Nottinghamshire Healthcare Trust)

47. Nottinghamshire's specialist Oral Health Promotion Team works to improve oral health within local communities and among vulnerable groups by delivering training for the health, social care and education workforce, a supervised tooth-brushing programme in targeted primary schools (with linked nurseries) and health promotion activities such as the provision of tooth-brushing packs to one-year olds.

48. During Q4, oral health promotion training among frontline staff was delivered to 70 staff working in child-related services and 48 in adult-related services, delivering full year totals of 278 and 221 respectively (2018/19 target of 200 each). The successful supervised toothbrushing programme has been active in 24 primary schools (against a target of 20) over the year, engaging with 2,948 children. In addition, parents of 7,196 children received oral health advice and resources at their child's one-year health review (87% of the 2018/19 one-year old child cohort). Overall, this represents very good performance by the award-winning service.

Single Person Supported Accommodation (Framework)

49. The service provides intensive support in short term hostel accommodation (up to 18 weeks) and less intensive support in Move On and Housing First Accommodation (typically for six months, and up to a maximum of 12 months) aimed at enabling the service user to achieve a range of outcomes including self-care, living skills, managing money, motivation and taking responsibility, social networks and relationships, managing tenancy and accommodation, reducing offending and meaningful use of time.

50. The service provides intensive support in short term hostel accommodation (up to 18 weeks) and less intensive support in Move On and Housing First Accommodation (typically for six months, and up to a maximum of 12 months) aimed at enabling the service user to achieve a range of outcomes including self-care, living skills, managing money, motivation and taking responsibility, social networks and relationships, managing tenancy and accommodation, reducing offending and meaningful use of time.

51. Since the new contract commenced a total of 80 people have exited the short-term hostel accommodation of whom 70 (87%) exited in a planned way and 10 (13%) in an unplanned way. This exceeds the target of 80% to be supported to exit in a planned way. For the move on accommodation a total of 71 people exited the service in a planned way (95% against a target of >80%) and 4 people exiting the service in an unplanned way (5% against a target of <20%).

Community Infection Prevention and Control (CCGs)

52. This service provides advice and assistance to prevent the spread of infectious and avoidable diseases. The team has provided initiatives in care homes, GP practices and

the acute hospital trusts including hand hygiene training, viral swabbing, advice and assistance. The service continues to meet all of the Authority's key performance indicators.

Resilience Building in Schools (Each Amazing Breath-EAB and Young Minds-YM)

53. The report 'Future in Mind', published in 2015 by the Department of Health (DH) in partnership with DfE, sets out detailed proposals for improving emotional health and well-being support available to children. The report outlines the risk of focusing too narrowly on targeted clinical care, ignoring wider influences, over-medicalising our children and the challenge of making some real changes across the whole system to place the emphasis on building resilience, promoting good mental health, prevention and early intervention.

54. In response, the Authority, in partnership with Nottinghamshire CCGs, commissioned academic resilience programmes to improve emotional health, wellbeing and resilience of children and young people in 30 Nottinghamshire schools. Taking a sustainable whole school approach, the programmes aim to enable schools to have the understanding, knowledge, skills and resources to continue independent delivery thus building resilience for new cohorts of children and young people after the direct contract activity ends. There are currently two provider organisations commissioned to deliver programmes within Nottinghamshire: 'Each Amazing Breath' and 'Young Minds'.

55. Across the districts of Bassetlaw, Newark and Sherwood, Mansfield and Ashfield 'Each Amazing Breath (EAB) is commissioned to deliver 'Take Five', a whole school programme based on breathing, grounding, and awareness that helps children to develop their capacity to handle life's challenges with awareness and confidence, building skills of self-regulation, and anger management. Direct service delivery of this programme is almost complete. Provider activity in Q3 and Q4 is focussed on training champions and ambassadors embedding the programme across the 15 participant schools, thus moving towards school led sustainability.

56. The Authority has commissioned Young Minds to deliver the evidence based Academic Resilience Approach (ARA) Programme in 15 schools, including Derrymount School for children with special educational needs and disability (SEND), in the boroughs of Broxtowe, Gedling and Rushcliffe. Schools are supported to develop their own practical, integrated whole-school approach to identifying and supporting vulnerable pupils to enable them to achieve their emotional and academic potential. The Provider had completed 100% of training for school staff by the end of Q2. Quarter 3 and Q4 activity focusses on sustainability, through the delivery of 'Train the Trainer' sessions, a champions programme and developing 'Communities of Practice' (COP's).

57. The services have both been extended for another year to March 2021 and a further 30 schools in the county will receive the above interventions.

Other Options Considered

58. None

Reason/s for Recommendation/s

59. To ensure performance of Public Health services is scrutinised by the Authority.

Statutory and Policy Implications

60. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

61. Robust performance and quality reporting ensures that financial implications are monitored and reviewed effectively to minimise financial risk to the council.

Public Sector Equality Duty implications

62. Monitoring of the contracts ensures providers of services comply with their equality duty. Equality performance is a standing agenda item of review meetings and providers are asked to provide case studies celebrating success and showing how complaints, if applicable, are resolved.

Safeguarding of Children and Adults at Risk Implications

63. Safeguarding is a standing item on contract review meeting agendas and providers are expected to report any areas of concern allowing the Authority to ensure children and adults at risk are safe.

Implications for Service Users

64. The management and quality monitoring of contracts are mechanisms by which commissioners secure assurance about the safety and quality of services using the public health grant for service users.

RECOMMENDATION

65. For Committee to scrutinise the performance of services commissioned using the public health grant.

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:
Nathalie Birkett
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Constitutional Comments (AK 25/06/2019)

66. The recommendation falls within the delegation to Adult Social Care and Public Health Committee under its terms of reference.

Financial Comments (DG 25/06/2019)

67. There are no specific financial implications arising from this report.

Background Papers and Published Documents

68. Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

69. 'None'

Electoral Division(s) and Member(s) Affected

70. 'All'

Nottinghamshire County Public Health Services Performance Report - Service description

PH Outcomes Framework Indicator	Indicator description	Service Name	Service description
2.22	Take up of the NHS Health Check programme - by those eligible	**NHS Health Checks**	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. http://www.nhs.uk/Conditions/nhs-health-check/Pages/What-happens-at-an-NHS-Health-Check-new.aspx
2.12	Excess weight in adults		
2.13ii	Proportion of physically active and inactive adults		
4.04ii	Under 75 Cardiovascular disease related death		
4.05ii	Under 75 Cancer related death		
2.04	Under 18 conceptions	**Integrated Sexual Health Services**	Good sexual health is an important part of physical, mental and social well-being. Over the past decade, there has been a steady rise in new diagnoses of STIs in England. Diagnoses of gonorrhoea, syphilis, genital warts and genital herpes have increased considerably, most notably in males. A proportion of this rise is due to improved access to STI testing and routine use of more sensitive diagnostic tests. However this has also been driven by ongoing unsafe sexual behaviour, with increased transmission occurring in certain population groups, including MSM.5 Of the 446,253 new STI diagnoses made in England in 2013, the most commonly diagnosed were: • Chlamydia (47%), • Genital warts (17%). • Genital herpes (7%), • Gonorrhoea (7%). Between 2012 and 2013 there was an increase nationally of 15% in diagnoses of gonorrhoea and 9% in infectious syphilis. The impact of STIs remains greatest in young heterosexuals under the age of 25 years and in MSM. www.fsrh.org www.bashh.org. The ISHS will support delivery to achieve the three main sexual health related Public Health Outcome Framework (PHOF) measures to improve sexual health in mid-Nottinghamshire: • A reduction in under 18 conceptions • Achieve a diagnostic rate of 2,300 per 100,000 for Chlamydia screening (15-24 year olds) • A reduction in people presenting with HIV at a late stage of infection. In addition, the service will deliver against the following overarching outcomes to improve sexual health: • Clear, accessible and up-to-date information about services providing contraceptive and sexual health for the whole population, including information targeted at those at highest risk of sexual ill health • Reduced sexual health inequalities amongst young people and young adults; for example, Black and Minority Ethnic (BME) groups and MSM through improved access to services and prevention interventions • Be responsive to potential gaps in provision especially in the areas of highest need and sexual ill health • Reduced rates of acute STIs through increased diagnosis and effective management and treatment of STIs and through targeting those groups most at risk • A high level of coverage for chlamydia testing, ensuring that services are accessible, are provided across a range of venues and exceed the national chlamydia diagnosis target of 2.3 per 1,000 • An increase in the number of people accessing HIV screening, particularly from those groups most at risk • A reduction in the proportion of people diagnosed with HIV at a late stage of HIV infection through increased education and screening to encourage earlier presentation and reduce the stigma of HIV • Increased access and uptake of effective methods of contraception, specifically Long Acting Reversible Contraception (LARC), for all age groups • Increased access and uptake of condoms; specifically targeted at young people (those aged 25 and under) and MSM • Increased identification of risk taking behaviour and risk reduction interventions to improve future sexual health outcomes across mid-Nottinghamshire • A reduction in unintended pregnancies in all ages • Increased quality standards across Nottinghamshire and Bassetlaw.
3.02	Chlamydia Detection Rate (15-24 year olds)		
3.04	HIV Late Diagnosis		
2.04	Under 18 conceptions	**Young Peoples Sexual Health Service - C Card**	Good sexual and reproductive health is important to physical and mental wellbeing, and is a cornerstone of public health. Young people who are exploring and establishing sexual relationships must be supported to take responsibility for their sexual and reproductive health. The C Card scheme aims to reduce teenage pregnancy and sexually transmitted infections amongst young people in Nottinghamshire by allowing young people to access free confidential sexual health advice and condoms.
1.05	16-18 year olds not in education employment or training	**Alcohol and Drug Misuse Services**	Drug use can have a wide range of short- and long-term, direct and indirect effects. These effects often depend on the specific drug or drugs used. Longer-term effects can include heart or lung disease, cancer, mental illness, HIV/AIDS, hepatitis, and others. Long-term drug use can also lead to addiction. Drug addiction is a brain disorder. Not everyone who uses drugs will become addicted, but for some, drug use can change how certain brain circuits work. These brain changes interfere with how people experience normal pleasures in life such as food and sex, their ability to control their stress level, their decision-making, their ability to learn and remember, etc. These changes make it much more difficult for someone to stop taking the drug even when it's having negative effects on their life and they want to quit. Drug use can also affect babies born to women who use drugs while pregnant. Broader negative outcomes may be seen in education level, employment, housing, relationships, and criminal justice involvement. Persistent alcohol misuse increases your risk of serious health conditions, including: •heart disease •stroke •liver disease •liver cancer and bowel cancer •mouth cancer •pancreatitis As well as causing serious health problems, long-term alcohol misuse can lead to social problems, such as unemployment, divorce, domestic abuse and homelessness The service aim is to reduce illicit and other harmful substance misuse and increase the numbers recovering from dependence.
1.13	Re-offending levels		
1.15	Homelessness		
2.18	Admission episodes for alcohol-related conditions		
2.15	Drug and alcohol treatment completion and drug misuse deaths	**Young People's Substance Misuse Service**	Young people's drug use is a distinct problem. The majority of young people do not use drugs and most of those that do, are not dependent. But drug or alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life. Each year around 24,000 young people access specialist support for substance misuse, 90% because of cannabis or alcohol. It is important that young people's services are configured and resourced to respond to these particular needs and to offer the right support as early as possible. The model used to illustrate the different levels of children and young people's needs in Nottinghamshire is referred to as the Nottinghamshire Continuum of Children and Young People's Needs which recognises that children, young people and their families will have different levels of needs, and that a family's needs may change over time. The agreed multi-agency thresholds are set out across four levels of need
2.03	Smoking status at time of delivery (maternity)	**Tobacco Control and Smoking Cessation**	Smoking is the primary cause of preventable illness and death. Every year smoking causes around 96,000 deaths in the UK. The prevalence of smoking across Nottinghamshire is equal to the English average at 18.4%. We are seeking to continue the downward trend in prevalence through this newly commissioned model. Our local framework for tackling tobacco use sets out a range of interventions that we will be implementing in order to achieve this aspiration, one key element that will contribute to and support these aspirations will be our local tobacco control service(s). To reflect the model 3 themes will be used to provide context; • Stopping smoking • Preventing the uptake of smoking • Reducing harm from tobacco use
2.09	Smoking prevalence - 15 year olds		
2.14	Smoking prevalence - adults (over 18's)		
2.14	Smoking prevalence - adults (over 18's)	**Illicit Tobacco Services**	Nationally, Tobacco smuggling costs over £2 billion in lost revenue each year. It undermines legitimate business and is dominated by internationally organised criminal groups often involved in other crimes such as drug smuggling and people trafficking. Trading Standards resource works to reduce illicit tobacco supply and demand within the county
1.16	Utilisation of outdoor space for exercise/health reasons		Being overweight or obese can bring physical, social, emotional and psychosocial problems, which can lead to the onset of preventable long term illness, stigma, discrimination, increased risk of hospitalisation and reduced life expectancy. Someone
2.06	Child excess weight in 4-5 and 10-11 year olds		

2.11	Diet	**Obesity Prevention and Wight Management (OPWM)**	who is severely obese is three times more likely to need social care than someone who is a healthy weight, so the need for quality weight management services does not only impact individuals, but also affects public funds and the wider community. The aim of this contract is to reduce the prevalence of overweight and obesity so that more adults, children, young people and families achieve and maintain a healthy weight therefore preventing or reducing the incidence of obesity related illnesses.
2.12	Excess weight in adults		
2.13	Proportion of physically active and inactive adults		
1.11	Domestic abuse	**Domestic Abuse Services**	This service aims to reduce the impact of DVA in Nottinghamshire through the provision of appropriate services and support for women, men and children who are experiencing domestic abuse or whose lives have been adversely affected by domestic abuse.
4.15	Excess winter deaths	**Seasonal Mortality**	In 2011, the Marmot Review Team released 'The Health Impacts of Cold Homes and Fuel Poverty' report16. The report reviews the evidence for the long-term negative health impacts of living in cold homes and concludes: "many different population groups are affected by fuel poverty and cold housing, with various levels of health impacts relating to different groups." Vulnerable children and the elderly are most at risk of developing circulatory, respiratory and mental health conditions as a consequence of cold, damp homes. The Health Housing Contract will maintain and improve the health of citizens in Nottingham City and Nottinghamshire, by facilitating insulation, heating improvements and preventative adaptations and giving advice to help reduce fuel poverty in the homes of citizens over 60 and to a lesser extent (up to 10% of the total), families with children under 5 and pregnant women
1.18	Social isolation	**Social Exclusion**	Nottinghamshire Homelessness Health Needs Assessment, July 2013 – this identified higher levels of need among non-statutory homeless people in relation to lifestyle health risks: hepatitis and flu vaccination, smoking, diet, substance misuse (including alcohol), TB screening, sexual health checks. Multiple physical health problems were common; especially musculoskeletal, respiratory and oral health. Mental health problems were common; especially stress, depression, sleeping difficulties and anxiety. The aim is to protect and support the health and well being of vulnerable adults using the person centred approach. Specifically this will be addressed via specialist one to one assessment and advice sessions as a means of accessing appropriate emergency practical support and co-located services. This will follow as far as possible an "under the same roof" and "one-stop" model.
1.01	Children in low income families	**Public Health Services for Children and Young People aged 0-19**	The foundations for virtually every aspect of human development - physical, intellectual and emotional, are established in early childhood. In 2009, the Department of Health set out an evidence-based programme of best practice, the Healthy Child Programme, with the ambition of making everywhere as good as the best by developing improvements in health and wellbeing for children and young people. The Healthy Child Programme provides a framework to support collaborative work and more integrated delivery. The Programme (0-19) aims to: • help parents develop and sustain a strong bond with children, • encourage care that keeps children healthy and safe, • protect children from serious disease, through screening and immunisation, • reduce childhood obesity by promoting healthy eating and physical activity, • identify health issues early, so support can be provided in a timely manner, • make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five'
1.02	School readiness		
2.02	Breastfeeding		
2.03	Under 18 conceptions		
2.05	Child development at 2-2½ years		
2.06	Child excess weight in 4-5 and 10-11 year olds		
4.02	Proportion of five year old children free from dental decay	**Oral Health Promotion Services**	In Nottinghamshire, oral health is an important Public Health policy area due to the diverse nature of the county and its associated health inequalities. The impact of poor oral health is felt within all seven districts with significant variation. To deliver an evidence-based oral health promotion service for identified individuals, communities and vulnerable groups in Nottinghamshire, to maintain and improve their oral health. The service is based on the recommendations from 'Local authorities improving oral health: commissioning better oral health for children and young people' and NICE guidelines.
2.05	Child development at 2-2½ years	**Children's Centres**	Children's Centres play a key role in early intervention and are a vital source of support for young children and their families…. They offer a range of activities, family services and advice to promote school readiness, improve family outcomes and reduce health inequalities in child development
1.15	Statutory homelessness	**Supporting People: Homelessness Support**	The aims of this service are: - To address homelessness, support people back to independence and prevent repeat homelessness - To reduce the adverse effects of homelessness on individual and population health and wellbeing - To improve the health and wellbeing of homeless service users - To promote social inclusion
4.09	Excess under 75 mortality rate in adults with serious mental illness	**Mental Health**	The Co-production Mental Wellbeing service provides a countywide service that aims to improve the health and wellbeing of adults and supports them in recovery. The service is for those people experiencing mental health problems
1.15	Statutory homelessness	**Reduction in statutory homelessness**	The Moving Forward Service aims to: Prevent homelessness and promote independence, reduce social exclusion and isolation, improve the general health of people with mental health problems, prevent hospital admissions and support timely discharge, support carers of people with mental health problems and develop efficient ways of working
1.01	Children in low income families	**Resilience Building in Schools**	The providers Each Amazing Breath (EAB) CIC, 'Take 5 at School Programme' in the north and west of the County and Young Minds (YM), 'Academic Resilience Approach' in the South of the County, develop and deliver an evidence-based resilience programme in schools that will improve the emotional health, wellbeing and resilience of children and young people in 30 Nottinghamshire schools. It is a whole school approach, this means school leaders, staff, children and young people which may include approaches such as training the trainer and pupils and students as coaches, mentors or teachers. The programmes are sustainable and will enable schools to have the understanding, the knowledge, skills and resources to continue independent delivery of the programme via a whole schools approach and to have maximum impact for children and young people after the direct contract activity ends
1.03	Pupil absence (from School)		
1.05	16-18 year olds Not in Employment, Education Training		
2.23	Self-reported wellbeing		

Nottinghamshire County Public Health Services Performance Report

Nottinghamshire County Council

Colour Code	Number	Quality standard
	YTD 80% or higher of expected	Standard met or exceeded
	YTD less than 80% of expected	Standard not met

Quarter 4 2018/19

Service Name	Indicator or Quality Standard	2017/18 final figures for comparison	Annual plan 2018/19	Q1	Q2	Q3	Q4	Performance against target	Actual YTD
NHS Health Checks	No. of eligible patients who have been offered health checks	28,540	32,874	5,941	8,228	8,263	9,458		31,890
	No. of patients offered who have received health checks	19,065	21,697	5,049	4,946	5,858	6,296		22,149
Integrated Sexual Health Services	**Total number of filled appointments**								
	Sherwood Forest Hospital NHS Trust	23,381	23,381	5,791	5,945	5,568	5,696		23,000
	Nottingham University Hospital NHS Trust	16,217	15,819	3,888	4,092	3,490	4,058		15,528
	Doncaster and Bassetlaw Hospitals NHS Trust	8,130	8,130	2,102	2,283	2,020	2,237		8,642
	Total	**47,728**	**47,330**	**11,781**	**12,320**	**11,078**	**11,991**		**47,170**
	Quality Standard 60 % of new service users accepting a HIV test								
	Sherwood Forest Hospital NHS Trust	39%	>60%	76%	78%	81%	81%		79%
	Nottingham University Hospital NHS Trust	66%	>60%	65%	61%	60%	65%		63%
	Doncaster and Bassetlaw Hospitals NHS Trust	53%	>60%	58%	62%	61%	76%		61%
	Quality Standard At least 75% of 16-24 year olds in contact with the service accepting a chlamydia test								
	Sherwood Forest Hospital NHS Trust	66%	>75%	80%	81%	85%	82%		82%
	Nottingham University Hospital NHS Trust	70%	>75%	71%	69%	63%	66%		67%
	Doncaster and Bassetlaw Hospitals NHS Trust	66%	>75%	63%	80%	66%	76%		70%
	Quality Standard 30% of women aged 16-24 receiving contraception accepting LARC								
	Sherwood Forest Hospital NHS Trust	47%	>30%	44%	48%	48%	50%		47%
	Nottingham University Hospital NHS Trust	38%	>30%	40%	38%	44%	45%		42%
	Doncaster and Bassetlaw Hospitals NHS Trust	49%	>30%	49%	50%	53%	49%		50%
Young Peoples Sexual Health Service - C Card	Number of individuals aged 13-25 registered onto the scheme	1,297	1,600	235	330	356	324		1,245
	Number of individual young people aged 13-25 who return to use the scheme (at least once)	2,197	2,000	400	333	480	574		1,787
Alcohol and Drug Misuse Services	Number of successful exits (i.e. planned)	904	-	263	249	256	253		1,021
	Number of unplanned exits	751	-	135	157	181	191		664
	Number of service users in the service (last day of quarter) Including transferred in	Rolling	10,394	6,582	8,857	10,957	13,168		13,168
Young People's Substance Misuse Service	Total referrals of young people requiring brief intervention or treatment	292	300	37	14	53	54		158
	Quality standard 80% Planned exit from treatment	98%	80%	94%	75%	88%	100%		88%
Smoking Cessation	Number of people setting a quit date	3729	-	923	915	1,041	1,465		4,344
	% actually quit - Russell standard	60%	>40%	64%	67%	71%	72%		69%
	Pregnant Smokers who successfully quit	74	500	38	38	41	32		149
	Under 18 Smokers who successfully quit	42	200	8	2	6	3		19
	Routine and Manual Workers successfully quit	648	1,500	159	188	208	335		890
	All other smokers who successfully quit	1,468	2,800	388	387	487	684		1,946
	Total Successfully Quit	**2,232**	**5,000**	**593**	**615**	**742**	**1,054**		**3,004**
Illicit Tobacco Services	Number of inspections	124	75	41	23	18	18		100
Obesity Prevention and Weight Management (OPWM)	Number of adults supported	1,058	260	175	171	146	216		708
	Number of children supported	87	108	24	35	15	43		117
	Maternity	43	104	16	15	26	50		107
	Adults triaged to other 12 week weight management	New KPI 2018/19	1,778	424	431	307	749		1,911
	Number of tier 1 prevention projects	New KPI 2018/19	65	35	17	19			71
	Number of tier 1 prevention sessions	New KPI 2018/19	376	194	148	97			439
Domestic Abuse Services	No of adults supported	1,881	2,088	536	468	421	527		1,952
	No of children, young people & teenagers supported	510	622	156	132	148	173		609
Seasonal Mortality	Number of people from the target groups given comprehensive energy efficiency advice and/or given help and advice to switch energy supplier or get on the cheapest tariff	391	259	160	68	213	58		499
	Number of individuals trained to deliver Brief Interventions i.e. number of people attending the training courses	319	187	51	42	72	54		219
Social Exclusion	Number of one-to-one specialist advice interviews undertaken	8,197	7,128	2,227	2,528	2,231	2,342		9,328
	Number of health care support and interventions undertaken	5,219	5,445	1,197	1,240	1,238	1,369		5,044
Public Health Services for Children and Young People aged 0-19	Percentage of New Birth Visits (NBVs) completed within 14 days	85%	95%	88%	89%	89%	90%		89%
	Percentage of 6-8 week reviews completed	87%	95%	86%	85%	88%	88%		87%
	Percentage of 12 month development reviews completed by the time the child turned 15 months	86%	95%	89%	91%	89%	89%		89%
	Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	78%	95%	95%	99%	99%	99%		98%
Oral Health Promotion Services	Number of frontline staff (CHILD RELATED) trained to deliver oral health brief advice	236	200	66	56	86	70		278
	Number of frontline staff (ADULT RELATED) trained to deliver oral health brief advice	257	200	60	70	43	48		221
Homelessness	Hostel Accommodation Number exited in a planned way	New service	-	31	34	39	31		135
	Hostel Accommodation % exited in a planned way	New service	>80%	70%	69%	96%	79%		78%
	Move on Accommodation Number exited in a planned way	New service	-	36	29	42	29		136
	Move on Accommodation % exited in a planned way	New service	>80%	100%	97%	98%	97%		98%
Resilience Building in Schools	North: Number of children undertaking a daily resilience building activity at school	2679	2500	53	587	0	0		640
	North: Number of prioritised schools signed up to the service	14	14	14	14	14	14		14
	South: Proportion of staff trained report increase in understanding of mental health and resilience	100%	80%	100%	100%	0%	0%		100%
	South: Number of children engaged in insights gathering for audits and action plan implementation	148	90	19	0	0	0		109

