Portsmouth CITY COUNCIL

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| **Title of Meeting:** | Health Overview and Scrutiny Panel |
| **Date of Meeting:** | November 2023 |
| **Subject:** | Adult Social Care Update |
| **Report By:** | Andy Biddle, Director of Adult Social Care |

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## 1. Purpose of Report

To update the Health Overview and Scrutiny Panel on the key issues for Adult Social Care, (ASC) for the period June 2023 to November 2023.

## 2. Recommendations

The Health Overview and Scrutiny Panel note the content of this report.

## 3. Overview

Portsmouth City Council Adult Social Care, (ASC) provides advice, information and support to Portsmouth residents aged 18 years and over who require assistance to live independently and to unpaid carers who look after someone who could not cope without their support including those looking after children with additional needs. This support may be needed as the result of a disability or a short or long term mental or physical health condition. The service aims to encourage people to use their own strengths and community resources to have as much choice and control as possible over how their care and support needs are met. For some, the service will also help people find the short, or longer-term care and support arrangements that best suit them.

Adult Social Care promotes health and wellbeing for all, helping people to build on their strengths through access to advice, support and care enabling them to feel safe and able to contribute to their communities.

Before the end of 2023 the duties and responsibilities obligated on Councils with Adult Social Services Responsibilities (CASSR), under Part 1 of the Care Act 2014, will be subject to regulation by the Care Quality Commission (CQC).

## 4. National Legislation & Guidance

Further to the enactment of the Health & Care Act 2022[1] the following has happened since May 2023:

The Care Quality Commission, (CQC) have completed their inspection pilot with 5 Local Authorities; Birmingham; Lincolnshire; North Lincolnshire; Nottingham City Council and Suffolk County Council. Reports, indicative scores for all quality statements and an indicative overall rating will be published in January 2024.

CQC have also reviewed published data for all 153 Councils with Adult Social Services Responsibility, (CASSR) against the quality statements of assessing needs and care provision, integration, and continuity, which was the first step in full assessment and the start of developing judgements. A high-level summary of the findings have been published in CQC's annual state of health and care report.[2]

CQC are currently developing how they will select first local authorities to be assessed, (20) and assessment is due to commence in 2023. The proposal for the secondary legislation required to give CQC the mandate to conduct the inspections has been submitted to the Secretary of State.

In August 2023, the government published the Adult social care intervention framework for local authorities[3]. This provided information to local authorities in England on the government's approach to intervention in adult social care. The powers of intervention introduced through the Health and Care Act (2022) enable the Secretary of State for Health and Social Care to intervene where they are satisfied that local authorities have failed or are failing to discharge Care Act functions to an acceptable standard.

The framework sets out a continuum of action where CQC identify that the Local Authority is not delivering its functions under the Care Act. This continuum ranges from direction to resources that the Authority can use to inform its improvement process to enabling the Authority to lead its own improvement process, to the Secretary of State appointing commissioners to an Executive Commissioner taking on the role of performing some of the functions of the Authority and directing the Authority in its actions[4].

[1] Health and Care Act 2022
[2] 'The state of health care and adult social care in England 2022/23'.
[3] Adult social care intervention framework for local authorities
[4] Summary here.

**4.1.** As reported to HOSP in May 2023, Hampshire & Isle of Wight (HIOW) Integrated Care Board (ICB) began undertaking a workforce review in February 2023 which is ongoing. It is expected to have a significant impact on the future shape and resource of ICBs; any deficit could place additional burden on Councils with Adult Social Services Responsibilities (CASSRs)

**4.2.** The draft Mental Health Bill, intended to modernise the Mental Health Act still awaits parliamentary approval.

## 5. Health & Care Portsmouth

Portsmouth City Council has a strong history of integrated working relationships with all NHS partners in the city. We continue to work with five partner organisations across the city: NHS Hampshire and Isle of Wight Integrated Care Board, (ICB) Portsmouth Hospitals University NHS Trust (PHU), Portsmouth Primary Care Alliance, Solent NHS Trust and HIVE Portsmouth and together we make up Health and Care Portsmouth (HCP). The impact of the ICB restructure on our partnership working is currently unknown.

HIOW ICB has recently taken the decision to institute the 'Fusion' project; this will lead to a single community health and mental health provider organisation for Hampshire & the Isle of Wight (which includes Portsmouth). Adult Social Care (ASC) and colleagues are in discussion with the ICB to try and understand the implications of this for our partnership working and integrated team structure.