		Q1			Q2			Q3			Q4			Total		
		Denominator	Numerator	%	Denominator	Numerator	%	Denominator	Numerator	%	Denominator	Numerator	%	Denominator	Numerator	Average %
Integrated Sexual Health Services	**Quality Standard 60 % of new service users accepting a HIV test**															
	Sherwood Forest Hospital NHS Trust	1087	826	76%	1026	799	78%	930	749	81%	690	560	81%	3733	2934	79%
	Nottingham University Hospital NHS Trust	1044	679	65%	1119	679	61%	919	549	60%	962	630	65%	4044	2537	63%
	Doncaster and Bassetlaw Hospitals NHS Trust	707	410	58%	684	425	62%	594	364	61%	678	437	64%	2663	1636	61%
	Quality Standard At least 75% of 16-24 year olds in contact with the service accepting a chlamydia test															
	Sherwood Forest Hospital NHS Trust	720	576	80%	591	479	81%	481	408	85%	600	491	82%	2392	1954	82%
	Nottingham University Hospital NHS Trust	465	329	71%	476	329	69%	465	294	63%	457	300	66%	1863	1252	67%
	Doncaster and Bassetlaw Hospitals NHS Trust	354	223	63%	290	231	80%	615	405	66%	361	273	76%	1620	1132	70%
	Quality Standard 30% of women aged 15-24 receiving contraception accepting LARC															
	Sherwood Forest Hospital NHS Trust	1016	447	44%	983	471	48%	954	454	48%	906	453	50%	3859	1825	47%
	Nottingham University Hospital NHS Trust	288	116	40%	276	105	38%	262	116	44%	482	215	45%	1308	552	42%
	Doncaster and Bassetlaw Hospitals NHS Trust	582	285	49%	624	314	50%	546	287	53%	578	283	49%	2330	1169	50%
Young People's Substance Misuse Service	Quality standard 80% Planned exit from treatment	50	47	94%	20	15	75%	8	7	88%	11	11	100%	8	7	88%
Public Health Services for Children and Young People aged 0-19	Percentage of New Birth Visits (NBVs) completed within 14 days	1853	1638	88%	1990	1771	89%	2034	1810	89%	1804	1632	90%	7681	6851	89%
	Percentage of 6-8 week reviews completed	1834	1577	86%	1954	1657	85%	2179	1928	88%	1853	1636	88%	7820	6798	87%
	Percentage of 12 month development reviews completed by the time the child turned 15 months	1990	1766	89%	2197	1991	91%	2221	1969	89%	2192	1945	89%	8600	7671	89%
	Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	1880	1788	95%	1704	1693	99%	1723	1703	99%	2011	1989	99%	7318	7173	98%
Homeleessness	Hostel Accommodation % exited in a planned way	44	31	70%	49	34	69%	41	39	96%	39	31	79%	173	135	78%
	Move on Accommodation % exited in a planned way	36	36	100%	30	29	97%	43	42	98%	29	28	97%	138	135	98%

Making the economic case for prevention

Posted by: John Newton and Brian Ferguson, Posted on: 6 September 2017

It is widely acknowledged that poor lifestyle behaviors as well as wider determinants of health place a significant burden on public finances now and in the future, and the evidence shows that a large number of prevention programmes represent value for money. Therefore there is a strong economic case for greater action.

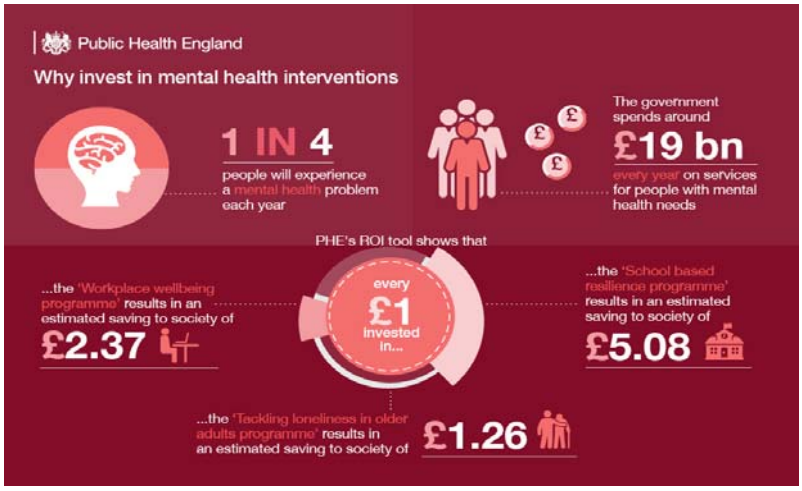
For example, our work shows that moving a person from unemployment into employment would save £12,035 per person over a one-year period.

Another example we can use to make the economic case is analysis of a 'targeted supervised tooth brushing programme'. This initiative provides a return of £3.06 for every £1 invested after 5 years and £3.66 after 10 years. On this occasion we are taking into account NHS savings, increased earnings for the local economy and improved productivity.

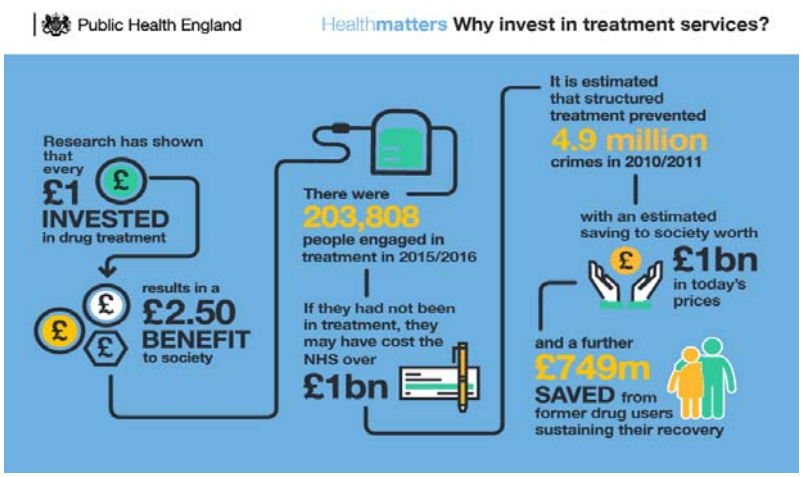
There is also excellent evidence to support investment in tobacco control services. Over a lifetime, for every £1 spent the return will be £11.20 when impacts to the local economy, wider healthcare sector and QALYs are considered. When omitting the health effects (measured by QALYs), there is still a saving of £1.90 for every £1 spent.

Every £1 spent on drug treatment services saves society around £2.50 in reduced NHS and social care costs and reduced crime in the short-term (85% due to reductions in offending).

And as we recently flagged as part of a suite of mental health resources, initiatives which prevent mental health problems can yield a good return on investment. We looked at interventions such as school-based resilience programmes, workplace stress programmes and support for people in debt.

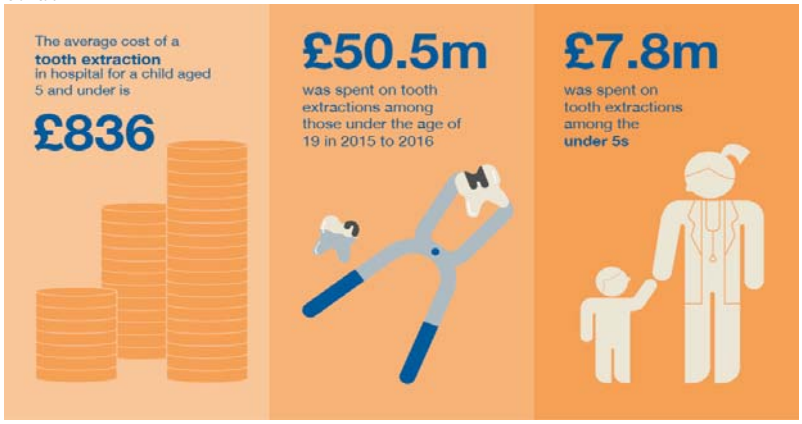


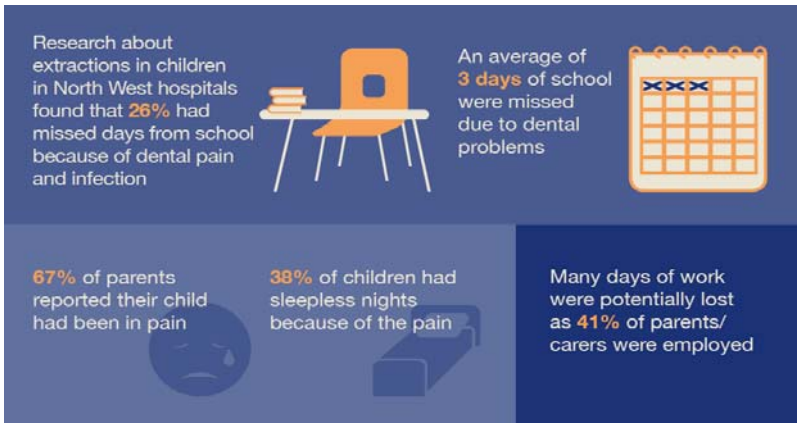
Drug treatment not only saves lives, it provides value for money to local areas:



https://publichealthmatters.blog.gov.uk/2017/09/06/making-the-economic-case-for-prevention/

Oral Health





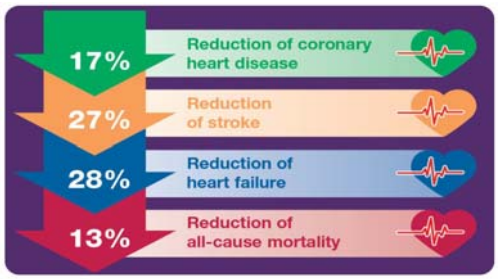
Social Value refers to wider financial and non-financial impacts of programmes, organisations and interventions, including the wellbeing of individuals and communities, social capital and the environment.
From a business perspective it may be summarised as the net social and environmental benefits (and value) generated by an organisation to society through its corporate and community activities reported either as financial or non-financial (or both) performance.

Useful links:

https://www.nice.org.uk/media/default/About/what-we-do/NICE-guidance/NICE-guidelines/Public-health-guidelines/Additional-publications/Cost-impact-proof-of-concept.pdf

It is estimated that up to 80% of premature deaths from CVD can be prevented through better public health. All current blood pressure guidelines agree that support for behaviour change to address modifiable risk factors (smoking, alcohol, inactivity, obesity and poor diet) should be the first step in preventing high blood pressure.

There is robust evidence that taking action to lower blood pressure can reduce the risk it poses to health. A major systematic review found that in the populations studied, every 10mmHg reduction in blood pressure resulted in the following reductions.



https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/672554/Tackling_high_blood_pressure_an_update.pdf

Prevention is better than cure: our vision to help you live well for longer, Published 5th November 2018:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 July 2019

Agenda Item: 5

REPORT OF THE SERVICE DIRECTOR, STRATEGIC COMMISSIONING, SAFEGUARDING AND ACCESS

INDIVIDUAL CONTRIBUTIONS TOWARDS THE COST OF CARE AND SUPPORT

Purpose of the Report

1. This report provides a summary of progress and support to service users in respect of the implementation of phase one of the changes to the individual contributions towards the cost of care and support.

2. The report also seeks to provide assurance that phase two of the implementation, which will commence in November 2019, will proceed smoothly applying lessons learnt through phase one.

Information

Background

3. At Policy Committee on 17th October 2018 it was agreed to adopt in full the national Department of Health and Social Care guidance to councils about the benefits they can take into account and the Minimum Income Guarantee levels that can be applied when determining the amount people are asked to contribute towards their care costs. This was a decision taken following eight weeks of public consultation in summer 2018 and in the context of the financial pressures the Council is facing.

4. This decision was due to come into effect on 12th November 2018, however, as a result of feedback received from some service users, their carers and other people in their support networks, it was recognised that more time was needed to enable people to adjust to the impact of the changes. In the light of this feedback, Adult Social Care and Public Health Committee on 10th December 2018 agreed to postpone the implementation of the policy until 8th April 2019 and to introduce the changes in two stages: phase one in April 2019 and phase two in November 2019. A further report, seeking the amendment to the Policy, was approved at Policy Committee on 13th February 2019.

5. From 8th April 2019 the Council began to take into account higher rate disability benefits in the assessment of what a person can afford to contribute towards the cost of their care

and support in full. Previously when a person was in receipt of the highest rate of Attendance Allowance, Disability Living Allowance (Care Component) or Personal Independent Payment a £28.30 disregard was applied.

6. There has also been a phased implementation of the new Minimum Income Guarantee level used when calculating contributions for people aged 18 years to under pension credit age. From April 2019 the rate used reflects the mid-point between the previous level used by the Council of £189 and the proposed level of £151.45. This phasing will apply between April and November 2019.

7. The Department of Health Guidance sets out the amount of money people are allowed to keep to cover their daily living costs. This is called the Minimum Income Guarantee (MIG). Prior to April the Council had one allowance for all service users of £189.00 per week. From April a second rate of £170.23 was introduced for people aged 18 years to under pensionable age. From November 2019 the allowance will be reduced to £151.45 based on the guidance from the Department of Health and Social Care.

Implementation update on progress and support to service users from Phase One

8. From the outset the Adult Care Financial Services Team (ACFS) has taken the lead in implementing the changes, supported by the Corporate Communications Team, Corporate Complaints Team, the Benefits Team, the Transformation Team and a Project Manager from the Programmes and Projects Team.

9. On 25th February 2019 letters were sent out to approximately 3,500 service users advising them of the new level of contribution that they would be asked to make towards their care costs. This work was subject to a tight timescale and it was anticipated that there would be a high volume of calls and contacts from people needing advice and guidance about the changes.

10. In preparation for the letters being received, a project team and process for managing the queries and responses was put in place. ACFS increased the numbers of experienced officers dedicated to answering telephone calls from one to four; this was to ensure that people could feel assured they were being listened to and confident that their queries and concerns would be dealt with in a timely manner. The policy change has created significant customer demand upon ACFS; from 13th February 2019 to 13th June 2019 a total of 2,200 calls have been received.

11. A daily project team Skype meeting was put in place to oversee the process, manage communications and to assess any issues that may need to be escalated to senior managers. A number of letters came in from service users, family, carers, MPs and Elected Members; these were acknowledged immediately and responded to within the required timescales.

12. A total of 25 letters have generated a formal complaint. In the context of 721 service users being asked to contribute for the first time, some of whom have not contributed for many years since receiving care and support, it was understandable that a significant alteration in disposable income created upset and challenge and, in some cases, difficult conversations.

13. Throughout the phase one of implementation, the ACFS team has worked with service users to maximise their benefits. In some cases ACFS and operational teams made home visits to undertake financial assessments and review care and support packages. From 13th February to 13th June 2019 a total of 341 people has requested a review of their financial assessment – looking at their income and expenditure. 7 people have had visits to help them complete their income and expenditure forms.

14. The team has also been successful in identifying unclaimed benefit entitlements for service users and have received thank you letters from people who have had backdated monies amounting to thousands of pounds.

15. Since December 2018 this additional income that people have received, due to advice from ACFS, amounts to approximately £5,000 per week. This equates to £250,000 per annum.

16. Every person is provided with a standard extra Disability Related Expenditure Allowance of £20 per week by the Council. Further to the policy change 155 people have requested additional disability expenditure, half of which have been approved.

17. The Benefits Team has been working proactively with approximately 17 service users who were referred to them for a review of their benefits. In one instance they identified an entitlement to Attendance Allowance of £58.70 per week, and supported the service user to successfully claim this. This subsequently led to an entitlement to Pension Credit which meant that they no longer had to pay council tax. This will undoubtedly have helped the service user to effectively contribute towards their care contributions.

18. The Customer Service Centre has received a smaller proportion of the total of 2,200 calls since the introduction of the changes in April and have worked closely with ACFS and operational teams to ensure that people are appropriately supported with their queries where they have not been able to resolve them at the point of contact.

Implementation Phase Two

19. Phase two will start on 4th November 2019. From this date the Council will implement the changes to the Minimum Income Guarantee levels in full. These are:

- 18 years to under pension credit age £151.45
- Pension credit age and over £189.00

20. As described in earlier reports, advice and guidance will continue to be available to service users who contact the Council at any time between April and November, and beyond.

21. As described in **paragraph 10** ACFS will again increase the availability of trained experienced staff to answer individual queries.

22. The Council continues to keep the impact of implementing the contributions policy under review and lessons learned from phase one will be incorporated into the next phase.

Other Options Considered

23. The Council could have maintained the decision already taken and apply three Minimum Income Guarantee levels as previously agreed by Policy Committee. Having listened to feedback from service users and their carers the Council agreed to amend the policy and phase its implementation as set out in the body of the report.

Reason/s for Recommendation/s

24. The report provides assurances about the individual support provided to people affected by the policy and preparations for phase two.

Statutory and Policy Implications

25. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

26. As reported to Adult Social Care and Public Health Committee on 10th December 2018, phasing the introduction of the revised policy for the way the Council calculates individual contributions towards the cost of care and support will mean that the full £3.8m per annum will not be realised until 2020/21. The impact in 2018/19 was reported as around £1.5m and the impact for 2019/20 was reported as a reduction in cost of around £2.8m rather than £3.8m, so a reduction of £1m. The proposal to apply two Minimum Income Guarantee levels, rather than three, will reduce the income to the Council by a further £200,000 a year.

Implications for Service Users

27. The Council's previous modelling showed that 7,069 people were receiving adult social care and support services to help them to remain independent at home. 452 people were aged 18 to under 25 years and of these 23 paid a contribution towards the cost of their care and support and, based on the outcome of their financial assessment, 429 did not pay a contribution. Applying three levels of Minimum Income Guarantee meant that:

- of the 23 people aged 18 to under 25 years who were contributing, 20 would contribute more and 3 would pay the same
- of the 429 people aged 18 to under 25 years who were not contributing, 196 would come into charging but 233 would continue to contribute nothing.

28. Applying two Minimum Income Guarantee levels, one for people aged over pension credit age and one for people aged 18 years to under pension credit age, rather than three, will reduce the financial impact of the changes for people aged 18 to under 25 yrs. Modelling as at January 2019 shows that 422 people aged 18 to under 25 years are receiving adult

social care and support services to help them to remain independent at home. Applying two levels of Minimum Income Guarantee will mean that 165 people aged 18 to under 25 years will come into charging, 31 people will be asked to pay an increase in their contribution and that 226 people will continue to contribute nothing.

RECOMMENDATION/S

1) That the Committee considers whether there are any further assurances required in relation to implementation of phase two of the policy, which will commence in November 2019.

Paul Johnson
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Constitutional Comments (LW 26/06/19)

29. Adult Social Care and Public Health Committee is the appropriate body to consider the content of the report.

Financial Comments (DG 21/05/19)

30. As a result of the changes in the contribution levels, £2.6m has been factored into the budget for 2019/20 and a further £1m will be included in 2020/21. At this time, the department is expecting to realise the saving, although this will be monitored each period. The savings arise from both an increase in income from client contributions and a reduction in the Direct Payment costs. The 2019/20 budget for client contributions is £36.2m and the net budgeted costs for Direct Payments are £34m.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Changes to the way the Council calculates individual contributions towards the cost of care and support - report to Policy Committee on 17th October 2018

Individual contributions towards the cost of care and support - report to Adult Social Care and Public Health Committee on 10th December 2018

Individual contributions towards the cost of care and support - report to Policy Committee on 13th February 2019.

Electoral Division(s) and Member(s) Affected

All.

ASCPH651 final

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 July 2019

Agenda Item: 6

REPORT OF THE TRANSFORMATION DIRECTOR AND THE DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT, NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE SYSTEM AND CLINICAL COMMISSIONING GROUPS

DEVELOPMENT OF A LOCAL SYSTEM PLAN IN RESPONSE TO THE NHS LONG TERM PLAN, NOTTINGHAM AND NOTTINGHAMSHIRE

Purpose of the Report

1. To ensure that members of the Adult Social Care and Public Health Committee are fully involved and engaged in the development of the local system plans for health and care which are due for publication in the autumn of this year.

2. To ensure that members of the Adult Social Care and Public Health Committee are able to consider opportunities to engage patients, members of the public and staff in the development of these local system plans.

3. To ensure that members of the Adult Social Care and Public Health Committee have an opportunity to consider priorities for the local system plan.

Information

4. As noted at the meeting of the Committee on 7th March 2019, on 7th January 2019 the Government and NHS leaders published the Long Term Plan for the NHS.

5. The Long Term Plan (LTP) sets out the strategy for the NHS for the next ten years and was requested by the Government in response to the announcement of additional funding for the NHS in June 2018.

6. The LTP was drawn up by people who know health and care the best: frontline staff, patients' groups, and national experts. A summary of the Long Term Plan is attached as **Appendix 1** to this report.

7. Following the publication of the LTP, each local area, led by its Integrated Care System (ICS) has been asked to draw up a local system plan, reflecting the local priorities and focus

areas, in order to implement the national plans. These local strategies are due for submission in the autumn.

8. In Bassetlaw, there is a Bassetlaw Place Plan and this plan was commented on by Adult Social Care and Public Health Committee on 4th February 2019.

9. In Nottingham and Nottinghamshire, the ICS is developing a new local system strategy plan. It builds upon good progress made through the original Sustainability and Transformation Plan.

10. The development of the new local strategy plan is being informed by engagement with the public. Through a range of engagement events the public has been asked to identify what are the priorities for the health and social care system.

- The engagement activities regarding the LTP commenced on 29 March 2019 and so far, have included:
    - the launch of a new microsite website at https://nottswhatmatterstoyou.co.uk/ which introduces the Long Term Plan to a local audience and asks them to contribute to the development of the local system response through completing a short survey.
    - promotion of this website through the system's social media channels (Twitter and Facebook) and the Clinical Commissioning Group (CCG) websites.
    - close working with Healthwatch as they also engage with the public to align activities and ensure that the same questions are used.
    - sharing of the promotional materials with system partners (NHS, Local Authority (including Councillors), Voluntary & Community Sector (VCS) and others) for amplification through their own channels.
    - sharing of information about this activity with the Nottinghamshire Members of Parliament and holding a briefing and discussion in Westminster on 14th May 2019.
    - promotion of the activity through press release and other media activity.
    - significant levels of face-to-face engagement with the public delivered by the in-house and Healthwatch teams, including:
        - Large local employers including Experian and EoN.
        - Blood glucose testing of public for Diabetes Awareness Week including promotion of the survey.
        - Meeting with social groups including local "Community Gardens"
        - Discussions and promotions of survey at health interest groups and public forums across Nottinghamshire including: Hucknall Carers, Arnold Mental Health Drop-In, The Hive in Mansfield, outBurst in Nottingham and many others.
    - detailed market research by social research company Britain Thinks including in-depth at-home discussions and focus groups with patients to measure their attitude to and experience of the services provided in Nottinghamshire.

- further details can be found in the background papers.

11. To date (as of 7th June 2019) there have been 374 individual responses and these initial views are shaping the emerging system priorities.

12. The emerging system priorities from ICS Leaders are receiving strong support from the public and are as follows:

- redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting (97% of respondents in the public engagement rated as Important or Very Important in initial engagement responses)
- improve the care of people with single and multiple long term conditions through greater proactive management and self-management to reduce crises (100% rated as Important or Very Important)
- improve the response to people with mental health needs (94% rated as Important or Very Important)
- reduce waste and improve efficiency and value across the system (including estates) (80% rated as Important or Very Important)
- more action on and improvements in the upstream prevention of avoidable illness (95% rated as Important or Very Important).

13. To support these priorities, it is recognised there needs to be a focus on the following system enablers:

- Workforce
- Digitalisation, Information Management & Technology (IM&T) and analytics
- System financial management and innovative payment models
- System governance and oversight (including programme delivery).

14. Detailed discussions with ICS Leaders have started on the emerging themes. Specifically, it is a high priority to improve urgent and emergency care. In terms of ambition there was broad recognition that attendance at A&E and reduced admissions needed to happen at pace.

15. It has also been discussed by ICS Leaders that the local health and care system is faced with an ever growing proportion of the population experiencing a preventable or treatable long term condition. It was agreed there needs to be a greater 'up-stream' focus on prevention and for those living with such conditions, individuals need to be supported to be as independent as possible, ensuring they feel equipped to manage their condition.

16. There was strong support for a greater focus on the proactive, coordinated care of specific groups of the population at risk of needing costly and long term health and social care. It was recognised people need as much control and quality to their life as possible by ensuring they are supported by a personalised care plan. The role of multidisciplinary teams working across health and social care (including the voluntary sector) was seen as key to keeping people well and independent and ultimately avoid crisis.

17. Groups of people identified as currently not being as well served as they could be included people with joint physical and mental health conditions, long term conditions, frailty, people living in care homes and those at end of life. Better management of data, case finding, joining up health and social care and utilising technology were all seen as key to improving care and support.

18. Further detail on these discussions can be found in in the report to the Integrated Care System Board as referenced below.

19. It is intended that the new local strategic plan is submitted to NHS England in the autumn.

Other Options Considered

20. No other options were considered. In order to ensure that members of the Committee are fully engaged with the development of the local system plans, it was considered essential to bring this report to the Committee.

Reason/s for Recommendation/s

21. To ensure that the Committee has an opportunity to consider priorities for the local strategic plan and to consider any further ways in which staff, patients and the public can be engaged in its development.

Statutory and Policy Implications

22. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

23. As part of the development of the local plans for health and care, one of the priorities of the strategy will be to reduce waste and improve efficiency.

RECOMMENDATION/S

That the Committee:

1) considers whether there are any priorities that would benefit from a particular focus in the emerging local plan for Nottingham and Nottinghamshire.

2) considers whether there are any further opportunities to engage with staff, patients and the public to build confidence in the local plan ahead of its publication in the autumn.

3) considers health and social care priorities for the local plan.

Jane North
Transformation Director
Adult Social Care and Health

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Constitutional Comments (LW 26/06/19)

24. Adult Social Care and Public Health Committee is the appropriate body to consider the content of the report.

Financial Comments (DG 26/06/19)

25. There are no specific financial implications arising from this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

The NHS Long Term Plan: https://www.longtermplan.nhs.uk/

June 2018 Funding announcement for the NHS: https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan

Report to the Nottingham and Nottinghamshire Integrated Care System re Engagement on the Long Term Plan, Item
7: http://www.stpnotts.org.uk/media/1737342/icsboardagendapapers20190509.pdf

Report to the Nottingham and Nottinghamshire Integrated Care System re the emerging strategy for the local area, Item
9: http://www.stpnotts.org.uk/media/1737342/icsboardagendapapers20190509.pdf

Electoral Division(s) and Member(s) Affected

All.

ASCPH665 final

The NHS Long Term Plan – a summary

Find out more: www.longtermplan.nhs.uk | Join the conversation: #NHSLongTermPlan

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients

These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life

- reducing stillbirths and mother and child deaths during birth by 50%
- ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most
- providing extra support for expectant mothers at risk of premature birth
- expanding support for perinatal mental health conditions
- taking further action on childhood obesity
- increasing funding for children and young people's mental health
- bringing down waiting times for autism assessments
- providing the right care for children with a learning disability
- delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.

Delivering world-class care for major health problems

- preventing 150,000 heart attacks, strokes and dementia cases
- providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths
- saving 55,000 more lives a year by diagnosing more cancers early
- investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital
- spending at least £2.3bn more a year on mental health care
- helping 380,000 more people get therapy for depression and anxiety by 2023/24
- delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.

Supporting people to age well

- increasing funding for primary and community care by at least £4.5bn
- 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, and speed up discharges home.
- upgrading NHS staff support to people living in care homes.
- improving the recognition of carers and support they receive
- making further progress on care for people with dementia
- giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How we will deliver the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how we think we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. **Doing things differently:** we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. **Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. **Backing our workforce:** we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. **Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. **Getting the most out of taxpayers' investment in the NHS:** we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

This means that over the next few months, whether you are NHS staff, a patient or a member of the public, you will have the opportunity to help shape what the NHS Long Term Plan means for your area, and how the services you use or work in need to change and improve.

To help with this, we will work with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

Find out more

More information is available at www.longtermplan.nhs.uk, and your local NHS teams will soon be sharing details of what it may mean in your area, and how you can help shape their plans.

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 July 2019

Agenda Item: 7

REPORT OF THE SERVICE DIRECTOR, STRATEGIC COMMISSIONING, SAFEGUARDING AND ACCESS

MANAGEMENT OF MEDICATION AND HEALTH AND SOCIAL CARE TASKS POLICIES FOR START REABLEMENT TEAM AND HOMEBASED CARE AND SUPPORT PROVIDERS

Purpose of the Report

1. The report seeks endorsement of the following policies and agreement to recommend them to Policy Committee for approval:

   a. Delivering health and social care tasks: policy for homebased care and support providers (attached as **Appendix 1**)

   b. an update to the Assisting with Medication policy for Short Term Assessment & Reablement Team (START) – Reablement Support Workers operating in a service user's home (attached as **Appendix 2**).

Information

2. The current policy "Responsibilities for Care in the Home" was written in 2010. It describes the responsibilities of community nursing services and domiciliary services in delivering health and social care tasks in an individual's own home.

3. "Assisting with Medication Policy for Short Term Assessment & Reablement Team (START)" was written in 2010 and was last updated in December 2015. The policy describes the responsibilities of the Countywide Reablement Teams around the safe and secure handling of medicines.

4. Since 2010, there have been major technological advances and updates to legislation and national guidance which warrant a review of the documents. These changes include:

   a. The introduction of the Care Act 2014 which focusses on prevention, person centred approaches and the promotion of an individual's wellbeing. Low level healthcare tasks being delivered by a homebased care and support or Reablement provider in line with the 'prevention of longer-term care and support needs' agenda which will offer a consistent service intervention where self-medication can be monitored and reviewed.

b. Advances in medications including administration and protocols encourages service users to self-manage or be supported by a non-healthcare worker to promote their independence.

c. Advances in assistive technology including aids can enable individuals to self-care or for a non-healthcare worker or family member to support with healthcare tasks.

d. The national driver to integrate health and social care validates the development of social care workers to take on low level healthcare and medication tasks.

e. A questionnaire was completed by local home care providers. The findings showed that they are carrying out healthcare tasks for privately funded packages of care. The new policies will therefore reflect current practices.

f. A Senior Prescribing and Governance Adviser who works for Clinical Commissioning Groups (CCGs), and has been the clinical expert for Nottinghamshire County Council for the last 10 years, contacted local authorities to find out what healthcare tasks they commission from home care providers. Her research has shown that in comparison with Nottinghamshire County Council more healthcare tasks are being undertaken by home care providers in other councils.

g. National guidance is published by organisations such as National Institute for Care and Health Excellence "Managing medicines for people receiving social care in the community" (NG67 & QS171) which recommend best practice. The Care Quality Commission has also recently published a report on Medicines in Health and Adult Social Care which support the actions in the implementation plan.

h. The inability to support service users with low level healthcare and medication tasks could decrease the number of referrals made to the START service or a homebased care provider, unnecessarily prolong an individual's stay in hospital, have a longer-term financial implication for the Council around the prevention of ongoing support needs and lead to an inequity of medication support being offered.

i. The policies do not circumvent any standards set by a Healthcare Professionals regulatory body such as the Nursing & Midwifery Council (NMC) or the Health and Care Professions Council (HCPC).

5. A multidisciplinary steering group including CCGs and community health providers was set up to review both policies. It was agreed that the policies would:

a. reflect the principles of the Care Act

b. give a clear rationale as to reasoning behind the changes

c. reflect current modern health and social care practices

d. follow current National Institute for Care and Health Excellence and Social Care Institute for Excellence guidance around delivering medication and health care tasks

e. address any funding or financial issues raised

f. clearly establish the tasks that social care can undertake with healthcare support

g. clearly establish the tasks that only healthcare professionals can deliver

h. ensure that social care workers delivering healthcare/medication tasks are appropriately supported e.g. ongoing learning and development provided by healthcare professionals

i. make the best use of financial and staffing health and social care resources.

6. The new documents have undergone a number of revisions to incorporate the extensive consultation with operational and strategic County Council teams, nursing staff working for Clinical Commissioning Groups, clinicians, District Nurses, hospital discharge team, Nottinghamshire Integrated Care Systems staff, Nottinghamshire Healthcare Trust staff (who are working on the delegating healthcare tasks to Personal Assistants project) and homebased care and support providers.

7. START is a short term reablement service whereas homebased care and support provide a longer term service; consequently there are differences in the two policies and the tasks that the workforce can undertake.

8. There are synergies between the workforce who deliver the START service, homebased care and support providers and the Home First team (a short term service which can help people to get home from hospital quickly and/or support someone at home if they have a short term crisis and are at risk of unnecessary readmission to hospital or urgent short term care in a care home). Therefore, the contents of the two documents are closely aligned. Independent homebased care and support providers who are contracted by Nottinghamshire County Council can adopt/adapt the START medication policy to reflect their local service.

9. A high level action plan has been developed to support the communication and implementation of the two policies and this is available as a background paper.

10. In the future, adult social care may be expected to support the NHS self-care agenda, where more products would be expected to be purchased by patients themselves as opposed to being prescribed by their GP.

11. A local project is seeking to support the delegation of healthcare tasks to Personal Assistants. A list of tasks has been drawn up. The proposal is that health care professionals will be responsible for the clinical oversight, accountability and governance of the scheme. They will train Personal Assistants to carry out delegated healthcare tasks.

Other Options Considered

12. The Council could continue to support the current documents but this has been discounted as it does not reflect current local and national practice, and trends. It also hinders continuity of care, decreases choice and control for the service user and could lead to duplication of services which is not cost effective.

Reason/s for Recommendation/s

13. Recent research and new working practices listed below support the implementation of the new guidance.

    a. A wider range of healthcare and medication tasks are being delivered by other councils in comparison to Nottinghamshire as illustrated in the findings of the survey carried out by the Senior Prescribing and Governance Adviser. For example, Leicestershire County Council has updated their health and social care protocol and are providing training. Nottinghamshire County Council will liaise with them to learn from their experience about setting up robust processes. http://www.lscdg.org/health-social-care-protocol-passports/

    b. Working in partnership with healthcare professionals such as the Senior Prescribing and Governance Adviser for the past 10 years has resulted in an improvement in working practices in care homes as well as in the START team and homebased care and support organisations

    c. Homebased care and support providers in Nottinghamshire are delivering additional tasks to those listed in the "Responsibilities for Care in the Home" 2010 policy under the terms of the new homebased care and support contracts for City and County Council.

    d. The updated guidance will reflect current practices in Nottinghamshire Reablement teams and set expectations with health colleagues around appropriate tasks to be undertaken.

    e. Evidence gathered by the Countywide START Teams has identified that referrals are being made to health partners for health tasks which could be met by non-health care staff once additional training and information is provided. This has meant a reduction in the number of referrals accepted by the START service where there is a low-level medication/minor health need.

    f. The new documents will standardise practice across Managed Packages of Care, Direct Payments and Privately Funded Packages of Care.

    g. Implementation of the policies will encourage collaboration between the health and social care workforce to promote good practice whilst supporting the integration agenda.

14. Updating the guidance and providing robust protocols and procedures, a learning and development programme, competency assessments and clinical oversight will have a major impact on health and social care workers in all organisations in a number of ways.

    - Staff will have the knowledge and skills to support service users to manage their own conditions wherever appropriate.

    - It will lead to a prevention of longer-term care and support needs as social care workers will have the knowledge to enable them to identify if an individual's condition is deteriorating and the protocols to follow to prevent further deterioration

- Social care workers will follow formal, consistent, person centred, safe working practices supported by a relevant health professional.

- Social care workers will have the skills and knowledge to undertake low level health care and medication tasks safely and competently and this could also improve staff retention in the adult social care sector.

- It will allow an increase in the number of service users being referred into the START service and increased support by Homebased care and support providers.

- Working together with health partners will ensure that limited resources are used more effectively by finding better, more efficient ways of working e.g. district nurses can focus on higher level tasks.

- There will be a reduction in the number of unnecessary delayed discharges of care from hospital, as social care workers will be able to carry out additional tasks from the commencement of the package which will be supported by health colleagues as per the caveats noted in **Appendix 2**. This will consequently reduce the likelihood of worsening health outcomes and increase in long-term care needs from extended hospital stays.

Statutory and Policy Implications

15. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

16. The focus of the policies is to ensure that the right support is provided at the right time in the most cost effective way. It is anticipated that the policies will result in cost efficiencies through better use of resources.

Human Resources Implications

17. Social care staff will be expected to undertake learning and development in health care tasks.

18. Healthcare resources will be realigned to provide clinical oversight and learning and development opportunities for social care staff.

Public Sector Equality Duty Implications

19. In compiling this report, the effects that these policies may have on people with protected characteristics have been considered. It has been concluded that there will be a positive effect because the policies will increase flexibility for the service user as the

interdependencies between those involved in their care will be reduced and there will be a quicker, seamless service.

Implications for Service Users

20. The new policies will support continuity of care and a service user's choice over who is best placed to deliver their care whether that be their START or homebased care and support provider or a health care individual. This will increase flexibility for the service user as the interdependencies between those involved in their care will be reduced

RECOMMENDATION/S

That Committee:

1) endorses the *Delivering health and social care tasks: policy for homebased care and support providers*, attached as **Appendix 1**, and recommends it to Policy Committee for approval

2) endorses the changes made to the Assisting with Medication policy for Short Term Assessment & Reablement Team (START), attached as **Appendix 2**, and recommends it to Policy Committee for approval.

Paul Johnson
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Constitutional Comments (EP 11/06/19)

21. The recommendations fall within the remit of the Adult Social Care and Public Health Committee by virtue of its terms of reference.

Financial Comments (DG 14/06/19)

22. There are no specific financial implications arising from this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Management of medication and health and social care tasks policies implementation plan

Supporting quality in care homes and domiciliary care medicines management annual report 18/19

Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

"Managing medicines for people receiving social care in the community" (NG67 & QS171)
https://www.nice.org.uk/guidance/ng67

Personalisation for home care providers
https://www.scie.org.uk/personalisation/practice/home-care-providers

Medicines in Health and Social care
https://www.cqc.org.uk/sites/default/files/20190605_medicines_in_health_and_adult_social_care_report.pdf

Electoral Division(s) and Member(s) Affected

All.

ASCPH662 final

APPENDIX 1

Delivering Health and Social Care Tasks: Policy for homebased care and support providers

Introduction

The Care Act (2014) requires Health and Social care to work in partnership to ensure good quality support, that focuses on a person's wellbeing, is provided to service users and their families.

This policy applies to homebased care and support providers also known as domiciliary agencies and to community health teams.

In Nottinghamshire, homebased care providers are commissioned to undertake social care and healthcare tasks on behalf of Nottinghamshire County Council and Clinical Commissioning Groups. These organisations must have clear policies, protocols, insurance and learning and development in place to allow and support staff to undertake any appropriate task.

Extensive consultation has been undertaken with operational and strategic County Council teams, nursing staff working for Clinical Commissioning Groups, clinicians, District Nurses, hospital discharge teams, Nottinghamshire Integrated Care Systems staff, Nottinghamshire Healthcare Trust staff (who are working on the delegation of healthcare tasks to Personal Assistants project) and homebased care and support providers to produce this policy.

This policy does not circumvent any standards set by a Healthcare Professionals regulatory body, which they are required to meet (e.g. Nursing & Midwifery Council (NMC) or Health and Care Professions Council (HCPC)).

The Purpose of the Policy

The policy has been developed to:

a. Articulate current and future service requirements
b. Reflect the principles of the Care Act
c. Give a clear rationale as to reasoning behind the changes
d. Reflect current health and social care practices
e. Follow current NICE and SCIE guidance around delivering health care tasks
f. Clearly establish the tasks that social care can undertake with healthcare support
g. Clearly set out the tasks that only healthcare professionals can deliver
h. Ensure that social care workers delivering healthcare tasks are appropriately supported e.g. ongoing learning and development provided by healthcare professionals

General Principles of the Policy

The following principles apply when deciding who is best placed to undertake a particular task with an individual service user in their own home. We must:

- Promote the wellbeing of the individual as defined in the Care Act
- Support people to manage their own conditions wherever appropriate
- Provide continuity of care for individuals
- Prevent an individual's condition from deteriorating
- Support an individual's choice over who is best placed to deliver their care

- Consider the skills, knowledge and risks required to undertake such tasks
- Provide opportunities for social care staff to develop their knowledge and skills which will help their career development
- Ensure staff follow formal, consistent, person centred, safe working practices led by a relevant health professional
- Ensure the homebased care and support providers have the appropriate insurance in place to cover the tasks described in this document.

Health and Social care Tasks

The list of tasks which have been agreed jointly with Nottinghamshire County Council, Health/CCGs, homebased care providers and partners have been divided into two sections.

- Section 1 describes the tasks routinely undertaken by Social care staff, those which can be undertaken by Social care on behalf of Healthcare Professionals and tasks which remain the responsibility of Healthcare Professionals. Additional information and notes for consideration by providers and Social care staff are included regarding some of the tasks listed.

- Section 2 describes the medication tasks for homebased care and support providers.

The role of healthcare professionals and social care staff in completing particular tasks as described in this document will be reviewed regularly; to reflect technological advances, legislative changes and the progress of health and social care integration.

This list of tasks is neither prescriptive, exhaustive nor needed in all cases, and will depend on which tasks are identified as most likely to meet agreed outcomes, as identified in the person's care and support plan. It should not preclude alternative solutions which may better suit a person (for example telecare). Where the person requires support in decision making or lacks the mental capacity to make specific decisions for themselves, the Principles of the Mental Capacity Act 2005 must be applied.

If "medication only" tasks or single "health" care needs tasks need to be carried out for a service user then this will be looked at on an individual case by case basis and liaison will occur between Health & Social care.

It should be noted that many of the activities are routinely performed by relatives and that adults should be encouraged to perform some of the health care tasks for themselves where appropriate.

A range of equipment is available to support individual service users receiving homebased care & support.

Service users may be able to access benefits such as the attendance allowance to pay for any their social care or health care needs. https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/benefits-for-over-65s/

Funding of social care and healthcare tasks

The tasks that need to be undertaken to meet an individual service user's needs and circumstances will be reviewed jointly by commissioners from Health/CCGs and social care to ensure the appropriate funding is in place (Local Authority funded, Continuing Health Care funded or Joint funded) and where appropriate for delegated tasks, this includes the provision to cover costs for any necessary training and competence assessment

Intermediate level tasks can be undertaken by social care staff providing their organisation has trained them and appropriate insurance is in place. Continuing Health Care or Joint Funding should be agreed prior to social care staff undertaking these tasks. This is to secure the appropriate funding and ensure robust processes are implemented regarding the specific roles & responsibilities of all involved.

Section 1

This is a description of the tasks routinely undertaken by social care staff, those which can be undertaken by social care on behalf of Healthcare Professionals and tasks which remain the responsibility of Healthcare Professionals. Additional information and notes for consideration by providers and social care staff are included regarding some of the tasks listed.

Definitions of low, intermediate and advanced levels of health & social care tasks

Low Level – As outlined in the Care Act, if a service user has an eligible need these activities can be routinely undertaken by all social care staff.

Intermediate Level – As outlined in the Care Act, if a service user has an eligible need, providers can also support with intermediate level tasks.

- The decision to allocate a healthcare task to social care should be made by a registered practitioner who is occupationally competent in the task, delegation of tasks must be in the best interest of the person receiving care and support.
- Where tasks are delegated, the Healthcare Professional must provide written procedures for social care staff to follow, as well as how ongoing clinical reviews of the persons' needs is maintained and by whom.
- The Healthcare Professional delegating to social care staff must identify and inform the provider of the type of training required for the type of task being delegated.
- Intermediate tasks must only be completed by staff who have completed the appropriate training followed by assessment and confirmation of competence. The training will give social care staff the knowledge, confidence and competence to undertake the task.
- The provision of appropriate training and competency assessment will vary depending upon the task, training can be delivered by a Healthcare Professional or competent person (either within the provider organisation or sourced from external organisations)
- The training could be generic and applicable to any service user or specific and particular to an individual service user, this would need to be proportionate to the specific tasks and individuals needs and circumstances.
- Training and competence to perform these tasks must be re-assessed on a regular basis. It is advisable to refresh knowledge and reassess competence annually.
- Social care staff may not assess an individual or make clinical decisions based on their own assessment; therefore Healthcare Professionals need to make arrangements for ongoing oversight and contact arrangements for advice and reassessment and ensure these are communicated as part of the procedures produced for social care staff.
- Social care staff responsible for completing risk assessments for undertaking Intermediate tasks must have completed specific risk assessment training.

Advanced Level – tasks which can only be carried out by Healthcare Professionals.

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Assistance with mobility	**Transfers** (e.g. Getting up/going to bed, transferring from a chair/wheelchair to a commode) Utilisation of all appropriate moving and handling equipment an individual service user has been assessed as needing e.g. hoists, stand aids, turners, glide sheets, handling belts etc.			
Personal Care	**Washing, bathing & hair care** Using appropriate equipment if needed			Social care staff must respect the personal religious beliefs and customs of the people they are supporting with regards to cleansing as long as it is within Health and Safety guidelines. If staff should notice any changes in an individual service user's appearance that may require attention e.g. rashes, blisters, sores etc. report to appropriate Healthcare Professional/manager and support the individual service user to seek medical attention.
	Dressing Using appropriate equipment if needed			
	Support with spectacles, hearing aids etc. May assist people to clean and put on glasses. May assist people to insert and adjust hearing aids.		Insert contact lenses not permitted by health or social care	

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Personal Care	**Apply sun creams, sun blocks, simple body moisturisers without prescription from a doctor or non-medical prescriber** If the service user has used these before. These preparations can be used as part of a personal care routine.			Products containing paraffin should be documented on the MAR chart e.g. Emulsifying ointment, Zinc ointment BP, Zinc and Salicylic Acid Paste BP, Diprobase® ointment, Hydromol® ointment, White Soft Paraffin, Liquid paraffin 50% WSP 50% ointment, Dihranol ointment, Epaderm and Imuderm liquid due to the flammability risk when applying to large areas.
	Shaving with an electric shaver			
	Wet Shaving Following consultation with Healthcare Professionals regarding known infections, diseases, skin conditions or other medical conditions that may make wet shaving inappropriate for the individual service user or when an they are prescribed anticoagulants (Blood thinning agents e.g. Warfarin/Aspirin)			Where information about blood borne infection/diseases (e.g. Hepatitis/HIV/AIDS) is not sourced Risk Assessments should include risks associated with possible blood borne infections/diseases and any appropriate incidents reported to RIDDOR due to the absence of such information.
	Routine nail care Care of finger nails may be undertaken where a risk assessment indicates there are no contra-indications. Nails should be filed with an emery board.		Podiatry services provided on the basis of assessed need and in accordance with eligibility criteria.	