Since December HCP has been working on several initiatives including how together we support improving quality in the care market; supporting care providers to embrace use of digital technology and working together to ensure appropriate alignment of our strategy and business plans.

## 6. Key Issues

### 6.1. National reform

Proposed reform constitutes significant changes to the law and related guidance and although elements have been delayed there are still requirements placed on local authorities, which places pressure on resource.

Since the last report to HOSP we have created and shared our Capacity Plan with DHSC, a requirement of grant funding (Market Sustainability and Improvement Fund), submitted responses and reported on similar grants to support health and social care. The funding is welcome, however reporting requirements do stretch commissioning, operational and reporting resource.

## 6.2. Adult Care and Support

### Occupational Therapy (OT)

Following the successful completion of our OT Project 100, a project aimed at reducing the Occupational Therapy waiting list by 100 people, we have managed to maintain waiting times for non-critical face to face assessments to approximately 8 weeks; this is a significant reduction from the 20 weeks starting point. All clients have a conversation with an OT duty worker on the same day they contact our service which ensures, where appropriate, we can provide immediate support.

In the last six months the service has focused on ensuring our case recording is strength based and robust with consistent language used by all therapy staff. Regular audits and observations in practice reassure us that staff continue to make a real difference to our client's lives.

We have introduced a customer feedback form to evidence the impact of our interventions and to learn if any improvements are needed to our service. Occupational Therapy week, which runs annually in November, focused on the value of occupation and how vital occupations are for all of us in our everyday life. We had some case reflections and customer feedback which demonstrated what our clients hoped to be able to achieve and how the occupational therapy intervention enabled them to do this. For example, one lady wanted to be able to attend her daughter's wedding but had been in bed for a lengthy period of time. The occupational therapist introduced a graded sitting out programme, specialist moving and handling equipment and made arrangements for a suitable wheelchair to be available. This enabled the lady to sit out at home and achieve her dream of seeing her daughter get married.

Three of our Occupational Therapy Associate Practitioners (OTAP) are on the OT degree apprentice course; a four-year course delivered by the University of the West of England with our first graduate due in July 2024. We are proud of our comprehensive mentor and assessor programme and have been

supporting Solent and Southampton colleagues in establishing apprentice support best practice.

We have no current vacancies, having successfully recruited to all vacant post from first advert.

## 6.3. Hospital Discharge

### Discharge to Assess Team (D2AT)

The team continues to experience recruitment issues, which is resulting is waiting lists for assessment remaining high across all areas covered by the Discharge to Assess Team.

The team are able to respond well to people who are in crisis to ensure that our citizens remain safe. However, this often has a detrimental impact on waiting lists and therefore assessment response times. The team have recently recruited an additional permanent full time Assistant Team Manager, 1 Senior Social Worker and 2 newly qualified Social Workers to replace locums, which will support better quality and more timely flow through the services which is expected to lead to a positive, sustainable change in numbers of people waiting assessment for over 4 weeks in the next month. Currently we have 19 awaiting assessment at home and 9 people in a residential care setting as part of the D2A process, which is a continually improving picture.

The team have received a number of complaints and concerns recently, which are being responded to accordingly. Any learning for individuals, the team, and wider service is shared where appropriate with additional support or training provided to staff where needed. We have started testing client feedback forms to ensure that everyone we are working with is given an opportunity to provide comments on the service to enable us to celebrate good practice and consider learning points and any action needed where appropriate.

### Integrated CHC - Adults

Key performance indicators have been achieved for this latest reporting period.

The service is working with other place based CHC teams, within HIOW, and the central ICB team to consider whether any of the processes could be aligned across the ICB for the benefit of our citizens (where appropriate).

The team have also been supporting the D2AT with assessments to help reduce the delays for our clients and manage our financial risk.

**Portsmouth Rehab and Reablement Team (PRRT) / Community Independence Service (CIS)**

Portsmouth Rehabilitation and Reablement Team (PRRT) have continued, over this period, to support timely hospital discharges to ensure those people that can go home, do so with access to rehabilitation and reablement support through in-reaching directly into the hospital.

CIS have also continued to support D2A, working more directly with the D2A team to focus on reducing the length of time people remain in interim placements and helping people return home where possible.