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Personal Care	**Dental Care & Oral hygiene** May assist individual service users to clean and insert false teeth. May assist individual service users to cleanse their natural teeth and perform mouth care tasks.			
	Support with menstruation care Support to apply, change, dispose of pads		Health or social care are not allowed to insert tampons	
Household	**General tidying** Including emptying bins, bed making, general tidying after carrying out tasks within the home			
	Cleaning Including cleaning things such as, floor areas (sweeping, mopping and vacuuming), baths, toilets, commodes (emptying and cleaning of), microwaves, ovens, work surfaces, crockery and cutlery			
	Ironing & Laundry			
	Shopping & Collecting Including shopping (May include shopping on-line) collecting, prescriptions, paying bills etc.			
	Fire Lighting As part of a Care Plan			
	Pet care Feeding/providing water/essential care			

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Care	**Care at night** (i.e. between 10 pm and 7 am)		If active health interventions are required e.g. specialist palliative nursing services i.e. through fast track or continuing health care. DN team also provide care through the night for catheter issues, and End of Life Care drug administration.	
	Respite for Carers On a regular and planned basis as part of the Service User's package of care			
General Health & Wellbeing	**Support with the organisation of essential day to day living activities** including household management and maintaining health and well-being e.g. assisting to make appointments, where the Service User has no other suitable person to offer support. Some of the time may be non-direct contact			
	Support with putting on appliances After having read the instructions (e.g. leg callipers, special boots, artificial limbs, trusses)	Social care staff could be trained in the application of specialist devices.	Social care staff will not: Adjust appliances or change the application without direction from healthcare professional.	Social care staff should always ensure that the individual service user is comfortable with the appliance after putting on. Report and record any difficulties experienced by the individual service user or staff member with putting on the appliance

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
General Health & Wellbeing	**Promote good health**	**Observation and monitoring of physical or mental health condition** where the Service User is under the supervision of a Healthcare Professional and specific guidance has been given as to the observations/monitoring required e.g. monitoring fluid charts	Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
Eating, Drinking, Nutrition & Hydration	**Basic food & drink preparation** Including associated kitchen cleaning and hygiene as appropriate	**Prepare modified liquids and food** Following a GP/SALT assessment **Use of drink thickeners** is covered in the "medication tasks" section of this policy	Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
	Assisting to eat and drink Where there is no identified risk of choking			

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Eating, Drinking, Nutrition & Hydration		**Assisting with feeds & fluids via a PEG (percutaneous endoscopic gastrostomy)** is covered in the "medication tasks" section of this policy	**Naso-gastric tube feeding** Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
Wound Care			**Wound care** including both simple and complex dressings (excluding application of Holding Dressings to pressure areas upon the advice of a healthcare professional see "Tissues Viability & Pressure Area Care)	
Tissue Viability & Pressure area care	**Supporting the maintenance and improvement of pressure areas** Through basic tissue viability advice/care and planned interventions such as positioning the person supported by the Tissue Viability Team Report and access appropriate health services as required upon identifying possible pressure ulcers	**Applying a "holding dressing"** without otherwise cleaning or treating the site Only with direction from a relevant Healthcare Professional as an interim measure until relevant Healthcare Professional can carry out required care. Not be completed on a regular basis, only when leaving a wound uncovered would increase risks. Agree	Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Social care staff should document who requested "holding dressings" are applied, hen this advice was given and when the dressing was applied.

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Tissue Viability & Pressure area care		**Clean & apply prescribed creams to pressure areas where the skin is not broken** (e.g. Grade 1 pressure sore)	Social care staff will not: Make any judgements on the care required Apply creams purchased by the service user to pressure areas Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
Continence	**Signpost** any issues to relevant services/agencies regarding continence		Manual evacuation of the bowel	
	Support to gain allocated or prescribed provision of incontinence materials (e.g. requesting deliveries/ringing regarding prescription)			
	Applying incontinence pads			
	Disposal of used incontinence materials			

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Catheter Care	**Catheter Bags** Empty day, night & leg bags Attach night bags to day bags Detach night bags from day bags For both urethral and supra-pubic catheters.	**Catheter Bags** Change day and night bags Keep the area clean where the catheter enters the body.	**Changing, inserting or removing catheters** Social care staff will not: Provide personal care where there is evidence of infection or soreness to the entry site. Make judgements on a person's health. Apply leg bags where there is broken skin	Social care staff should report any change in appearance of condition/bodily fluids, no matter how small to appropriate Healthcare Professional/manager and support the individual service user to seek medical attention. Risk assessments should be carried out regarding the application of leg bags.
		Intermittent self-catheterisation The individual service user does this themselves, Social care staff can be trained/briefed to help the individual	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Risk assessments & care plans should outline what the individual service user does themselves and what help Social care staff can provide
Male sheath (Conveen)	**Catheter Bags** Empty day, night & leg bags Attach night bags to day bags Detach night bags from day bags	**Change the sheath**	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Stoma Care colostomy/ ileostomy/urostomy	Empty the bags if the flange connection to the user does not have to be disturbed but NOT where "closed" systems are in use.	Empty the bags if "closed" systems are in use Support with the removal of the bag, cleaning the area and applying the new bag.	Social care staff will not: Provide assistance where there is evidence of infection or soreness to the site. Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Social care staff should report any change in appearance of condition/bodily fluids, no matter how small to appropriate Healthcare Professional/manager and support the individual service user to seek medical attention.
Post-Operative Care		**Post-Operative Care** Discharge reports and post-operative care guidance should be received by Social care staff. Specific support plans to be implemented for post-operative care needs as per Healthcare Professionals guidance. Information should be included about who to contact if there are any changes in a person's presentation/health & wellbeing following post-operative discharge	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Where Social care staff are involved in post-operative care and specific Healthcare Professional input has not been allocated to review following discharge from hospital, Social care staff should support the individual service user to seek a review from the GP to assess the post-operative care being delivered and the individual service users health and wellbeing

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Other		The taking of a **capillary blood test** - finger prick test (e.g. to test blood glucose levels)	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
			Bladder compression	
			Taking pulse or blood pressure readings	
			Assisting with the dialysis process	
			Fitting of prescribed supports for the control of hernias	
			Assisting with the cleaning and replacement of tracheostomy tubes	
			Oral suction	

Section 2 Medication Tasks for Homebased Care and Support Providers

This is guidance for **homebased care and support providers only**.

All homebased care and support providers must have a comprehensive medication policy (or may adopt /adapt the "Nottinghamshire County Council Assistance with Medication Policy") in order to support with medication tasks. If providers are using their own policy this must follow the principles and guidance included in the NCC policy.

Definition and requirements of levels of medication tasks

Level 1
Following induction, social care staff may carry out Level 1 support tasks.

Level 2
Following enhanced training and competency sign off, social care staff may also carry out level 2 support tasks.

Competency assessment and appropriate training should be delivered by a Healthcare Professional or competent person (either in their own organisation or an external organisation). Refresher medication training and competency will take place at least annually.

Level 3 (support tasks associated with a higher level of risk)

The following tasks are associated with a higher level of risk and must only be undertaken by social care staff who have also been signed off as competent to support with level 2 tasks.

Those marked with an **asterisk *** also require specific training and competency sign off before social care staff can carry out the specific task.

Competency assessment and appropriate training for specific medication tasks should be delivered by a Healthcare Professional or competent person (either in their own organisation or an external organisation). Refresher medication training and competency will take place at least annually.

All level 3 tasks should have the following:

- A specific risk assessment must be carried out by a competent person (someone who has received Risk Assessment training) for all level 3 tasks, this should be in conjunction with staff from applicable healthcare professions e.g. community nursing service, GP practice etc.
- A specific support plan for that area of need/task should be completed for those tasks marked with an **asterisk *** Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs and will provide Social care staff with information of contact arrangements for advice and reassessment.
- Input required should be negotiated on a case by case basis
- Responsibility will be retained by healthcare professionals with clear documentation, detailing roles and responsibilities.

Health Care only/Not permitted to be carried out by social care staff
Tasks which can only be carried out by health staff

	Level 1	Health Care only/Not permitted by Social Care Staff
Preparation of medication/ Non Administration	**Collect prescriptions from surgery or medicines from the pharmacy** when there is no alternative means of collection and delivery. Ensuring the name on the medicines matches the name on the MAR chart and that of the service user when delivered to their home.	Social care staff will not: Accept any change to medication unless it is clearly identified on the Medication Label.
	Make sure medicines are stored safely and securely in the individual service users own home	
	Note and record any change in the individual service user's ability to manage their medication. Notifying their line manager if there are any concerns.	

	Level 2	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Support to take oral medication**	
	Take tablets/ capsules out of pharmacy labelled containers, remove tablets/capsules from foil strips contained within an original pharmacy labelled pack. (NB assistance with medication may not be given for medicines that are not in their original pharmacy labelled containers).	Transferring medication from their original containers
	Shake bottles of liquid medicines and remove the bottle cap so that the individual service user can take the required dose.	
	Pour liquid into measuring cups, spoons	
	Draw up liquid into an oral syringe	
	Mix or dissolve soluble medicines	
	Insert an eye drop bottle into a compliance aid So that the individual service user can self-administer their eye drops. Assistance may only be provided for eye drops that have been prescribed by a doctor or non-medical prescriber.	

	Level 2	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Administer eye drops/ointment that** have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed. Prior to administration of eye drops the use of an aid to assist with instillation of eye drops should be tried (opticare available via prescription) and deemed to be unsuitable.	Provide assistance with any drops that are over the counter.
	Administer ear drops that have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed.	Provide assistance with any drops that are over the counter
	Administer nasal drops, nasal creams or nasal sprays that have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed.	Provide assistance with any drops that are over the counter
	Assist with the use of inhaler devices By passing the device to the individual service user, inserting a capsule into the device or, where necessary, press down the aerosol canister when the inhaler is used in conjunction with a spacer device. Prior to assisting with inhaler devices, the use of a compliance aid should be tried.	Make decisions on when required inhalers
	Application and removal of transdermal patches With appropriate documentation to include body maps regarding application sites & where applicable, monitoring charts for rotation of application.	
	Apply creams and ointments To clean skin and only to the area it has been prescribed for by a doctor or non-medical prescriber. Only apply to skin that is **not** broken or inflamed (unless documented as the reason it is being applied). Any concerns on the skins condition should be reported to line manager.	
	Use of drink thickeners That have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed. There needs to be a regular review from the prescriber.	Supplement drinks on advice from anyone other than a relevant medical professional which must be recorded.
	Compression stockings Provided they have been prescribed by a doctor or non-medical prescriber and a shared care agreement is in place with the community nursing team. The agreement details the reasons for use, responsibilities of healthcare staff and social care staff, including how often stockings need to be changed. The Nottinghamshire Community Health nursing team and prescribing advisor have developed a 'working in partnership agreement' for assistance with application of compression hosiery (Information can be found within the START Medication Policy – Appendix 3 regarding agreements for application of compression hosiery)	Apply stockings where there are areas of broken skin

	Level 3	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Administration of Controlled drugs** Administered in the same way as all other forms of medication, however, their documenting and storage may be different for some individual service users. (Examples include morphine tablets and solution; buprenorphine sublingual tablets; oxycodone tablets, capsules and solution.)	
	Cytotoxic oral medicines Administered in the same way as all other forms of medication, however, their documenting and storage may be different for some individual service users. These preparations are usually supplied from a hospital pharmacy. (Examples include methotrexate tablets, hydroxycarbamide capsules, fluorouracil cream, mercaptopurine tablets and fludarabine phosphate tablets)	
	Administration of Warfarin Under no circumstances should social care employees remind/ assist/administer with warfarin that is not in the original container. The dose should always be checked against written instructions provided by the anticoagulant clinic or GP practice.	
	PRN Medication Some medication will only be required to be taken when needed e.g. painkillers A clear protocol must be in place which includes the following: • Why it is needed (e.g. for pain) • When should it be taken/dose interval (e.g. four hourly, when required) • Time needed between doses • Maximum dose/quantity to be given in any 24 hour period • Clear information about what would indicate that the medication should be administered ('for pain' or 'for agitation' is not adequate) Where an individual service user lacks the capacity to identify when PRN medication is required the protocol must include the behavioural indicators that the individual service may display when they need the medication. Advice and guidance should be sought the doctor or non-medical prescriber to inform the assessment. The following should be recorded on the MAR chart: • Actual dose given (where this is variable) The effect of the medication (if known); usually recorded on the back of the MAR chart.	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.

	Level 3	Health Care only/Not permitted by Social Care staff
Medication & prescription only	**Administration of Buccal midazolam** * (Examples include Buccolam and Epistatus)	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.
	Support with TED (Thrombo-Embolic-Deterrent)/ compression stockings * Provided they have been prescribed by a doctor or non-medical prescriber and a shared care agreement is in place with the community nursing team.	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment. <u>Social care staff will not:</u> Remove or apply TED stockings.
	Assisting with the use of oxygen at home * via a pre-set facility **ONLY** Report and access appropriate health services as required upon if concerned regarding oxygen intake. • Assist the individual service user to fit the mask/tube. • Switch the machine on or off as required. • Notify appropriate Healthcare Professional/manager when pressure gauge indicates the contents of the cylinder are running low.	<u>Social care staff will not:</u> • Make any decision as to when the oxygen is or is not required. • Set any controls to regulate the flow of oxygen. • Change oxygen cylinders. Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.
	Support with use of nebulisers & medication via a nebuliser* Provided they are routine and have been prescribed by a doctor or non-medical prescriber. Medications should preferably be pre measured	The administration of medicines through a nebuliser for acute/emergency conditions
	Support with use of a PEG (percutaneous endoscopic gastrostomy) * Only using feeds, fluids and medications prescribed by a doctor or non-medical prescriber. Ensure tubes are clean and running free - Inserting water through the tube before and after the feed. Clean PEG site area when required and attaching the pump Attaching feeds, inserting fluids into the tube using the correct utensils provided. Insert medication into the tube as per MAR chart using the utensils provided.	<u>Social care staff will not:</u> • Make decisions about the quantity, content and speed of the feed provided. • Rectify any faults identified with the feed apparatus. • Flushing to unblock the tube Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.

	Level 3	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Administering laxative suppositories*** Must be linked to a review by a Healthcare Professional	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.
	Administration of Adrenaline auto-injectors * Brands include EpiPen, Jext and Emerade. These devices are prescribed to people with allergies who are at risk of having a severe allergic reaction (anaphylaxis). The devices and dose administered can differ between brands, therefore the risk assessment & support/care plan should be reviewed following each prescription/pharmacy dispense.	Social care staff will not: Make any judgements on the dose required by the individual service user Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.

	Health Care only/Not permitted to be carried out by Social Care staff
Medication & prescription only	Social care staff will not carry out any invasive procedure including:
	Rectal administration of creams or enemas Vaginal administration of creams or pessaries
	Injection or procedures which break the skin (with the exception of an adrenaline auto injector e.g. EpiPen) including administration of insulin
	Syringe drivers
	Assisting or supporting the individual service user with medication that has not been prescribed by the individual service user's GP
	Any procedure that requires the Social care staff to make medical judgements.

This policy replaces the "Responsibilities for Care in the Home" 2010 document.

GLOSSARY

Carer - A family member or friend of the service user who provides day-to-day support to the service user without which the service user could not manage

Care and Support Plan - A document that explains the type of support an individual needs, how this support will be given & the responsibilities of people involved in care delivery

CCG - Clinical Commissioning Groups

Competency Assessment – The system to measure and document that social care staff are applying the knowledge, skills and behaviours required to perform specific tasks.

Health/CCG – NHS (National Health Service)

Homebased Care & Support Providers - Also known as domiciliary agencies are private, independent organisations which provide staff who support individual service users in their own home.

Healthcare Professional – A person qualified in a healthcare related profession, who is regulated by statute and so is specifically accountable to their regulatory body as well as to their employer. Healthcare Professionals may include; Nurses, GPs, Physiotherapists, Occupational Therapists, dieticians, Speech & Language Therapists and psychiatrists (this list is not exhaustive).

Joint Funding - a package of care which is jointly funded between the local authority and health.

Local Authority – Nottinghamshire County Council

NHS Continuing Health Care Funding – Is funding through the NHS for people who are assessed as having significant ongoing healthcare needs.

PRN – pro re nata – medication as needed

RIDDOR – Reporting of injuries, diseases and dangerous occurrences regulations

Risk Assessment – A document that records what might cause harm to people when carrying out a certain activity and the steps that will be taken to prevent or reduce that harm

SALT – Speech and Language Therapy

Social care staff - Staff employed by Homebased Care & Support providers to support individuals in their own home.

Title:
Assistance with medication policy for Short Term Assessment & Re-ablement Team (START) re-ablement support workers operating in a service users home

Aim / Summary:
To detail the principles that must be followed by re-ablement support workers in relation to medication.

Document type *(please choose one)*			
Policy	*X*	*Guidance*	
Strategy		*Procedure*	

Approved by:	***Version number:*** *3.0*
Date approved:	***Proposed review date:***

Subject Areas *(choose all relevant)*			
About the Council		*Older people*	*X*
Births, Deaths, Marriages		*Parking*	
Business		*Recycling and Waste*	
Children and Families		*Roads*	
Countryside & Environment		*Schools*	
History and Heritage		*Social Care*	*X*
Jobs		*Staff*	
Leisure		*Travel and Transport*	
libraries			

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Please include any supporting documents	
1.	
Review date	***Amendments***
September 2014	*Addition of Bassetlaw CCG GPs and community pharmacists contact details*
December 2015	*Addition of updated Medicine Risk Assessment Form*
January 2019	*Review of policy*

Nottinghamshire County Council Adult Social Care, Health & Public Protection

ASSISTANCE WITH MEDICATION POLICY FOR START RE-ABLEMENT SUPPORT WORKERS OPERATING IN A SERVICE USER'S HOME

Contents:

1. INTRODUCTION

This document details the policy on the safe and secure handling of medicines by the Short Term Assessment and Re-Ablement Team (START) staff of Nottinghamshire County Council (NCC).

Care providers need to ensure they can respond to the Care Quality Commissions (CQC) 5 key questions for services

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

CQC Inspectors will use professional judgement, supported by Key Lines of Enquiry (KLOEs) and evidence, to assess services against these five key questions.

It is important that care providers:

- Handle medicines safely, securely and appropriately
- Ensure that medicines are prescribed and given by people safely
- Follow published guidance about how to use medicines safely

This policy sets out the principles that must be followed throughout the START service of the Council so that the CQC fundamental standards of quality and safety are met. It provides clarity on the medication tasks that can be undertaken by START staff (following training and assessment of competency) and those tasks which should remain the responsibility of healthcare.

All medication is potentially harmful, if not used correctly, and care must be taken with its storage, administration, control and safe disposal. It is important therefore that START employees who provide support are confident about their role in the management of medication.

The responsibilities of health and social care staff in relation to tasks other than medication are set out in the policy on "*Responsibilities for Care in the Home', June 2010,* (the Wavy Line document), available via the re-ablement manager and team managers.

There may be occasions where situations are not covered in this policy. Therefore any concerns must be brought to the attention of the workers line manager or person on call.

Independent home care providers who are contracted by Nottinghamshire County Council to provide medication support as part of a package of care may wish to use/adapt this medication policy to reflect their local service.

1.1. Consultation

Consultation on previous versions of this document occurred widely within Nottinghamshire County Council, Nottinghamshire Clinical Commissioning Groups (CCGs) and Nottinghamshire Health community groups. The groups listed below were involved in the original consultation process and supported the medication policy as set out in this document.

NHS Nottinghamshire County and Bassetlaw

NHS Nottinghamshire County Medicines Operational Group
NHS Nottinghamshire County Community Pharmacy Development Group
Nottinghamshire Local Pharmaceutical Committee - covers Nottinghamshire County, Nottingham City and Bassetlaw CCGs
Nottinghamshire Local Medical Committee, (electronically). Covers Nottinghamshire County, Nottingham City and Bassetlaw CCGs
Nottinghamshire Community Health locality service managers
Bassetlaw PCT Provider Clinical Governance Group
NHS Nottinghamshire County Medicines Management Sub-Committee,
NHS Nottinghamshire County Quality and Risk Sub-Committee
Nottinghamshire Community Health Senior Management Team

Nottinghamshire County Council

START Countywide Operational Managers
Unions
Independent providers of homecare services
Risk Safety Emergency Management Group (RSEMG)
Commissioning Managers (COMMS)
Adult Care Management Team (ACMT)
Safeguarding Adult Mental Capacity Act Team (SAMCAT)

Due to the restructuring of NHS organisations some of the above mentioned groups now cease to exist. The following additional groups/ staff were therefore involved in the consultation and/or the review notification process.

Greater Nottingham CCGs Medicines Optimisation Committee, Mid- Notts CCGs Joint Prescribing Sub group, Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and Nottingham University Hospitals NHS Trust Pharmacy staff.

Feedback was also sought from START and NCC staff on previous policy content and how this translated to patient facing care. Domiciliary care policies were also viewed from councils both locally and nationally to establish that the contents of this policy were in line with local and national thinking.

1.2. Working together and taking risks

All members of staff have an important role to play in risk identification, assessment and management of medication. It is important the service learns from events and situations where things have, or could have gone wrong in order that the reasons for the occurrence of the event or situation can be identified and rectified. This is to encourage a culture of openness and willingness to admit mistakes.

Service users may require social care support and health related input. This will necessitate employees from all agencies to work together in partnership to meet individuals' needs.

Nottinghamshire County Council fully indemnifies START staff against claims for alleged negligence provided they are acting within the scope of their employment and following guidelines set out within this policy.

1.3. Capacity and Consent

The majority of service users take responsibility for taking their own medication and their independence should be supported as much as possible.

This part of the policy should be read in conjunction with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice.

1.3.1. Any professional who prescribes medication has a responsibility to assess that their patient / service user has capacity to consent to treatment with medication at the point of prescribing, or, if the person lacks capacity, that it is in their best interests to take the medication. Any advance decisions to refuse treatment should be taken into account by this professional.

1.3.2. Within the START service a peripatetic (peri)-re-ablement support worker or a re-ablement manager will undertake an assessment of the service user's ability to manage their medication, during their first visit. They will then have a separate responsibility to ensure the person has capacity to consent to medication assistance (if applicable) or, if the person lacks capacity, that it is in their best interests to have medication assistance.

1.3.3. Consent must be given by the service user in writing during the first visit with the peri-re-ablement support worker or re-ablement manager, before re-ablement support workers may support with medication related tasks (whether this is reminding, assisting and or administration tasks). If the service user appears to lack capacity to give consent for medication assistance, the peri-re-ablement support worker or re-ablement manager will undertake a mental capacity assessment.

1.3.4. If the service user lacks capacity, the peri-re-ablement support worker or re-ablement manager must check if there is a Lasting Power of Attorney (for health and welfare) who may have authority to make the decision about assistance with medication. If not, when a service user is assessed as lacking capacity a best interests decision must be made by the peri- re-ablement support worker or re-ablement manager on their behalf consulting relevant people based on the best interests checklist and local guidance taking into account any advance statements. A record must be made in the health section of the service users support plan of the reasons and circumstances of the best interest's decision and who was involved in the process.

1.3.5. Confirmation of consent for support with medication will be noted on the service user's support plan. Unless it has been concluded that the service user lacks capacity to provide authorisation, the service user should sign to confirm authorisation on the support plan.

1.4. Authorisation

1.4.1. Re-ablement support workers and peri re-ablement support workers must only support with medication related tasks following authorisation by their line manager, and where the authorisation of the service user has been obtained or where a record has been made in the health section of the support plan identifying it is in the best interests of the service user to receive assistance (see 1.3).

1.4.2. All re-ablement support workers and peri re-ablement support workers can undertake Level 1 support tasks once they have received induction training and provided conditions described in sections 1.3 and 1.4 apply. Level 2 tasks may only be undertaken following enhanced training and once confirmation of competency has been signed off by their line manager and provided conditions described in section 1.3 and 1.4 apply.

1.5. Reporting concerns

1.5.1. Re-ablement support workers and peri re-ablement support workers must report any concerns relating to a service user's medication to their line manager (or if out of hours the person on call).

1.5.2. Where a service user has responsibility for their own medicines and the re-ablement support worker is concerned about the service user's ability to continue to manage their own treatment, the re-ablement or peri re-ablement support worker must report this to their line manager (or if out of hours the person on call). It is the responsibility of the line manager to arrange a further assessment of the service user's need for assistance with their medication.

1.5.3. If the peri or re-ablement support worker has any concerns about any aspects of medication assistance in relation to a service user who lacks capacity, this must be notified at once to the re-ablement manager.

2. AIMS AND PRINCIPLES

The aim of this policy is to provide clear guidance to the re-ablement support worker, service user, and their relatives as to the nature of support that may be given with medication administration by paid carers in the domiciliary setting.

The result of using this policy must be that service users have the,

- **Right medicine**
- **Right dose**
- **Right time**
- **Right route**

and medication is assisted/administered to the **Right person.**

The recent NICE guideline 67 “Managing medicines for adults receiving social care in the community” also states service users have a **Right to decline.**

The following **principles** will also apply:-

- Independence will be promoted, encouraging service users to manage their own medicines as far as they are able, and for as long as possible
- The service user’s independence at home will be maintained
- If the person is assessed as lacking capacity, the principles in the Mental Capacity Act must be applied.
- Where there is no carer or other responsible adult willing and able to assist service users to take their medicines at home, or where the service user requests that informal carers are not to be involved in administration of their medication, START staff will undertake this task as part of the agreed personal care.
- Where START staff assist service users to take their medication there must be a formal agreement with the service user and their relatives as to which tasks are the responsibilities of START.
- Any assistance provided with medication will be by trained competent employees.
- The START service will not be provided solely for the purpose of administering/assisting with medication however, this may be considered as an interim arrangement on a case by case basis. At point of discharge, where there are medication only needs, ASCH will be unable to provide an ongoing service”.

3. ROLES AND RESPONSIBILITIES

There are three main roles of START staff involved with supporting a service user with their medication, these are a re-ablement support worker, peri re-ablement support worker and the re-ablement manager:-

3.1. Responsibilities of the re-ablement support worker

The re-ablement support worker must,

- Adhere to procedures set out in this policy.
- **Not** undertake Level 1 medication support tasks until induction training has been completed
- **Not** undertake Level 2 medication support tasks until they have received training and been signed off as competent.
- Concentrate on support with medication tasks to the exclusion of all other duties and distractions.
- Talk to the service user about the support they are providing with their medication. The views of the service user should be taken into account and acted upon as appropriate.
- Ensure the service user's name and the name of the medication on the container match with the Medication and Administration Record (MAR) chart.
- Record all provision of support with medication as detailed in section 12 on the MAR chart including any refusal/omission of medication along with reason for the refusal occurring.
- Ensure they complete the authorised signature sheet in order to identify their signature. The signature sheet will be kept in the office bases.
- Notify the re-ablement manager (or person on-call) of any changes to a service user's medication regime so that the support plan can be updated by the peri re-ablement support worker or the re-ablement manager.
- Refer any observations/concerns about a service user's condition back to the re-ablement manager (or person on-call).
- Inform the re-ablement manager (or person on-call) of any risks and potential for error associated with medication in order that risk assessments can be undertaken and safe systems and processes can be implemented. In addition any occurrence of errors should be reported immediately (see section 14).
- Inform the re-ablement manager (or person on-call) immediately should they become aware of discrepancies in quantities of medicines. Whether the discrepancy is due to medicines being mislaid, stolen or the incorrect quantity being supplied by the pharmacy, a medication incident form should be completed in conjunction with their line manager.
- Ensure any reported medication changes are updated promptly in the support plan, and ensure arrangements have been made to update the MAR chart in line with procedure by the peri- re-ablement support worker or re-ablement manager. The support plan must be signed and dated by the service user and appropriate social care staff.

3.2. Responsibilities of the peri re-ablement support worker

As for the re-ablement support worker above with the addition of

- Undertakes the first visit to service users to introduce the service.
- Completes the service users support plan
- Carries out all risk assessments needed and mental capacity assessment, if required.
- Ensures details of current medicines are obtained (including any over-the-counter medicines and creams for personal care) and produces a MAR chart for the service user, which is then checked on a regular basis.
- Ensures the required medication is available in the service user's home
- Provides an on-call function out of hours.

3.3. Responsibilities of the re-ablement manager

It is the responsibility of the re-ablement manager to,

- Ensure that all peripatetic (peri) re-ablement support workers and re-ablement support workers can access/view a copy of this policy along with the summary of tasks that can be undertaken by each group.
- Provide information to all re-ablement support workers, as part of their induction training, as to what tasks they can and cannot undertake prior to receiving enhanced training and being signed off as competent to assist with Level 2 medication tasks.
- Ensure that re-ablement support workers and peri re-ablement support workers receive training on assistance with level 2 medication tasks and competency sign off in a timely manner. Records should be kept of the date training is undertaken and the date of competency sign off.
- Establish that the re-ablement support worker and peri re-ablement support worker is competent in the EPDR each year.
- Undertake a new competency on each re-ablement support worker and peri re-ablement support worker every year.
- Ensure a MAR chart and the required medication is available in the service user's home.
- Line manage peri re-ablement support workers and re-ablement support workers

Managers must,

- **Not** request any staff to undertake Level 2 medication tasks prior to them receiving training and subsequently being signed off as competent.
- Ensure any reported medication changes are updated promptly on the support plan and ensure arrangements have been made to update the MAR chart in line with procedure. The support plan should be signed and dated by the service user and appropriate START staff.
- Ensure an up to date authorised signatories list is maintained in order that signatories on the MAR chart can be easily identified by staff.
- Provide support to employees who report errors and facilitate a culture of "Fair Blame". Implement a fair blame culture in which staff are not blamed, criticised or disciplined as a result of a genuine slip or mistake that leads to an incident. Disciplinary action under Nottinghamshire County Council's

Disciplinary Procedure may still follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm.

- Ensure where an error has been reported, or the re-ablement manager is made aware of potential for an error to occur, a review of systems and processes is undertaken, in conjunction with the team manager to determine appropriate actions.

3.4. Responsibilities of the Occupational Therapist & Community Care Officer (Occupational Therapy)

It is the responsibility of the Occupational therapist and Community Care Officer (Occupational Therapy) to:-

- Participate in appropriate training on the medication policy in order to become familiar with it.
- Keep up to date with any memos, amendments or changes to the policy.
- Abide by the procedures set out in the Medication policy
- Ensure that any START Goal Plans or Support Plans comply with the procedures set out in the Medication Policy.
- Notify the Re-ablement Manager of any changes to a service users medication regime that they become aware of.
- Notify the Re-ablement Manager immediately if they become aware of any concerns.

4. ACCOUNTABILITY

All START staff are accountable for ensuring they comply with the Council's START medication policy. They should only undertake actions for which they have been trained and have been deemed competent to do so. In cases of uncertainty they should refer to their line manager.

5. ASSESSING LEVELS OF SUPPORT

This is key to the whole process to identify what assistance is required. It will also highlight service user's whose medication needs are beyond the knowledge and competence of the Re-ablement Support Workers.

5.1. First visit

Following referral the first visit must be undertaken by a peri re-ablement support worker or a re-ablement manager.

As part of the visit the peri-re-ablement support worker or the re-ablement manager will speak to the potential service user and complete:-

A Support with Medication Risk Assessment form (START/AMP/7)
This will determine the level of support, if required, by the service user.

A support plan
This will detail the level of support to be provided to the service user. It must include an up to date list of prescribed medicines from the service users GP or a hospital discharge letter. Information should also be clarified as to any medicines the service user is taking which they have bought themselves and any creams used for personal care. The service user must sign the relevant sections of the support plan, including the statement of permission to identify that they consent to a level of service support. A first contact form must also be completed, if applicable.

Where START staff support service users to take their medication there must be a formal agreement with the service user and their relatives as to which tasks are the responsibilities of the START staff. This must be clearly documented in the support plan and form START/AMP/1 completed where there may be a necessity to clarify in more detail. For example, where relatives are in dispute over what is provided and by whom or where there is shared responsibility

Even when staff do not routinely give medicines, it is important to document whether the service user has any medicines, what the medicines are and the dosage instructions on the dispensing label.

Warfarin Risk assessment form
This must be completed if it is identified that the service user is prescribed warfarin.

Mental capacity assessment
If the support with medication assessment form identifies a possible issue with capacity then a mental capacity assessment (MCA) must be undertaken and the results documented. The MCA will be completed by the peri re-ablement support worker or re-ablement manager. See section 1.3 for additional information.

Production of a MAR chart
If the assessment form identifies that the service user requires support with their medication by the START team the peri-re-ablement support worker or re-ablement manager will produce a MAR chart for the service user. See section 9. The MAR chart will then be checked by the peri- re-ablement support worker on the first day of their subsequent shifts.

5.2. First visit outcomes:

At the end of the first visit the outcomes will be one of the following:-

- The service user is able to self-medicate **all** their prescribed medication. Therefore no further action required with medication from the START service
- A family member or informal carer assists them with **all** their prescribed medication.
  Therefore no further action required with medication from the START service
- A family member or informal carer assists with some of the service user's medication e.g. they may assist with a tea-time dose of medication. Hence support required from START service at other administration times.
- Service user requires support from the START service. The support can include verbal reminders, the use of compliance aids, preparation, assistance and administration. For example a service user may be able to self-medicate some of their medication but not others, or a service user may require administration support with all their medication.

In all cases where support (including verbal reminders) is to be provided by the START service a MAR chart must be completed and kept at the service user's home. This will be checked on a regular basis to ensure medication has been documented correctly e.g. no missing administration signatures.

As per above if family members or informal carers assist with a service user's medication this must be clearly documented in the support plan and a START/AMP/1 form completed. This ensures that family members or informal carers understand their responsibilities, including signing the MAR chart to document that they have assisted with a dose of medication.

Joint working between health and social care is important to ensure service users receive integrated person-centred support. The START service should notify the service users GP and supplying pharmacy when starting to provide medicines support.

A range of compliance aids are available to help service users administer their medicines independently. START staff should contact the service user's community pharmacist for advice. (See appendix 7 and 8)

Service users who may need support with medication would include those with:

- No sight/partial sight
- Severe mental health problems
- Complex medicine regimes
- Dementia
- Learning difficulties
- Poor mobility or manual dexterity
- Stroke
- Arthritis

- Multiple Sclerosis /Parkinson's disease
- Poor literacy
- Inability to read or interpret
- Language barriers

It should be noted that if any START staff notices a change in the service user's condition, they must contact their line manager to arrange a review of the service user's support with medication risk assessment.

6. TRAINING AND COMPETENCY ASSESSMENTS

Following induction training all re-ablement support workers will be able to assist with Level 1 medication tasks.

On induction all staff will be expected to successfully complete the following:

- Attend a medication training session specified by Nottinghamshire County Council
- Work through the Supporting with Medication workbook
- Answer a selection of short questions and scenarios as part of the knowledge assessment
- Demonstrate competency to undertake tasks as specified in this policy by observation or simulation.

Competency will be assessed and signed off by the Re-ablement Manager.

Only trained certificated re-ablement staff who have demonstrated competency are able to undertake Level 2 assistance with medication tasks.

All staff will have refresher medication training and undertake a competency assessment every year.

7. ORDERING, COLLECTION AND STORAGE OF MEDICATION

7.1. Appropriate arrangements must be taken to ensure there is a continuous supply of medication for the service user.

7.2. It must be clearly documented how the service user orders their medication how it is obtained (collected) and who is responsible for this.

7.3. Requests for a supply of medication i.e. ordering from the service user's GP, should wherever possible remain the responsibility of the service user, or their relatives. In exceptional circumstances where this is not possible a re-ablement support worker may undertake this task following authorisation from their line manager, and this must be documented in the support plan.

7.4. Re-ablement staff may collect prescriptions from the surgery and or medicines from a community pharmacy.

7.5. If re-ablement staff assist with the collection of medication from a community pharmacy or dispensing doctors, this must be collected and returned directly to the service user's home. Staff should transport medication out of direct view.

7.6. Re-ablement staff should ensure that all ordered medication has been received from the community pharmacy. They must check that the name on the medications matches that of the service user and the MAR chart. Staff must contact their line manager (or person on-call) for advice if an item is missing or is owed by the pharmacy. If an item is owed it must be documented in the support plan who and when it will be collected for the service user.

7.7. Re-ablement staff that collect schedule 2 or 3 controlled drugs from the community pharmacy or dispensing doctor, will be required to show proof of identity and sign the back of the service user's prescription.

7.8. Medicines should be stored appropriately in the home environment, e.g. out of reach of children and animals. Medicines should not be exposed to extreme temperatures (hot or cold) or to excessive moisture. As part of the risk assessment process, any specific issues for the safety and storage of medication will be identified in the support plan.

7.9. Medication should be left in a safe place that is known and accessible to the service user. Where, following risk assessment and in line with the Mental Capacity Act, it has been determined that the service user is unable to take safe control of their medication and re-ablement support staff are responsible for the administration of medicines, medication should be stored safely and appropriately in accordance with instruction documented in the support plan. Other relatives, carers and health professionals should be told where it is stored.

7.10. When medication is stored away from the service user (as per 7.9) it may be more appropriate for a family member or re-ablement staff to collect the service user's medication rather than arrange for it to be delivered to the service user's home by their community pharmacy.

7.11. Medication safes are available for relatives to purchase for safe storage. Staff should contact their line manager for further details.

7.12. Medication that has to be stored in the refrigerator should be held in a separate re-sealable container to avoid cross contamination with food. These medicines should not be stored in or adjacent to the ice box/freezer compartment.

7.13. Whenever new medication is received into the service user's home expiry dates should be checked and medication stored in such a way that those medicines that expire first are used first.

8. MEDICATION SUPPORT TASKS

START peri and re-ablement support workers may assist a service user to take medication that has been prescribed by the service user's general practitioner, dental practitioner, non-medical prescriber or hospital doctor responsible for aspects of the service user's medical care.

8.1. Level 1 & 2 medication support tasks for START staff

Following induction training peri and re-ablement support workers may carry out **level 1 support tasks**. This means they can,

- Collect prescriptions from surgery or medicines from the pharmacy when there is no alternative means of collection and delivery. Ensuring the name on the medicines matches the name on the MAR chart and that of the service user when delivered to their home.
- Make sure medicines are stored safely and securely in the service user's own home
- Note and record any change in the service user's ability to manage their medication. Notifying their line manager if there are any concerns.

Following enhanced training and competency sign off, peri and re-ablement support workers may also carry out **level 2 support tasks**. This means they can,

- Take tablets/capsules out of pharmacy labelled containers, remove tablets/capsules from foil strips contained within an original pharmacy labelled pack. (NB assistance with medication may not be given for medicines that are not in their original pharmacy labelled containers).
- Shake bottles of liquid medicines and remove the bottle cap so that the service user can take the required dose.
- Pour liquid into measuring cups, spoons.
- Draw up liquid into an oral syringe
- Mix or dissolve soluble medicines or thickening agents.
- Insert an eye drop bottle into a compliance aid so that the service user can self-administer their eye drops. Assistance may only be provided for eye drops that have been prescribed by a doctor or non-medical prescriber.
- Administer eye drops/ointment that have been prescribed by a doctor or non-medical prescriber.
- Administer ear drops that have been prescribed by the service user's GP or non-medical prescriber.
- Administer nasal drops, nasal creams or nasal sprays
- Apply creams and ointments to clean skin and only to the area it has been prescribed for by a doctor or non-medical prescriber. Only apply to skin that is **not** broken or inflamed (unless documented as the reason it is being applied). This should only be undertaken when a service user is unable to do this for him or herself and there is no other appropriate person to assist

them. Any concerns on the skins condition should be reported to line manager.

- Apply sun creams, sun blocks, simple body moisturisers without prescription from a doctor or non-medical prescriber, if the service user has used these before. These preparations can be used as part of a personal care routine and are recorded in the personal care plan. Staff should not apply products containing paraffin due to the flammability risk when applying to large areas unless these have been prescribed.
- Assist with the use of inhaler devices by passing the device to the service user, inserting a capsule into the device or, where necessary, press down the aerosol canister when the inhaler is used in conjunction with a spacer device. Prior to assisting with inhaler devices, the use of a compliance aid should be tried.
- Apply transdermal patches for the treatment of Parkinson's disease e.g. Rotigotine.
- Support with compression stockings; provided they have been prescribed by a doctor or non-medical prescriber and a shared care agreement is in place with the community nursing team. The agreement (appendix 3) details the reasons for use, responsibilities of healthcare staff and social care staff, including how often stockings need to be changed., in addition form START/AMP/2 should be completed. Compression stockings are generally removed at bedtime and reapplied the following morning, but may be kept on for up to 7 days. Refer to section 9.13 for additional information.
- Support with Thrombo – Embolic Deterrant (TED) stockings; provided the service has been informed of the treatment duration for these. Refer to section 9.13 for additional information.

8.2. Support tasks associated with a higher level of risk

The following tasks are associated with a higher level of risk and must only be undertaken by peri and re-ablement support workers who have been signed off as competent to support with **level 2 tasks**. Wherever possible these tasks should remain the responsibility of the service user and or their relatives. However, where this is not possible the following must be undertaken before support from the START team is provided

- **A risk assessment must be carried out by the re-ablement manager this should be in conjunction with staff from the community nursing service and the service user's GP practice as applicable**.
- Input should be negotiated on a case by case basis in all cases involving support with the medication listed below.
- Responsibility will be retained by healthcare professionals with clear documentation, detailing roles and responsibilities.
- Additional documentation and training may be necessary. This will be agreed by the re-ablement manager and healthcare professionals with input from the NCC prescribing advisor as appropriate.

Tasks include, assisting with the administration (including reminding) of:

- **Warfarin** - under no circumstances should social care employees remind/ assist/administer with warfarin that is not in the original container from a community (or hospital) pharmacy or dispensing doctors. The dose should

always be checked against written instructions provided by the anticoagulant clinic or GP practice and documented clearly on the service users MAR chart.

- **Controlled drugs** – these are administered in exactly the same way as all other forms of medication however their documenting and storage may be different for some service users. This should therefore be determined as part of the service users care plan and a risk assessment completed if applicable. Examples include morphine tablets and solution; buprenorphenine sublingual tablets; oxycodone tablets, capsules and solution. Other controlled drugs may be considered, provided they are not for administration via injection.
- **Cytotoxic oral medicines-** these are administered in exactly the same way as all other forms of medication however their documenting and storage may be different for some service users. This should therefore be determined as part of the service users care plan and a risk assessment completed if applicable. Examples include methotrexate tablets, hydroxycarbamide capsules, fluorouracil cream, mercaptopurine tablets, fludarabine phosphate tablets. These preparations are usually supplied from a hospital pharmacy.
- **Adrenaline auto-injectors-** Brands include Epipen, Jext and Emerade. These devices are prescribed to people with allergies who are at risk of having a severe allergic reaction (anaphylaxis). The devices and dose administered can differ between brands hence an appropriate risk assessment/treatment protocol must be completed and training provided to staff by a healthcare professional prior to support from START being agreed. It must be specified in the assessment that START staff will not make any judgements on the dose required by the service user. Staff are also requested to familiarise themselves with the patient information leaflet for this product, which will be included as part of its packaging.
- **Buccal midazolam**- includes Buccolam and Epistatus. Risk assessment and individual treatment protocol must be completed and training provided to staff by a healthcare professional prior to support from START being agreed. Staff are also requested to familiarise themselves with the patient information leaflet for this product, which will be included as part of its packaging.
- **Transdermal patch medication**- Patches containing controlled drugs or dementia medication should not routinely be supported by the START service. Managers will assess whether a service user prescribed this type of medication satisfies the criteria for re-ablement.

8.3. Tasks that re-ablement staff CAN NOT undertake

These tasks include:

- Any invasive procedure including:
  - Rectal administration of creams, suppositories or enemas
  - Vaginal administration of creams or pessaries
- Wound care: including both simple and complex dressings
- Injection or procedures which break the skin (with the exception of an adrenaline auto injector e.g. epipen)
- Syringe drivers
- Any procedure that requires the re-ablement support worker to make medical judgements.
- Assisting with nebulised medication
- Assisting or supporting the service user with oxygen therapy
- Supporting with medication via a PEG tube
- Assisting or supporting the service user with medication that has not been prescribed by the service user's GP

A summary of these tasks can be found in Appendix 9.

9. ADMINISTRATION OF MEDICATION

Administration of medication for the purposes of this policy means supporting the service user to take medication. The type of support will vary and will be identified from the support with medication risk assessment form completed with the service user at their first visit.

9.1. Types of Support

Support can be:-

Verbal reminder - asking a service user if they have taken their medication or reminding them that it is time that they take it. (except where this occurs on an occasional basis). A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medication. This would be coded as **R** on the MAR chart.

Reminded and service user observed taking the medication -reminding a service user to take their medication and observing them taking their medication. This would be coded as **RO** on the MAR chart.

Prepared and service user observed taking their medication- handling the service user's medication in some way, i.e. preparing the dose required, either by shaking a bottle of liquid medication, mixing soluble medicines, taking tablets out of containers and putting onto a spoon/saucer or pouring liquids into measuring cups or onto a spoon or squeezing a tube of ointment for use. This would be coded as **PO** on the MAR chart.

Assisted e.g. pressing an inhaler device **Applied** e.g. applying a cream to a service user's skin or **Administered-** physically giving a service user their medication by either placing it in their hand or mouth. These would all be coded as **A** on the MAR chart as in all 3 scenarios the support worker is physically ensuring the service user has their medication.

9.2. Containers and monitored dosage systems

Re-ablement staff must only support with medication from containers that have been assembled and supplied by a community pharmacy, hospital pharmacy or dispensing doctor practice.

Medication may only be used if the container is clearly labelled with the service user's name, the name of the drug and the dosage. Most of the containers used today by pharmacists for packaging medication in are the manufacturers foil blister strip packs. Occasionally medication may be placed in brown plastic bottles or brown glass bottles for liquids.

A pharmacy may also supply the medication in a monitored dosage system (sometimes referred to as a blister pack). If so this should be clearly labelled with each medication in it. There should also be a means of identifying each tablet i.e. by description of tablets colour, markings etc.

If a label becomes detached from the container, is illegible, or has been altered, medication must not be used. Advice should be sought through the line manager who should seek further advice where necessary.

Please note: - Re-ablement Staff are trained to support service users from original containers as well as monitored dosage systems.

Community Pharmacists are not obliged to dispense a prescription presented to them in a monitored dosage system and are entitled to charge for this service, if the service user does not satisfy Disability Discrimination Act (DDA) criteria.

9.3. Medication Administration Record (MAR) charts

The standard NCC MAR chart (See appendix 2) must be used and maintained for each service user who is receiving support with medication tasks (level 2). A separate patch chart should be used to record administration of patches (see appendix 10). CQC refer to the guidance 'The handling of medicines in social care' published by the RPSGB which states that

'In every social care service where care workers give medicines, they must have a MAR chart to refer to. The MAR chart **must** detail

- Which medicines are prescribed for the person
- When they must be given
- What the dose is
- Any special information, such as giving the medicines with food'

The legal direction to administer a medication is as per the medication dispensing label. The MAR chart is a record of medication to be given and taken. Both the dispensing label and MAR chart must be an exact match. If this is not the case, the medication must not be supported with and the re-ablement manager must be contacted.

MAR charts must be completed correctly and in full to ensure a service user's safety. Handwritten medication details e.g. name of medication and dosage instructions must be in indelible ink, use capital letters and words used instead of numbers. For example a dosage must be written as "Two to be taken in the morning" not "2 to be taken in the morning". **All** medications must then be signed by that staff member who entered the information. This must then be countersigned by the next staff member who undertakes a visit to that service user to ensure that the MAR chart has been completed correctly. If the staff member has any concerns they must contact their line manager or person on-call immediately.

Any medications which are labelled "as directed" must be referred back to the service users GP for a specific dose to be defined.

Please note: "As per blister pack "must not be written on the MAR chart as it is not accepted by the CQC. This is because it does not satisfy the requirement of "which medications are prescribed for the person" and hence does not support a clear audit trail for the service user's care.

It is the staff member's responsibility who undertakes the first visit to ensure the correct medications are detailed on the MAR chart. This must be done through referring to the service users GP or a hospital discharge letter. On each entry it should be documented if the medication is in a blister pack (MDS) or box.

If the staff member is unsure about the service user's current medication and it is out of hours they should try to determine the current medication from the service user's relatives and notify their line manager. Advice may also be sought from the service user's usual community pharmacy (See appendix 7), NHS 111 telephone service or another community pharmacy, many of whom are now open 100 hours a week. Professionals working in these areas will be able to advise.

The MAR chart must be kept in the service user's home in an agreed location, and must be examined on each occasion that the re-ablement support worker attends the service user's home, in order to make themselves aware of any changes in medication.

Re-ablement staff must always check the MAR chart to ensure that the medication has not already been administered and, in addition, check verbally that the service user has not already taken or been given the medication. Re-ablement staff will also count the tablets in-situ prior to administration to ensure medication has not already been taken and document the number of tablets remaining on the MAR chart after administration. This will be done using gloves (or a counting triangle if available) for those tablets in bottles. For liquids, including oramorph, a visual check (no need to measure) should

be carried out to check that the quantity remaining is approximately what is in the bottle.

Where a service user remains in the service for over six weeks, the MAR chart should be copied and returned at regular intervals to the locality office (at least monthly). A new MAR chart will be written if required by the peri re-ablement support worker. Monitoring and oversight of the MAR chart will be maintained by the re-ablement manager.

Re-ablement support staff must record details of administration on the MAR chart at the time the medication is administered.

Where a service user receives support with medication from re-ablement staff and new medication is received into their home the quantity and date received should be recorded on the MAR chart by the peri-re-ablement manager or re-ablement manager. This also applies if there is discontinuation of medication or a change of dose.

9.4. Administration procedure

Medicines must only be supported with in accordance with the prescriber's specific instructions (Medicines Act 1968). The directions of how the drug must be taken will be detailed on the dispensing label attached to the medication.

Re-ablement staff must adhere to the following administration procedure:-

- Check that they are giving the right medication to the right service user by asking their name or asking an informal carer if unsure.
- Check verbally that the service user has not already taken or been given the medication.
- Check that the service user's name, the name of the medication on the container and the dosage instructions on the label match with the MAR chart. If there is a discrepancy the line manager must be notified.
- Check that there have been no recent changes in medication. If there is a discrepancy the line manager must be notified.
- Check the containers have been assembled by a community/hospital pharmacy or doctors dispensing practice and are clearly labelled.
- Check that the medication has not exceeded its expiry date. Eye drops should not be used if the date of opening exceeds 28 days. The date of opening should be marked on the eye drop bottle.
- Check the dosage instructions and any other specific instructions regarding time of administration e.g. before food.
- Check it is the correct time to administer the medication, paying attention to pain killing medication e.g. paracetamol, that must have at least four hours between doses.
- Check the label to determine if medication should be dissolved / dispersed in water before administration.
- Check the way in which the medication is to be administered e.g. eye drops left or right eye, etc.
- Check that the dose has not already been administered by checking the MAR chart and counting the tablets in-situ (gloves and counting triangle to be used

for tablets in bottles) or if in a pharmacy dispensed monitored dosage system that the tablets are not there. If there is a discrepancy the line manager (or person on-call) must be notified to make contact with the pharmacy/GP to find out if a further dose should be given.

- Measure doses of liquid medication using a 5ml medicine spoon, a graduated medicine measure or an oral syringe supplied by the pharmacist. Where a service user is experiencing difficulties with liquid medicines the re-ablement support worker must contact their line manager.
- Check old patch has been removed before applying a new one. Ensuring old patch is disposed of safely and gloves are worn.
- Ensure that if a thickening agent is prescribed this is mixed to the correct consistency.
- Ensure that compression stockings, if applicable, are applied correctly according to manufacturers instructions.
- Appropriate hand hygiene must occur before and after any direct handling of medication and before and after the wearing of disposable gloves.
- Medication must not be handled; solid dose forms e.g. tablets or capsules should be passed to the service user on a spoon or saucer. Disposable gloves must be worn by re-ablement staff where the dose has to be placed in the service user's mouth.
- Disposable gloves should be worn when applying skin treatments (e.g. creams, ointments, lotions). **Fire Hazard: all paraffin-containing emollients (regardless of paraffin concentration) and paraffin-free emollients, when used in large quantities, pose a fire risk which could result in severe or fatal burns. Service users should be kept away from naked flames, ignited cigarettes or open fires after the use of such preparations.**
- Check the service user has taken their medication and record this on the MAR chart straight away in the correct day and time box, using the appropriate code followed by the support workers initials.
- Ensure that medication is returned to its safe storage place
- Report any concerns about the service user experiencing any side effects from their medication.
- Report any concerns about any aspects of medication support in relation to a service user who lacks capacity at once to the re-ablement manager (or if out of hours the person on call)

When supporting with medication do not:

- Give medications from unlabelled or illegibly labelled bottles, containers or compliance aids.
- Give medications via a PEG line
- Give medications from compliance aids filled by family members
- Make alterations to the dosage directions on the dispensing label
- Force a service user to take their medication
- Transfer medication from their original containers to a different container for later administration by a third party such as a family member. If medication is required to be administered at a different setting e.g. day service or a visit to family – the medication should be sent in its original container and the MAR chart must remain in the service user's home.
- Prepare medicines or drugs in advance of administration. (Except in rare occasions see 9.5) Once prepared they must be used immediately or discarded.
- Handle medication directly when administering, as far as is practicable.
- Give discoloured solutions, disfigured tablets, substances etc. These must be returned to the community pharmacist.
- Give medication from containers that have **not** been assembled by a community pharmacy, hospital pharmacy or dispensing doctor practice.

9.5. Leaving medication out

Generally re-ablement support workers should **not** put medication out for the service user to take themselves at a later (prescribed) time.

There may be rare occasions when leaving medication out to be taken later enables the service user to have greater independence. For example, if Re-ablement staff visit at 7.00pm and the service user is prescribed sleeping tablets, it may be appropriate for these tablets to be put in an agreed accessible place for the service user to take later.

Before medication is put out a risk assessment must be undertaken and agreement obtained from the re-ablement manager. Arrangements agreed must be documented in the support plan and recorded as **O = Other** on the MAR chart.

No more than one dose of medication must be left out.

9.6. Crushing tablets, opening capsules, splitting tablets

Tablets must **not** routinely be crushed or capsules opened. There may be circumstances however where tablets or capsules may need to be crushed or opened to enable the service user to take their medication. This should be carried out with the service user's consent.

In these circumstances the following must apply:-

- Crushing or opening must be authorized with the prescriber and pharmacist using form START/AMP/4, as the efficacy and legal status of the medicine can be altered.
- Guidance on how to prepare the medication for administration by re-ablement support workers must be sought from the supplying pharmacy
- Information and authorisation must be recorded in the support plan.
- The direction to crush/open should be added to the dispensing label by the GP practice/Pharmacy
- The correct equipment should be used to crush tablets e.g. a pill crusher, available from community pharmacies.

Occasionally it may be necessary to split a tablet to achieve the required dose. If this is required this should be done by the service user's community pharmacy or dispensing doctor.

9.7. Imprecise or ambiguous directions

Where medication is labelled with imprecise or ambiguous directions e.g. 'take as directed', 'take as before', 'apply to the affected part' the re-ablement support worker must seek clarification through their line manager and/or service user's GP or community pharmacist. Clarification in writing using form START/AMP/3 may be necessary to gain confirmation of the intended direction of the prescriber and then noted in the support plan and on the MAR chart.

9.8. When required (PRN) medication

Medication with a when required (PRN) dose is usually prescribed to treat short term or intermittent conditions. The service user may not need the medication at every dosage time.

Where medication is to be taken on a when required (PRN) basis sufficient information should be available detailing the condition for which the medicine should be given, the interval between doses and the maximum dose in 24 hour period. Where the label does not provide this information, confirmation should be sought from the service user's GP using form START/AMP/5 and a note of the outcome made in the support plan and on the MAR chart if applicable.

The re-ablement support worker must document the actual dose the service user has received. This should be documented as an O code on the MAR chart with the dose details documented on the RSW medication notes section of the MAR chart.

If the frequency of PRN medication changes by increasing or decreasing then a referral to the service user's prescriber, via the line manager should be considered for a review of the service user's medication. This is because their medical condition may have changed and the treatment required may need altering.

9.9. Variable dosages

If a variable dose is prescribed e.g. one or two tablets or 5-10mls, the decision regarding the dose to take rests with the service user.

The re-ablement support worker must ask the service user how many they wish to take. If the service user is unable to decide or respond the re-ablement support worker must contact their line manager, who will seek advice from the prescriber. The circumstances in which the variable dose is to be taken must then be documented in the support plan. This should also be documented as an O code on the MAR chart with the dose details documented on the RSW medication notes section of the MAR chart.

9.10. Warfarin and new anticoagulants

Warfarin is a high risk drug due to the specific dosing required for each service user. Blood tests (INR) are carried out to determine the dosage of warfarin required. Robust arrangements are required to ensure that re-ablement workers support the administration of warfarin at the correct dose.

The level of support required with warfarin will be identified through completion of the support with medication risk assessment form. In addition the warfarin risk assessment algorithm (see appendix 4) must be followed, with completion of a risk assessment form to identify and control any additional risks.

All service users should have an “oral anti-coagulant therapy pack” commonly known as a “yellow book”. The INR results may be recorded in the yellow book or on an INR chart supplied from a GP surgery or hospital anti-coagulant clinic with the current dosage of warfarin to be taken. If START staff are assisting or administering warfarin to a service user they must check the yellow book or INR chart, which must be kept with the MAR chart, to check the dose of warfarin to be given each day.

The re-ablement manager may consider requesting a community pharmacist /GP to label the warfarin “to be taken as per INR chart/yellow book” as an additional reminder for START staff member to check that information.

If the yellow book or INR chart is not available START staff must not support the service user until the correct dose has been clarified. They must contact the re-ablement manager (or person on-call) for advice on who to contact.

If START staff support service users to attend healthcare appointments, dentist, hospital etc. they should take the yellow book to the appointment and inform the relevant healthcare professional that the service user is on warfarin.

It must be documented in the support plan how any communication related to changed doses will be addressed.

Staff should be aware that there are newer anticoagulants e.g. dabigatran, rivaroxaban and apixaban. These do not require regular monitoring of INR

but due to the risk of blood clots it is extremely important that a dose of these medications is not missed.

Due to the risk of bleeding when receiving anticoagulants if a service user suffers a knock or injury carers should inform their line manager and the service users GP as soon as possible for advice on what action to take.

9.11. Food and drink interactions

Some medicines can interact with certain foods and drinks. One of the most common ones is grapefruit juice. Similarly, milk can also affect some medicines by reducing the amount of drug that is absorbed by the body. The pharmacist may add this information onto the label.

Alcohol can interfere with the action of many drugs. Where a known interaction exists between a medicine and alcohol, a warning will appear on the label of the medicine container. If the service user appears to be intoxicated with alcohol or other substances, staff must not administer any medicine until their line manager (or person on-call) has been informed.

Further information on interactions can be found in the patient Information leaflet, in the BNF or by talking to a community pharmacist.

9.12. Food supplements and Thickening agents

Both of these items may be administered by the service providing they are prescribed and documented on the MAR chart.

Staff must ensure that they follow the mixing instructions on the label of thickening agents. This will include using the appropriate measuring spoon provided to ensure that the consistency made up is that specified on the dispensing label. If this is not correct, this must be re done to avoid the risk of choking.

Advice must be sought from the prescriber or speech and language therapy service in relation to the other medication prescribed to the service user to ensure this is not a choking risk also.

9.13 Support with TED and Compression Stockings

TED stockings

Thrombo- Embolic Deterrent (TED) stockings are recommended for patients who have had surgery or are bed ridden to prevent blood clots. The stockings should be worn all the time including through the night and may be worn for up to 3 weeks after which time they lose their elasticity. They are generally white in colour and are not available on prescription so are supplied normally by a hospital or district nurse.

As the TED stockings should remain in place, support with personal care may need to be adapted by START staff e.g. flannel washes instead of a shower or bath. The service should determine before the service user is supported by the START team the duration that the stockings are required to be kept on for. After this time they may be carefully removed taking care not to damage any fragile skin. Staff must contact their line manager if they are in doubt / concerned about their removal and support from the district nursing team may be required.

Compression stockings

Compression stockings are available on prescription they are generally brown in colour and may be below knee or above knee, closed or open toe styles. They have a higher compression than TED stockings, are generally only worn during the day and are removed at night. They are used to treat conditions such as varicose veins and so are worn for long periods of time e.g. years.

A shared care agreement Appendix 3 should be completed with district nursing staff to ensure that necessary checks have been undertaken e.g. ruling out of arterial disease and that any venous leg ulcers have healed. The agreement (appendix 3) details the reasons for use, responsibilities of healthcare staff and social care staff, including how often stockings need to be changed, in addition form START/AMP/2 should be completed. Compression stockings are generally removed at bedtime and reapplied the following morning, but may be kept on for up to 7 days. Staff must follow the manufacturers instructions on how to apply the stockings correctly ensuring that no skin is damaged. If worn incorrectly stockings may cause local pressure on toes leading to skin necrosis. Sometimes it may be recommended that a skin emollient is applied while the stocking is off to reduce skin dryness and irritation. Staff must contact their line manager if they are in doubt / concerned about their removal/ application and support from the district nursing team may be required.

As part of the reablement process a stocking aid may be required in order for the service user to apply stockings themselves. These are available from community pharmacies.

9.14 Application of eye drops and ointment

Staff must ensure that they follow strict hand hygiene rules when applying eye drops or ointment. Drops or ointments may be prescribed to treat dry eye conditions but also eye infections or prevent eye infections following eye surgery. Staff must ensure that dropper bottles or ointment tubes do not come into contact with the eye surface or lid. If staff observe there is a change in appearance of the eye area e.g. redness, weeping or inflammation they should contact their line manager for advice.

9.15 Application of transdermal patches

Patches must be applied to clean, dry, non-irritated skin generally on the torso, upper arm or shoulder area. Staff must record application on the MAR chart as well as the patch application record as per appendix 10, which details where the patch has been applied. Before another patch is applied the old one must be located, carefully removed and disposed of whilst wearing disposable gloves. Staff should refer to the manufacturers leaflet for information on where to apply the patch and any special instructions. The START service will support with those patches that contain medication to treat Parkinson's disease. For patches that contain different medication e.g. controlled drugs this must first be agreed with the START manager as to the service user's suitability to be supported by the START service.

10. OMISSIONS AND REFUSAL TO TAKE MEDICINES

It is a service user's choice not to take medication. Administration cannot be forced but some degree of encouragement may be given.

Medicines must not be administered covertly to anyone who is deemed to have capacity on whether or not they take medication.

If a service user refuses their medication or does not take their medication or a dose is omitted for any reason, an entry on the MAR chart must be made.

The reason for refusal/omission should be documented on the reverse of the MAR chart, for example, "following guidance from a health professional, Lactulose has not been given because the service user has diarrhoea".

If the re-ablement support worker has any concerns about the service user's medical condition and the appropriateness of a medication they should seek advice from a health professional and inform their line manager.

If a service user refuses their medication or does not take their medication the re-ablement staff should inform their line manager. They will make a judgement about whether to seek further advice.

11. COVERT MEDICATION

Medication must always be administered by consent with the full agreement and understanding of the service user, and, where appropriate, their relatives, wherever possible. Every effort must be made to obtain consent.

Where the service user is deemed to have capacity to make an informed decision, refusal of treatment must be respected. The re-ablement staff should endeavour to make enquiries as to why the service user is refusing their medication and report back to their line manager for notification to the service user's GP. Actions undertaken must be documented in the service user's support plan.

All service users must be presumed to have mental capacity to consent to treatment unless proved otherwise. The service user must be able to understand the information relating to the decision, retain and weigh up the information and communicate their decision. If the service user is unable to do any of these they will be classed as lacking capacity to make the decision regarding giving consent.

When a service user is deemed to lack capacity, a best interest decision must be made on their behalf consulting relevant people and taking all relevant circumstances into account. The best interest meeting may include START managers, the service user's GP (or consultant psychiatrist or psychologist), and relatives. This may include considering the administration of medication covertly, although this should only ever be seen as a last resort.

If it is agreed it is in the service user's best interests to receive their medication covertly this must be risk assessed, detailed in the support plan and a date specified for when the decision will be reviewed.

Confirmation should be obtained from a pharmacist and included in the risk assessment that the medication can be administered in this way (i.e. medication is suitable to be mixed with food or liquid).

Only medication which is regarded as essential for the service user's health and well-being, or for the safety of others, should be considered for administration in a covert way.

12. RECORD KEEPING

12.1. Support Plan, Risk Assessments and MAR charts

The support plan will detail the level of support required by the service user from the START team. This will have been assessed through the support with medication risk assessment form and any accompanying specific risk assessments.

All of these must be referred to by START staff prior to supporting with medication. These documents are all confidential records and should only be shared with others on a professional basis and with permission from the service user, referring to the mental capacity act if necessary.

All medication should be recorded on the MAR chart including those prescribed medications that the service user is self-medicating, the latter of which the re-ablement worker should document on the MAR chart.

MAR charts must be retained in the service user's home whilst in use. They should then be transferred to the re-ablement manager's offices and stored for 6 years in line with Nottinghamshire County Councils retention policy.

12.2 MAR chart codes

The re-ablement staff must record details of assistance with medication on the MAR chart in line with the medicine administration codes described below.

R = Verbal reminder-asking a service user if they have taken their medication or reminding them that it is time that they take it. (except where this occurs on an occasional basis). A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medication.

RO = Reminded and service user observed taking the medication - reminding a service user to take their medication and observing them taking their medication. No physical help given.

PO = Prepared and service user observed taking their medication- handling the service user's medication in some way, i.e. preparing the dose required, either by shaking a bottle of liquid medication, mixing soluble medicines, taking tablets out of containers and putting onto a spoon/saucer or pouring liquids into measuring cups or onto a spoon or squeezing a tube of ointment for use.

A = Assisted e.g. pressing an inhaler device **Applied** e.g. applying a cream to a service user's skin or Administered**-** physically giving a service user their medication by either placing it in their hand or mouth. These would all be coded as **A** on the MAR chart as in all 3 scenarios the support worker is physically ensuring the service user has their medication.

X = Refused, a service user refuses to take their medication

O = Other, document reason on reverse e.g. in hospital, medication left out, variable dose of medication.

If a service user self-medicates their medication this can be written under the drug and dosage description in the medication label box on the MAR chart

12.3 Recording application of topical products (creams, ointments, patches)

When emollient creams are prescribed as a soap substitute, moisturiser or barrier cream the support plan should record what the cream is and where it is to be used. This should also apply to prescribed medicated creams/ointments.

A MAR chart must document all prescribed creams/ointments and where they are to be applied.

The application of sun creams, sun blocks and simple body moisturisers purchased by the service user and applied as part of their personal care routine do not need to be recorded on the MAR chart as long as the service user has used these before. They should however be documented in the support plan.

Any products containing paraffin cannot be applied unless they are prescribed and documented on the MAR chart due to their flammability risk when applying to large areas.

It is important that the removal and application of patches is documented accurately see Appendix 10 for record chart. The administration of patches containing controlled drug medication or for dementia is not supported by the START service.

12.4. Discharge from the START service

A social worker will discharge a service user from the START service. They will complete a community care assessment and support plan (CCASP) for the service user and commission an on-going package of care if required.

On discharge the re-ablement support worker must collect the support plan and any other service documentation from the service user's home. This must then be brought back to the locality offices, scanned and uploaded onto framework.

13. DISPOSAL OF MEDICATION

13.1. All medication prescribed for the service user is their property and must never be removed by re-ablement support staff from the service user's home without written consent.

13.2. The service user or their relatives should be encouraged to return excessive amounts of unused or unwanted medicines to a pharmacy. They should not be encouraged to add them to their household waste or flush them away via the toilet. Empty bottles of liquid medication may be rinsed out and disposed of in the household waste.

13.3. Return of medication should wherever possible remain the responsibility of the service user and/or their relatives. In exceptional circumstances re-ablement support staff may return medication to a community pharmacy, having obtained written consent from the service user and sought approval from their line manager (START/AMP/8)

13.4. Details of medication returned for disposal by START staff should be recorded on the MAR chart and countersigned by the community pharmacist, the Peri re-ablement support worker or the re-ablement manager on the appropriate form (START/AMP/8). Information recorded should include the quantity removed and the date of return to the pharmacy.

13.5. Any medication that is taken out of its original container but is then not taken by the service user (for instance refusal, or medication is dropped on the floor) should be placed in an envelope with identification that it is waste medication. The service user's family should be requested to return this medication to a community pharmacy for disposal. Dropped tablets can be avoided with good administration technique e.g. preparing doses over a work surface.

13.6. In the event of a service user's death all medication should remain in the service user's home for seven days in case there is a coroner's inquest.

14. ERROR AND NEAR MISS REPORTING

14.1. Any instances of error involving medication **must** be reported to the re-ablement manager immediately (or if out of hours the person on call). Medical advice must be sought via the services user's GP, NHS 111, or out of hours service (GP telephone service will direct you to the out of hours service) as appropriate. This also applies to errors that staff identify, but have not made themselves e.g. errors made by prescribers, pharmacists and other care workers.

14.2. In the event of a serious error outside normal office hours NHS 111 or out of hours service and the Emergency Duty Team (0300 456 45 46) must be contacted immediately for further advice and next steps.

14.3. The re-ablement manager will complete a Medication Incident Report Form (START/AMP/6) with information provided by the re-ablement support worker.

A copy of this form will be sent to the Shared Medicines Management Team. The Re-ablement Manager will enter details of the incident onto the Well-Worker system for monitoring and audit purposes.

14.4. Following report of an error or circumstances where an error could have occurred (a near miss) the Team Manager must investigate systems and processes to identify contributing factors and implement appropriate actions. The re-ablement manager should facilitate shared learning with colleagues to prevent reoccurrence of the error in the START service, and through the appropriate mechanism for independent providers.

14.5. At all times support must be provided to employees who report errors or near misses in order to encourage an environment of openness and shared learning.

15. GIVING ADVICE TO SERVICE USERS ON MEDICAL ISSUES

15.1. Advice on medicines is the responsibility of the service user's GP, pharmacist or clinician who has responsibility for the service user's medical care. Re-ablement support staff must not advise on medication issues (including over the counter medicines). Any question should be referred to the service user's GP or pharmacist.

15.2. It is the responsibility of the prescriber to explain the reason for the treatment and the likely effects (including side effects) of any medication prescribed to the patient.

15.3. Patient information leaflets are included with prescribed medicines dispensed by a community pharmacist, dispensing doctor or hospital pharmacy. Re-ablement support workers may need to assist service users to access this information e.g. by reading the leaflet to them if required.

15.4. Re-ablement workers should refer to appendixes 6 and 7 for contact details for GPs and Community pharmacists, including opening hours.

15.5. Medication advice is available from the CCG medicines management team, via referral through the re-ablement managers and team managers.

16. CONFIDENTIALITY

Re-ablement staff must not discuss or disclose a service user's medical history or treatment to a relative or lay person. Any questions must be re-directed to the service user, the service user's medical practitioner or the re-ablement manager.

17. DEFINITIONS

Assessor: Social care professional authorised by Adult Social Care, Health and Public Protection (ASCHPP) to undertake an assessment of a service users need and eligibility under Fair Access to Care Services (FACS) for on-going services e.g. a social worker or a community care officer (CCO)

Container: The packaging in which medication is supplied by the community (or hospital) pharmacy or dispensing doctor. For example: glass or plastic bottle, foil strip or blister packaging, tube containing ointment or cream for external application. Includes monitored dosage system or other compliance aid

Cytotoxic medicines: used in the therapy of various cancers and other conditions. Their effects are produced by interference with some human cell functions. There is a possibility that prolonged; uncontrolled exposure to cytotoxic drugs could produce some type of adverse effect on people who handle these medications.

Disability Discrimination Act (DDA): Community pharmacists will ask service users a series of questions. If the service user satisfies the DDA criteria, they may be eligible to have their prescription dispensed in a compliance aid.

Emollient: Defined as a preparation listed under section 13.2.1 of the British National Formulary (BNF); does not include barrier preparations.

'Fair Blame' culture: A culture in which staff are not blamed, criticised or disciplined as a result of a genuine slip or mistake that leads to an incident. Disciplinary action under Nottinghamshire County Council's Disciplinary Procedure may still follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm.

Framework: An electronic system for recording contact and relevant information regarding a service user's social care support

Medication Administration Record (MAR) chart: this is a document which gives details of all medicines that a service user is given support to manage. It shows the name of the medicine, the dose to be given, the time it is to be given and the identity of the person supporting with administration

Monitored dosage system/compliance aid: A form of packaging in which all medication required at specific times of the day are grouped together in individual compartments of the container

Non-medical prescriber: A registered healthcare professional, other than a doctor or dentist, who has been accredited as a prescriber by their professional body. At present such professionals include: nurses, midwives, pharmacists, optometrists, physiotherapists or chiropodists/podiatrists who have completed the relevant training programme.

Occupational Therapist: ASCHPP worker who visits all service users to provide equipment or re-ablement goals. May also complete the first visit if needed. Refers to Social Worker for assessment for on-going service.

Perigastric endoscopic tube (PEG): A feeding tube which is surgically inserted directly into the stomach to provide a safe and long term method of obtaining nutrition.

Peripatetic Re-ablement Support Workers: ASCHPP worker who undertakes the first visits to introduce the service and complete the Support Plan. They will also complete a medication risk assessment form as well as other risk assessments. He/she is also responsible for obtaining the consent of the service user for a re-ablement support worker to assist them with their medication.

Re-ablement Manager: the ASCHPP manager who is responsible for the management of the START and line management and day to day supervision of the re-ablement support workers. He/she undertakes the first visit and completes the risk assessment and support plan only when the Peri Re-ablement Support Workers are not available.

Re-ablement support worker: ASCHPP worker who provides support to service users with a range of personal and practical tasks while enhancing independence. He/she carries out the support plan and monitors and provides feedback.

Remind/prepare/assist/apply/administer: Situations where the service user is not able to take full responsibility for their medication and staff are required to provide varying degrees of assistance through to full administration. This includes selection of medicines by staff from a monitored dosage system or compliance aid.

Team Manager: Has overall responsibility for the service as the Registered Manager with CQC. Has line management responsibility for the Re-ablement Managers.

Transdermal patches: A medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream.

18. FORMS TO USE

START/AMP/1 – Information for relatives/friends of service users receiving support with their medication from the START service.

START/AMP/2 – Agreement for assistance with application of compression hosiery.

START/AMP/3 – Fax confirmation of prescriber directions.

START/AMP/4 – Confirmation agreement for crushing tablets or opening of capsules.

START/AMP/5 – GP Instructions – prescribed medication (PRN) when required.

START/AMP/6 – Medication incident report form

START/AMP/7 – Support with medication risk assessment form

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 July 2019

Agenda Item: 8

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH

ADULT SOCIAL CARE AND PUBLIC HEALTH STAFFING ESTABLISHMENT

Purpose of the Report

1. To seek approval for the conversion of some existing temporary posts in to permanent posts to support the delivery of the Departmental Strategy and the Adult Social Care Strategy.

2. To seek approval for the extension of a temporary Commissioning Manager post until 31st March 2020 to ensure the continued successful implementation of the department's housing strategies.

3. To seek approval for the establishment of two temporary Public Health posts through external funding from the national Childhood Obesity Trailblazer Programme and Public Health Reserves.

Information

4. The Council Plan 2017-2021 was agreed by County Council in July 2017 and articulates the ambition to provide the best possible services for local people, improve the place in which we live, and give good value for money. The Plan sets out the Council's 12 commitments for Nottinghamshire and how success in delivering them will be measured.

5. The Departmental Strategies sit just below the Council Plan in the planning hierarchy and set out the aspirations, priorities and outcomes that each Department will work towards in support of the Council Plan. The most recent Departmental Strategies were considered and approved by Policy Committee on 22nd May 2019 and the associated report is available as a background paper.

6. The Departmental Strategy sets out how the Adult Social Care and Public Health Department aims to support the delivery of the wider Council plan highlighting some priority programmes of transformation required to achieve this. These programmes of transformation are to:

   - Improve wellbeing through prevention and promoting independence

- Develop our integrated health and social care system
- Deliver high quality public health and social care services.

7. In Adult Social Care, to ensure that the ambitions of the Corporate and Department Strategies can practically be translated into action, the Adult Social Care Strategy has been developed and was refreshed in 2017. The Adult Social Care Strategy outlines the key principles of the department social care offer and these state that we will:

- Promote individual health, wellbeing and independence
- Share responsibility with partners, providers, families, carers, friends and the voluntary services in the local community to maintain the health and wellbeing of people in our communities
- Work to prevent or delay the development of care and support needs by providing advice, information and guidance to support independence for all, regardless of their financial circumstances
- Promote choice and control so people can receive support in ways that are meaningful to them but is balanced against effective and efficient use of resources
- Work to ensure people are protected from abuse and neglect, and if people do suffer harm we will work with them to achieve resolution and recovery in line with their wishes
- Provide support that is proportional to people's needs in order to make the best use of resources available.

8. Since 2011, in order to deliver the Adult Social Care Strategy and to respond to the significant financial pressures faced by the Council there have been a number of large changes to the way that services are delivered. These changes include:

- Adoption of new approach to dealing with initial queries and requests for support with the introduction of the 3-conversation model, which aims to resolves people's needs as early as possible often before formal social care support is required
- The development of a more enablement focussed approach, where the Council works intensively for short periods of time with service users to support them to regain or increase their levels of independence
- Expansion of the Reablement offer to support more people to greater levels of recovery after an illness or accident, helping them to return to living as independently as possible
- Changes to the way the Council reviews existing service users to ensure that independence is being maximised, which includes the development of reviewing pathways and specialist reviewing teams.

9. To develop and embed these changes several areas of the workforce have changed significantly and often only with temporary funding, such as the Better Care Fund. It is now time to review the need for some of these services and posts in the longer term.

10. Having a large number of temporary posts (initially created as fixed term contracts due to temporary funding) creates difficulties in recruiting and retaining a stable workforce. It also means that staff cannot access Apprenticeship funding for essential skill development, because the national criteria states that the contract has to last the length of the Apprenticeship training period. Increased staff vacancy rates and turnover leads to additional risks against delivering current statutory obligations and service objectives. As the table below demonstrates, £34.528m (16.9%) of the proposed net budget for Adult Social Care in 2019/20 is being funded by temporary money. After working for

Nottinghamshire County Council for one year, staff accrue the same rights and entitlements of a permanent employee including redeployment rights and after two years entitlement to redundancy if the Council is unable to redeploy them. Therefore, there is little difference or additional risk to the Council in making contracts and posts permanent because in a significant number of cases the person in post will already have permanent employment rights as they have often held consecutive temporary posts across a number of teams.

Figure 1: Additional temporary monies against the Adult Social Care and Health budget 2019/20:

	2019/20 (£m)
ASCH original Net Budget	**203.743**
Temporary sources of funding	
Better Care Fund (BCF) Care Act	**2.060**
Original Improved BCF Grant Additional Improved BCF Grant	**21,505** **4,979**
Winter Pressures Grant	**3.527**
BCF Reserves	**2.436**
Total of temporary funding	**34.507**

11. Given the heavy reliance on temporary monies (as highlighted by the above table) and current uncertainty of Adult Social Care funding nationally the department is working on contingency plans for reducing spend should part or all of the existing temporary funding not be continued. It is the current expectation that the Better Care Fund (BCF) and Improved Better Care Fund (iBCF) will continue although there has, as yet, been no confirmation of this and there is uncertainty around whether the additional IBCF and Winter Pressure grants will continue beyond this year.

12. At present there are circa 250 fte temporary posts established across the department. This equates to around 13% of the department's workforce in 2018/19. While some of these posts are temporary because the work they are servicing is temporary there are a number of areas where core business is being supported by the use of temporary posts. As an example, in the Adults 65+ service some teams have up to 25% of their posts established on a temporary basis. Analysis of the assessment and reviewing activity for the department indicates that over 2,600 assessments and reviews are completed annually by the temporary workforce.

13. In addition to the risk posed to delivery of service, temporary posts also create other significant issues for the department and the organisation. It reduces retention as staff in temporary posts will seek to move to alternative permanent posts as they become available therefore creating additional turnover as well as impacting negatively on the morale of the workforce. As one of the largest employers in Nottinghamshire this is something the Council seeks to improve to fulfil its commitment as an investor in people.

14. Low retention and high turnover rates of temporary posts are further exacerbated by the time taken to recruit to vacant posts. Recent changes to the recruitment system have reduced the number of days taken from the point of advert to the point of making an offer. Whilst this is a positive step it does still mean that it is not unusual, after also factoring in

the vacancy control procedure, pre employment checks and notice periods, for a post to take 5-6 months to be recruited to. Given that a large proportion of the temporary posts only require 1 months' notice period, there is often a significant gap between one post holder leaving and another starting. Not only is this an issue for service continuity, it can also make temporary posts unattractive due to the short length of time left before the funding expires.

15. There are some service areas with high numbers of temporary posts that the future delivery of departmental strategies and service plans depend upon. This report therefore focuses on service areas where approval is sought to convert some temporary posts into permanent posts to continue to support the delivery of the Adult Social Care Strategy, Departmental Plan and Council Plan.

Reablement

16. The Council's Short-Term Assessment and Reablement Service (START) provides reablement to people in their own homes, often following a period of ill-health and a stay in hospital. START is successful at helping adults to regain or retain their independence and is therefore key to delivering the Departmental and Adult Social Care Strategies.

17. START in Nottinghamshire performs well. A total of 1,780 people completed reablement with START during 2018/19. This exceeded the Council's target by 77 additional people. 75% of service users who completed reablement in 2018/19 required no ongoing homecare, exceeding the annual target of 70%. The service also performs well against the key national performance indicator of the proportion of older people (65 years & over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. In 2018/19 the performance in Nottinghamshire was 89%, exceeding the national annual target of 85%.

18. There have been a number of developments by the Council over recent years which have supported increased capacity across the reablement service, including Improved Better Care Fund monies in 2017/18 and early 2018/19 to recruit additional Reablement Support Workers, Occupational Therapists and other key frontline reablement roles. As a result, there are now the following 42.75 FTE temporary posts as part of the Council's Reablement service:

Post Title	**FTE**	**Grade**	**Total cost p.a.**
Community Care Officer	6.8	Grade 5	£236,174
Occupational Therapist	11.5	Band A/B	£550,375
Peripatetic worker	4	Grade 3	£117,877
Promoting Independence Worker	3	Grade 3	£88,408
Reablement Manager	2.3	Band A	£95,749
Reablement support worker	13.9	Grade 2	£333,048
Team Manager	1.25	Band D	£73,009
Total	**42.75**		**£1,494,641**

19. The Council is committed to building on the success of START to support even more adults to maximise their independence. Analysis work carried out for the Council in 2017, workshops with START colleagues across Nottinghamshire and consideration of best

practice in other authorities, all identified the potential to further transform the Reablement Service. The department therefore established a 2 year Transforming Reablement Project in April 2018 to increase the capacity within START without requiring any additional budget. The project has been tasked with helping START to save £2,157,233 in community care costs by March 2020 through supporting more adults to retain or regain as much independence as possible.

20. One initial area of focus for the project has been to overcome difficulties in recruiting to the temporary service posts. In particular, the Reablement Support Worker (RSW) posts are affected by nationally recognised problems with recruitment and retention to the caring professions. During 2018/19 the project has therefore established bespoke recruitment processes for START, including a Reablement Supply Register. As a result, the number of vacancies has significantly reduced down to a 2018/19 turnover rate of 11.53% which is positive, however it requires further improvement because this still means a significant reduction in the numbers of people that the service has the potential to work with if fully staffed.

21. Despite these improvements, the use of temporary posts creates an ongoing risk to the overall performance of the Council's Reablement Service. These temporary posts are vital to the delivery of a transformed START service and thus contribute to the delivery of required savings. However, the current lowered turnover rate is expected to increase in the run up to the end of the funding for these temporary posts in March 2020. This will inevitably create instability and a dip in capacity in the service at a crucial time in its transformation. Furthermore, these temporary posts are needed beyond March 2020 to help ensure the continuity of a transformed START service beyond the life of the current project.

Enablement for people aged 18-64 years

22. The Nottinghamshire Enabling Service (NES) offers working-age adults a focused period of enablement to improve skills, confidence and independence. This short-term intervention is either instead of, or before, longer term support is considered. This service has helped to improve outcomes for individuals to live happy and independent lives, as well as reducing the cost and level of ongoing care required.

23. Whilst a reablement/enablement service has been available for some years for older adults, there was no equivalent service for younger adults. Hence, NES supports the Council in meeting its statutory responsibilities, and delivering on the ambitions of the Adult Social Care Strategy.

24. Based within NES is also the Co-Production team, which complements the work of NES by working together with people who need support to reduce loneliness and improve their overall wellbeing. The Co-Production team works with people who have mental health difficulties, a learning disability and/or a physical disability, autism, Asperger's Syndrome, as well as working with older adults. The team supports people to attend existing groups, and also develops new groups and activities for people to attend with the aim of making as many of these as possible self-sustaining. In the 2018/19 period, a total of 1,890 people have been exposed to the Co-Production service, with a total of 25 new groups having been established.

25. The Institute of Public Care (IPC) has advised that local authorities should aim to provide enablement to 90% of younger adults with a newly acquired physical disability and 37% of people with learning disabilities. Current levels of enablement in the Council are below these suggested levels. The IPC advice is supported by the Newton diagnostic in Nottinghamshire, which found 37% of people with learning disabilities would have benefited from enablement but did not have access. The intention is to increase the opportunities for enablement to enable a larger number of younger adults to benefit.

26. The Notts Enabling Service works with individuals to increase their independence and reduce their reliance on social care services for up to 12 weeks in any of the following areas:

- developing or learning new skills at home, for example preparing food/domestic tasks
- preparing for and connecting with opportunities for voluntary/paid work
- using the internet/apps etc. to support communication/self-care/using Assistive Technology
- travel training and support to access the community - finding places to go and how to travel independently
- building links with other people to support and promote opportunities to meet people and make connections to promote wellbeing
- keeping safe - support with building confidence and skills
- supporting the person to connect with other services of interest or value to the individual.

This is illustrated by the case study below:

A young man with autism & ADHD (Attention Deficit Hyperactivity Disorder) was referred to NES as he was struggling at college and was being considered for day services to meet his needs. It was established in discussion that he was unhappy at college and preferred to work outside. He also had limited social opportunities. A Promoting Independence Worker worked with him to increase his confidence with travelling independently on public transport. He connected him with a cycling group and a gardening project where he made new friends and enjoyed his weekly time there. A Community Independence Worker for Transitions also helped him to start a Duke of Edinburgh Award. Both his confidence and independence have grown so much so that he is now about to start full time paid work as a brick layer

27. The NES has demonstrated good outcomes with 79.31% of younger adults who received a range of enablement not requiring any other services following this.

28. The NES also provides savings to the Council through achieving better outcomes. These include:

- supporting the delivery of agreed savings - the team is directly delivering £1.718 million between 2018/2019 and 2020/2021 and is supporting delivery of a number of other savings projects across Adult Social Care
- managing demand for services going forward - since its establishment the team is reducing the number of new services users coming into the service with a 37% reduction in learning disability assessments, as people's needs are being met by a short-term intervention provided by the team
- providing long term savings over the course of an individual's life by keeping them independent for longer with a reduced need for formal services. This is particularly

significant considering that the average time someone aged 18-64 years receives services is currently 22 years.

29. The Notts Enabling Service is made up of two teams one based in the North of the County and one in the South to effectively provide the service countywide.

30. In order to continue this positive work, it is requested that the following posts that are currently agreed until the 31st March 2020 are established on a permanent basis:

Post Title	**FTE**	**Grade**	**Total cost p.a.**
Team Manager	2	Band D	£116,815
Team Leader	2	Band A	£83,260
Occupational Therapist/Social Worker	2	Band A/B	£95,717
Promoting Independence Workers	17.5	Grade 3	£446,250
Community Independence Worker	1	Grade 3	£25,500
Business Support	1.5	Grade 3	£38,250
Co-Production Development Worker	2	Band A	£83,260
Total	**28**		**£889,053**

31. The reason for seeking approval to establish these posts permanently, in addition to them being key to delivering the Adult Social Care Strategy, is due to the difficulties that have been experienced whilst the posts have been temporary.

32. Staff turnover within the 2018/19 period for the service is 38%; as a comparison, for all directly employed Nottinghamshire County Council staff the turnover rate for that same period is 11%. Information gathered at exit interviews shows in a high number of cases the reason for leaving is to seek more secure and permanent employment. Whilst the management team attempts to mitigate against this with support and re-assurance to their staff, it is increasingly difficult to retain staff on this basis. As the end of the temporary contracts draws closer this effect is being felt more acutely.

33. Recruitment across the NES and the Co-Production Service has been, and continues to be, an on-going issue which is becoming increasingly acute. At the time of writing this report the NES is in the process of re-advertising for three roles for staff who have already left the service and to which the team is struggling to recruit. A locum worker has been secured for one of the more senior roles from June 2019 for three months, with the advertisement for the role having been issued for a third time. A further four Promoting Independence Workers left during May and June 2019. In exit interviews completed by the team the temporary contract is often cited as a reason for leaving.

34. The loss of staff and difficulties in recruitment will have an impact on the numbers of people which the Service can work with at any given point and will have a significant impact on the department's ability to offer enablement to Adults aged 18-64 years as well as on the planned delivery of savings.

35. High turnover and therefore increased recruitment activity is also costly, the staff time alone required to complete the recruitment for NES in 2018/19 is estimated to be around £17,500.

Statutory Mental Health Services

36. The Advanced Mental Health Practitioner (AMHP) team faces multiple challenges in relation to staff carrying out the Council's statutory provision of mental health services. Nationally local authorities report difficulties in recruiting, retraining and training sufficient AMHPs to meet the increasing demand for the specialist input to multi-disciplinary assessments and work that they provide. 2 FTE AMHP posts are temporary until 31st March 2020. The reduction of the temporary 2 posts in 2020 would have a significant bearing on resource provision given the year on year increase of mental health act assessments. At present the team is managing the work load with the temporary posts in place but there are still at times strains on resource provision due to conveyance, bed or out of area issues.

37. Each full time equivalent AMHP completes on average around 125 assessments a year and reduction in capacity to complete assessments would directly conflict with the operational priorities of the AMHP team.

38. More recently there has been an additional challenge noted regarding the team's age profile which is weighted towards an older age demographic. 21% of the team is in the 60 – 64 years age bracket and recently workers have either considered or applied for retirement. To continue with succession planning for the AMHP service it is proposed to convert the existing 2 FTE temporary posts into permanent posts, to allow them to support the programme of work underway to support the development of additional AMHPs in the department. For context the Association of Directors of Adult Social Services (ADASS) recommends that there should be 100 FTE AMHPs to a (shire) population of 1.1 million. Nottinghamshire (excluding Nottingham city) has a population of 810, 700. Therefore, on these recommendations Nottinghamshire's optimum number of AMHPs would be 73.7 FTE. Currently in Nottinghamshire there are 41 FTE which includes 7 EDT AMHPs.

    Therefore, approval is sought for the following posts to be made permanent from 1st August 2019.

Post Title	FTE	Grade	Total cost p.a.
Advanced Mental Health Practitioner	2	Band C	£108,892

Service Delivery Posts

39. As part of an internal exercise to review the ongoing requirements for posts there are a small number of temporary posts that are required until the end of the financial year but where current approvals expire before 31st March 2020. These posts, the rationale for their requirement and proposed in year source of funding are summarised below for approval.

40. The department has two approved housing strategies, Housing with Support and Housing with Care, that are both currently being implemented to ensure that adults across Nottinghamshire have their accommodation needs met in line with the Adult Social Care Strategy. The successful implementation of these two strategies in addition to improving outcomes for people will also achieve savings of £5.847m over the next four years. To ensure continued successful implementation of the department's housing strategies it is requested that the current Commissioning Manager (Band E) post that leads this work is

extended until 31st March 2020. The cost of this extension will be up to £34,563 and will be met from anticipated underspends in existing budgets created by delays to recruiting to vacancies.

41. In 2017 the Integrated Community Equipment Loan Service (ICELS) Partnership Board approved the creation of three additional temporary post within ICELS which was subsequently ratified by Committee in November 2017. These posts are 2 FTE Qualified Clinicians (Band B, at a total cost of £95,717 p.a) and 1 FTE Review Support Worker (Grade 3, at a cost of £25,500 p.a).

42. The Partnership Board has recently reviewed the need for these posts and at the Board meeting on 8th May 2019 gave approval for the posts to be made permanent and funded from within the ICELS pooled budget. This was on the basis that these posts have contributed to the £2.1m worth of equipment being reviewed, returned and reused, so the cost of the posts is covered from within the savings made.

43. The Equipment Review Team posts have successfully added to ICELS capacity and enabled the team to reach more clients and review and return more equipment. The second clinical post in the Clinical Team is to provide advice and guidance to staff about non-standard equipment which is being sought for clients with complex needs. These items are known as 'Specials' and as they are often bespoke can be expensive. The post is also to support the implementation of the new ICELS 'Specials Panel' which is a joint county-wide health and social care panel which has been introduced to manage the increasing number of requests for special equipment and demand on the budget.

44. The ICELS Partnership Board is requesting that the Committee ratifies the approval of these posts as permanent and funded from the ICELS pooled budget.

Establishment of temporary Public Health posts

45. Nottinghamshire County Council has been selected to be one of five local authorities to participate in the Department of Health funded and Local Government Association managed three-year Childhood Obesity Trailblazer Programme. The Council will be in receipt of a grant of £75,000 per year to deliver the project. This follows being short-listed from 102 local authorities which submitted an expression of interest, and 13 of which were involved in a three-month Discovery Phase from February to April 2019.

46. In summary the Council's project aims to enable and support families with children in the early years to eat a healthy diet by improving access to affordable and healthy food in their local areas. This will be done through a range of measures including using the school meals service supply chain and community food initiatives to offer low cost food, accompanied by improved support in Children Centres and other community venues; improving awareness and uptake of Healthy Start Vouchers; and developing food and nutrition skills and provision in the early years and the independent childcare sector.

47. It is intended to establish 1 temporary Public Health Support Officer (Band B, 1 FTE) to coordinate the project over the three years. It is also intended to establish 1 temporary Public Health Support Officer (Band B, 1 FTE) for 18 months to promote and develop the local uptake of Heathy Start vitamins and develop new innovative approaches in relation to Healthy Start Food Vouchers for eligible Nottinghamshire families.

Other Options Considered

48. The option to continue funding these adult social care posts on a temporary basis has been considered, however this option was ruled out for the reasons stated in the body of the report linked to the difficulties and costs of retaining and recruiting to temporary posts.

49. The option to not recruit to the Public Health post to coordinate the Nottinghamshire Childhood Obesity Trailblazer Project would mean that there was insufficient capacity to deliver the agreed project plan. The option to not recruit to the Public Health post to increase uptake of the Healthy Start Programme would mean that the plan to increase uptake of the vitamins and food vouchers would not be enacted.

Reason/s for Recommendation/s

50. The recommendations are made to support the future delivery of the Departmental Strategy and the Adult Social Care Strategy.

51. The recommendations relating to the establishment of Public Health posts are made to enable the County Council to deliver its Childhood Obesity Trailblazer Project, and plan to increase uptake of the Healthy Start Programme.

Statutory and Policy Implications

52. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public-sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Data Protection and Information Governance

53. The data protection and information governance requirements for each of the savings projects is being considered on a case by case basis and Data Protection Impact Assessments will be completed wherever necessary.

Financial Implications

54. The ongoing commitment per annum of making the posts in this report permanent is £2,613,801, the BCF Care Act and Original IBCF Grant are already permanently committed, so the intention in the first instance would be for these posts to be funded from additional IBCF Grant or Winter Pressures Grant. However, if both ceased and were not replaced with other funding, these posts could be funded from Reserves in 2020/21 only.

55. The cost, of up to £34,563, for the extension to 31st March 2020 of the 1 FTE Temporary Commissioning Manager (Band E) post to ensure the continued successful implementation of the department's housing strategies, will be met from anticipated underspends in existing budgets created by delays to recruiting to vacancies.

56. Funding for 1 FTE Public Health Support Officer (Band B) post to coordinate the Childhood Obesity Trailblazer project will be funded by the £75,000 per year Trailblazer external funding grant from the Department of Health and Social Care over the three years at a cost of up to £47,858 per year. Funding for a second 1 FTE Public Health Support Officer (Band B) post for 18 months to improve uptake of the Healthy Start Scheme at a cost of up to £47,858 per year will be 50% from the Trailblazer grant and 50% from the County Council Public Health General Reserves. The use of £60,000 Public Health General Reserves for a project to increase uptake of Healthy Start Scheme was approved by Adult Social Care and Public Health Committee in May 2019. It is anticipated that the posts will not be recruited at the top of the payscale enabling more to be invested in project activities.

Human Resources Implications

57. These are described throughout the body of the report.

Public Sector Equality Duty Implications

58. The equality implications of the Adult Social Care & Health savings and efficiency projects have been considered during their development and, where required, Equality Impact Assessments undertaken.

Implications for Service Users

59. As above, the implications of the savings projects on service users have been considered during their development.

RECOMMENDATION/S

That Committee:

1) gives approval for the following posts to be established as permanent from 1st August 2019:

Service	Post Title	FTE	Grade/ Band	Total cost p.a.
Reablement	Community Care Officer	6.8	5	£236,174
Reablement	Occupational Therapist	11.5	A/B	£550,375
Reablement	Peripatetic worker	4	3	£117,877
Reablement	Promoting Independence Worker	3	3	£88,408
Reablement	Reablement Manager	2.3	A	£95,749
Reablement	Reablement support worker	13.9	2	£333,048
Reablement	Team Manager	1.25	D	£73,009
Notts Enabling Service	Team Manager	2	D	£116,815
Notts Enabling Service	Team Leader	2	A	£83,260
Notts Enabling Service	Occupational Therapist/ Social Worker	2	A/B	£95,717
Notts Enabling Service	Promoting Independence Workers	17.5	3	£446,250

Notts Enabling Service	Community Independence Worker	1	3	£25,500
Notts Enabling Service	Business Support	1.5	3	£38,250
Notts Enabling Service	Co-Production Development Workers	2	Band A	£83,260
Statutory Mental Health Posts	AMHP	2	C	£108,892
ICELS	Qualified Clinician	2	B	£95,717
ICELS	Review Support Worker	1	3	£25,500
Total		75.75		£2,613,801

2) gives approval for the following post to be extended from the existing end date until 31st March 2020:

Service	Post Title	FTE	Grade/ Band	Current end date	Cost until 31st March 2020
Strategic Commissioning	Commissioning Manager	1	E	30th Sept 2019	£34,563

3) gives approval for the establishment of the following temporary Public Health posts:

Post Title	FTE	Grade/ Band	End date	Cost per annum	Funding Source
Public Health Support Officer	1.0	B	30th June 2022	£47,858	Childhood Obesity Trailblazer Programme Grant
Public Health Support Officer	1.0	B	18 months from recruitment	£47,858	Childhood Obesity Trailblazer Programme Grant and Public Health Reserves (as agreed May 2019)

Melanie Brooks
Corporate Director, Adult Social Care and Health

For any enquiries about this report please contact:

Stacey Roe
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Constitutional Comments (LW 11/06/19)

60. Adult Social Care and Public Health Committee is the appropriate body to consider the content of the report.

Financial Comments (KAS 07/06/19)

61. The temporary Reablement, Enablement and Mental Health posts that are being requested to be made permanent are currently funded by the Additional IBCF Grant or Winter Pressures Grant, which are only confirmed for this financial year. Should these grants not continue the department will need to make other reductions to remain within their overall budget allocation.

62. The cost for the extension to 31 March 2020 of the Temporary Commissioning Manager (Band E) can be met from anticipated underspends in existing budgets created by delays to recruiting to vacancies.

63. The temporary ICELS posts that are being requested to be made permanent will be funded from the ICELS Pooled Budget.

64. 1 FTE Public Health Support Officer (Band B) post to coordinate the Childhood Obesity Trailblazer project will be funded by the £75,000 per year Trailblazer external funding grant from the Department of Health and Social Care. This funding will also fund 50% of the cost of a second 1 FTE Public Health Support Officer (Band B) post for 18 months to improve uptake of the Healthy Start Scheme. The remaining 50% cost of this post can be funded from the £60,000 Public Health General Reserves already approved in May 2019 for a project to increase uptake of Healthy Start Scheme.

HR Comments (SJJ 11/06/19)

65. The creation of permanent posts will stabilise the structure and the relevant HR policies and procedures will be applied accordingly.

66. In relation to the creation of posts in Public Health, these posts will be recruited to and appointed to on temporary fixed terms contracts.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Progress Report on Budget, Savings and Improving Lives Portfolio - report to Adult Social Care and Public Health Committee on 10th June 2019
- DEPARTMENTAL STRATEGIES & COUNCIL PLAN LEVEL DATA SET – report to Policy Committee 22nd May 2019
- Update on Tender for Home Based Care and Support Services - report to Adult Social Care and Public Health Committee on 9th July 2018
- Progress report on Budget, Savings and Improving Lives - report to Adult Social Care and Public Health Committee on 10th December 2018
- Progress Report on Improving Lives - report to Adult Social Care and Public Health Committee on 8th October 2018
- Assessment and advice provided by external savings partner, Newton, to support savings programme - report to Adult Social Care and Public Health Committee on 12th March 2018

- Appendix Assessment and Advice Newton – to Adult Social Care and Public Health Committee on 12th March 2018
- Monitoring of savings in Adult Social Care - report to Improvement and Change Sub-Committee on 25th June 2018
- Programmes, Projects and Savings – Quarter 1 - report to the Improvement and Change Sub-Committee on 4th September 2018
- Progress Report on Savings and Efficiencies - reports to Adult Social Care and Public Health Committee on 10th July 2017, 11th December 2017 and 16th April 2018
- Progress Report on Delivery of Programmes, Projects and Savings - report to the Improvement and Change Sub-Committee on 26th September 2017
- Financial Monitoring Report: Period 5 2017/2018 - report to Finance and Major Contracts Management Committee on 16th October 2017
- Proposals for allocation of additional national funding for adult social care – report to Adult Social Care and Public Health Committee on 12th November 2018
- Equality Impact Assessments
- Use of Public Health General Reserves - report to Adult Social Care and Public Health Committee on 13th May 2019.

Electoral Division(s) and Member(s) Affected

All.

ASCPH666 final

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8th July 2019

Agenda Item: 9

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH AND THE DIRECTOR OF PUBLIC HEALTH

ADULT SOCIAL CARE AND PUBLIC HEALTH - EVENTS, ACTIVITIES AND COMMUNICATIONS

Purpose of the Report

1. To seek Committee approval to proceed with a range of events and activities within adult social care and public health and undertake promotional work to publicise activities as described in the report.

Information

2. Over the course of the year, the range of public events, publicity and promotional activities that may be undertaken by adult social care and public health are wide ranging and there are a variety of reasons for doing so, for example:

- promotion of services to give information to people in need of social care and public health services and their carers
- encouraging interest in recruitment campaigns for staff, carers and volunteers
- engagement of communities with services in their locality
- generation of income through public events.

3. Over the next quarter, Public Health would like to undertake the events and activities detailed in **paragraphs 4 - 11.**

NHS Health Checks Awareness-Raising Campaign

4. Public Health has a key role in the prevention and early diagnosis of cardiovascular disease. The Local Authority is therefore mandated to commission NHS Health Checks for eligible 40-74 year old residents, which are currently delivered by GP practices across the County.

5. The NHS Health Checks team within Public Health plans to conduct communication activity to raise local awareness of the programme and its benefits, and to encourage an increase in uptake. This would take place on an ongoing basis through a range of promotional initiatives, including leaflets and banners at community venues and workplaces, social

media and filmed patient stories, content within multi-agency newsletters and information on digital screens at key locations. Costs will be met through the existing service budget.

World Suicide Prevention Day on Tuesday 10th September 2019

6. World Suicide Prevention Day (WSPD) is an international annual campaign to promote worldwide action to prevent suicides. It is organised by the International Association for Suicide Prevention (IASP) https://www.iasp.info/wspd2019/. The purpose of this day is to raise awareness around the globe that suicide can be prevented. The 2018 theme "Working together to prevent suicide" has been continued in 2019.

7. Public Health is the local lead and a joint campaign with partners of the Nottingham City and Nottinghamshire County Suicide Prevention Steering Group will consist of distribution of flyers and leaflets to raise awareness of suicide prevention. Awareness flyers and leaflets will include a leaflet called It's safe to talk about suicide, available on the Nottinghamshire Help Yourself website. This has been adopted for local use by the Suicide Prevention Steering Group with the permission of Exeter University who have developed and evaluated the leaflet for use by concerned family members and friends – the evaluation can be accessed via this link: Health Education Journal 2017, Vol. 76(5) 582–594.

8. There will also be information highlighting sources of professional help and support. Internal and external distribution will be via Workforce Health Champions and the Council's intranet and social media with the support of the Council's communications team. Wider circulation of leaflets will be via Steering Group partner organisations and networks.

I-work team attendance at local employer event

9. The i-Work team has been asked to attend an event called 'Recruiting Talent 2019: New Approaches for a New Era' on 19th July at Derby College. The event is focused on employers learning, sharing and discussing new approaches to recruiting talent to their organisations. It is connected to and supported by the Local Enterprise Partnership for Derby, Derbyshire, Nottingham and Nottinghamshire (D2N2).

10. At this event employers will hear from businesses who are already adopting innovative approaches to recruiting their talent. A host of local businesses from Derby and Nottinghamshire will be attending.

11. The i-Work team will have a stall in the market place area to promote the work that they do to support people with disabilities into employment. There are no costs to attending this event other than staff time and travel which are covered by the team's budget.

Other Options Considered

12. To not undertake events, activities and publicity relevant to adult social care and public health would result in lack of awareness or understanding of services available and lack of engagement with local communities.

Reason/s for Recommendation/s

13. To ensure that people in need of adult social care and public health services and their carers are aware of the range of services on offer; encourage engagement with local communities, increase income generation and highlight and share good practice.

14. To enable the Local Authority to contribute to suicide prevention population awareness and prevention campaigns and events as described above.

Statutory and Policy Implications

15. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

16. Costs for the planned NHS Health Checks Awareness-Raising Campaign activity will be covered by the relevant service budget.

17. There are no financial implications for the World Suicide Prevention Day promotion events described in **paragraphs 6 - 8** above.

18. There no financial implications for the attendance of the i-Work team at the employers' event in Derby.

Implications in relation to the NHS Constitution

19. The Suicide Prevention communications outlined above support the ethos of the NHS constitution to "*…improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives*".

Public Sector Equality Duty implications

20. The aim of the campaign described above is to educate the population around suicide prevention and supports the principles of reducing stigma and discrimination.

RECOMMENDATION/S

1) That Committee approves the plan of events, activities and publicity set out in the report.

Melanie Brooks
Corporate Director
Adult Social Care and Health

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:

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Constitutional Comments (EP 11/06/19)

21. The recommendation falls within the remit of the Adult Social Care and Public Health Committee by virtue of its terms of reference.

Financial Comments (DG 12/06/19)

22. The costs associated with the NHS Health Checks Awareness-Raising Campaign will be met from the Public Health Grant. The budget for Advertising and Marketing is £800 for the Health Check programme.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

None.

Electoral Division(s) and Member(s) Affected

All.

ASCPH663 final

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 July 2019

Agenda Item: 10

REPORT OF THE SERVICE DIRECTORS FOR SOUTH NOTTINGHAMSHIRE AND NORTH NOTTINGHAMSHIRE & DIRECT SERVICES

RESPONSE TO A PETITION REGARDING JAMES HINCE COURT CARE AND SUPPORT CENTRE

Purpose of the Report

1. The purpose of this report is to recommend to Committee the response to the issues raised in a petition to the County Council regarding the closure of James Hince Court Care and Support Centre, as detailed in **paragraph 10**.

Information

2. A 262 signature petition was submitted to the Full Council meeting held on 16th May 2019 by Councillor Alan Rhodes. The petition calls on the Council "to think again and keep this vital service open".

3. The petition further states that James Hince Court:

- is home for many elderly residents and has supported many local people
- local people work here and their jobs are now under threat.

4. Approval was given to develop Extra Care Housing and promote independent living in place of the current provision of six Care and Support Centres at Full Council in February 2015. In response to consultation feedback, it was also approved that three of the centres (Leivers Court, James Hince Court and Bishop's Court) would be kept open for another three years.

5. Subsequently a target closure date of March 2018 was agreed which has since been revised through change requests approved by the Adult Social Care and Public Health Committee and the Improvement and Change Sub-Committee.

6. On 1st April 2019, the Adult Social Care and Public Health Committee approved a final closure date for James Hince Court of September 2019. The reports are listed as background papers and include the reasons for the decisions, as well as options considered.

7. Since then a great deal of work has been undertaken to ensure that appropriate alternative arrangements are in place for long term residents. Also, work has taken place in partnership with health colleagues, to ensure that appropriate alternative services are available so that people can be discharged safely home from hospital in a timely way. Wherever possible the aim is to discharge people directly back to their own homes, with appropriate support if needed. Some people, however, may need a short stay for further assessment and/or re-ablement in an accommodation based service.

8. The outcome of this work is that:

- significant work has been undertaken to plan for moves to alternative placements for the two remaining long-term residents currently living in James Hince Court, ensuring that the individuals and their families are fully involved in the planning

- investment in a new Home First Rapid Response Service means that more people are now able to go directly home after a stay in hospital. This has reduced the number of people who may have needed homecare as part of their discharge plan but because it was not available quickly enough, had to move into a short term residential care bed until it could be arranged

- increased investment in the Council's Short Term Assessment and Re-ablement Team (START), alongside a project that is increasing capacity in the service though use of technology, means that more people are now going directly home for their re-ablement support to regain their independent living skills

- Priory Court Housing with Care scheme in Worksop will be open for people to move in from September 2019. The Council will have nomination rights to 37 units, which includes 10 assessment and re-ablement beds, out of a total of 51 units

- there is also sufficient capacity and choice of independent sector residential care for older people in the north of the County.

9. Appropriate, alternative, short term re-ablement services are now in place that support local social care and health's principle of 'Home First' after a stay in hospital and overall there is now a greater variety of options available to meet older people's needs.

10. In light of the information provided in this report it is not proposed to change the decision to close James Hince Court in September 2019 and to notify the lead petitioner accordingly.

Reason/s for Recommendation/s

11. The option of keeping James Hince Court open is not viable as the building is no longer fully fit for purpose and is not an optimal model of modern care home design in line with what would now be expected under national minimum standards.

12. Given that the planned closure is now only a few months hence, staffing levels are reducing rapidly as staff find alternative job roles or are released to redeployment opportunities.

13. Also, there is a need to have a diversity of provision in place to both provide appropriate care to people with increasingly complex needs and ensure that people are supported to be as independent as possible, with a focus on reablement and a Home First approach.

Statutory and Policy Implications

14. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

15. There are no financial implications arising from the report.

RECOMMENDATION/S

That:

1) the proposed response to the petitioner, as set out in **paragraph 10**, is approved and that the lead petitioner is informed accordingly

2) the outcome of the Committee's consideration is reported to Full Council.

Sue Batty
Service Director, South Nottinghamshire

Ainsley Macdonnell
Service Director, North Nottinghamshire and Direct Services

For any enquiries about this report please contact:

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Constitutional Comments (EP 21/06/19)

16. The Adult Social Care and Public Health Committee is the appropriate body to consider the contents of this report and approve the recommendations.

Financial Comments (KAS 24/06/19)

17. As stated in paragraph 15, there are no financial implications arising from this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Annual Budget 2015/16 - report to County Council on 26th February 2015

Progress on the Procurement Plan for Short Term Assessment/ Re-ablement Beds and Next Phase of the Care and Support Centre Closure Programme - report to Adult Social Care and Public Health Committee on 1st April 2019

Electoral Division(s) and Member(s) Affected

Worksop North Councillor Alan Rhodes

ASCPH664 final

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 July 2019

Agenda Item: 11

REPORT OF SERVICE DIRECTOR, CUSTOMERS, GOVERNANCE AND EMPLOYEES

WORK PROGRAMME

Purpose of the Report

1. To consider the Committee's work programme.

Information

2. The County Council requires each committee to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the committee's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and committee meeting. Any member of the committee is able to suggest items for possible inclusion.

3. The attached work programme has been drafted in consultation with the Chair and Vice-Chair, and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

4. As part of the transparency introduced by the revised committee arrangements in 2012, committees are expected to review day to day operational decisions made by officers using their delegated powers. It is anticipated that the committee will wish to commission periodic reports on such decisions. The committee is therefore requested to identify activities on which it would like to receive reports for inclusion in the work programme.

Other Options Considered

5. None

Reason/s for Recommendation/s

6. To assist the committee in preparing its work programme.

Statutory and Policy Implications

7. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty,

safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

That the committee considers whether any amendments are required to the work programme.

Marjorie Toward
Service Director, Customers, Governance & Employees

For any enquiries about this report please contact: Sara Allmond – sara.allmond@nottscc.gov.uk

Constitutional Comments (HD)

8. The Committee has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (NS)

9. There are no direct financial implications arising from the contents of this report. Any future reports to Committee on operational activities and officer working groups, will contain relevant financial information and comments.

Background Papers and Published Documents

- None

Electoral Division(s) and Member(s) Affected

- All

ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE – WORK PROGRAMME 2019-20

Report Title	Brief Summary of Agenda Item	Lead Officer	Report Author
9 September 2019			
Quality auditing and monitoring activity - care home and community provider contract suspensions	Regular report on contract suspensions and auditing activity.	Service Director, Strategic Commissioning, Access and Safeguarding	Cherry Dunk
Performance Update for Adult Social Care and Health	Quarterly update report on the performance of Adult Social Care and Public Health.	Corporate Director	Matthew Garrard
Integrated Wellbeing Service and Substance Misuse Service	To inform committee of the outcome of procurements	Director of Public Health	Rebecca Atchinson / Sarah Quilty
Dementia Declaration Action Plan		Consultant in Public Health	Jane O'Brien
Adult Social Care and Health – Senior Leadership structure	Recommendations on the Senior Leadership Team and Group Manager structure further to a review within the department.	Corporate Director	Jennie Kennington
Adult Care Financial Services – changes to staffing establishment	Report requesting approval for staffing changes within Adult Care Financial Services	Service Director, Strategic Commissioning, Access and Safeguarding	Cherry Dunk
Approval for attendance at the National Conference for Adults and Children's Social Care	Report requesting approval for attendance at annual national conference in Bournemouth in November.	Chairman of the ASC&PH Committee	Jennie Kennington
7 October 2019			
Planning for winter pressures		Service Director, South Nottinghamshire	Sue Batty
Progress report on savings and efficiencies and update on Improving Lives portfolio	Regular update report to committee on progress with savings projects within the department	Transformation Programme Director	Stacey Roe
Novel Psychoactive Substances: update	To provide information on service users presenting to CGL where NPS is stated as a	Director of Public Health	Amanda Fletcher / Sarah Quilty

Report Title	Brief Summary of Agenda Item	Lead Officer	Report Author
	drug used		
Public Health Services Performance and Quality Report for Funded Contracts	Regular performance report on services funded with ring fenced Public Health Grant (quarterly)	Consultant in Public Health	Nathalie Birkett
Progress update on older adults' services	Report on progress across older adults' services, to include update on housing with care development.	Service Director, Mid-Nottinghamshire	Sue Batty
11 November 2019			
Adult Social Care and Public Health departmental strategy – 6 monthly performance report	Report on progress against the commitments and measures in the departmental strategy	Transformation Programme Director/Director of Public Health	Jennie Kennington/Will Brealy
9 December 2019			
Quality auditing and monitoring activity - care home and community provider contract suspensions	Regular report on contract suspensions and auditing activity.	Service Director, Strategic Commissioning, Access and Safeguarding	Cherry Dunk
Performance Update for Adult Social Care and Health	Quarterly update report on the performance of Adult Social Care and Public Health.	Corporate Director	Matthew Garrard
Update on Domestic Abuse Support Services Procurement	Update on services following contract award	Director of Public Health	Rebecca Atchinson
Public Health Services Performance and Quality Report for Funded Contracts	Regular performance report on services funded with ring fenced Public Health Grant (quarterly)	Consultant in Public Health	Nathalie Birkett