There are several commissioned rehabilitation and reablement services working across Portsmouth, which includes CIS, PRRT and Community OT. This has led to a fragmented and inconsistent pathway for referrers to navigate, with lack of clarity on the appropriate service to refer patients and service users. The Portsmouth health and care vision is to provide a single rehabilitation and reablement offer across the City, ensuring that Portsmouth residents needing care or support receive rehabilitation and reablement as a default offer. The aim to optimise individuals' independence, reduce reliance on more formal statutory services and promote a strength-based approach. Work reviewing these two functions, with an aim of bringing together continues; expected to conclude before the end of the year and lead to shaping the new service with the teams.

## 6.4. Work with People with a Learning Disability

The Integrated Learning Disability Service (ILDS) continues to have high levels of referrals with an overall caseload increase. There has been a significant increase in transition referrals (those Portsmouth residents turning 18 and needing support) and a proportion of those eligible for Continuing Health Care (CHC). This has placed a major strain on the service and has required investment in staffing from both the City Council and Solent NHS Trust. Similar investment was also sought from HIOW ICB to ensure sustainability, which has just been agreed. We are still recruiting to additional CHC posts.

In the previous 24 months the ILDS caseload has increased from 778 to 954 Portsmouth residents, representing 23% growth (an additional 176 cases).

Currently, there are 146 residents waiting allocation to a named worker; this represents 15% of the entire caseload. Of these 64 (44%) have been assessed as very high priority for support. We anticipate this situation will begin to improve following successful recruitment to our ASC vacancies.

The service has achieved 84% of annual reviews of the residents we support. We expect this to rise above the 85% expected performance level with additional capacity for new staff, now in post.

In the next four years, there are an estimated 70 Portsmouth residents who will turn 18 and need care and support from the service. It should be noted that an unusually high proportion of these young people have significant care and support needs, with several having been placed outside of the city by Children's Social Care.

Alongside continuing fieldwork pressures, the ILDS:

- are developing innovative and cost-efficient local commissioning solutions for young adults in transition with high-cost care packages. This has been achieved for some in a new development (Fir Trees); another local initiative for 7 young people currently placed outside of the city is in development and an expression of interest for capital to purchase a local property has been submitted.
- have developed a powerful video resource recounting the experiences of 5 people who lived in institutional care (Coldeast Hospital) before moving back into local community services. The personal stories help us remember why the continued development of community services for vulnerable adults is so important.
- continue with the introduction of the “safe places” scheme within the city.
- continues to host a provider partnership forum that champions quality improvement initiatives. More recently this has started working with a newly appointed LD community pharmacist to help better respond to medication errors across services.
- are refreshing the commissioning framework for supported living services with the dual ambition of driving up quality whilst managing the market in a way that is sustainable.
- are in the process of refreshing the commissioning strategy for local opportunities for day activities.
- are reviewing the local short break (respite) provision, with an ambition to develop a new offer that reflects the wishes of our community, is cost efficient, and introduces more choice.

## 6.5. Adult Mental Health (AMH) Support Services

Over several years, for our AMH Supported Living pathway we have been working towards some key outcomes including:

- increasing the number of high-quality accommodation placements and independent housing opportunities
- greater utilisation of housing stock and more flexibility of timely movement throughout the pathway
- increased service user satisfaction through coproduction, choice, and control
- a much-improved shared accommodation offer (incorporating supported accommodation with 24-hour support, self-contained supported accommodation with on-site staff support, and shared or self-contained accommodation with floating support)
- significant increase in independent housing options with assured shorthold tenancies as opposed to licence agreements.
- improved relationships between landlord and tenant due to shared understanding of rights and responsibilities on both sides
- increased service user support when required.

To achieve these outcomes all our recent service improvements have developed individualised provision within an affordable framework, based upon economies of scale. This has allowed us to repatriate people back into the city to be closer to their families; also, we have managed to redirect provision away from private hospital inpatient placements and high-cost residential care services to recovery focussed supported accommodation services, like the 18-bed Oakdene supported living service that opened in July 2021.

We continue to use some specialist residential services for a small number of people, these are mainly out of the city. These arrangements are regularly reviewed to ensure that that they continue to meet the needs of the individuals. Monitoring of quality and review of progress are integral to our work, and this supports us, where appropriate, to ensure that there is a clear recovery plan in place to step the person down to a less restrictive environment.

Prevention of homelessness is key to good mental health. The community floating support service has successfully supported people to remain in their own homes, some of whom would otherwise have been evicted, creating homelessness and a need to access a crisis service, and sometimes leading

to inpatient admission, due the adverse impact this experience has on a person's mental health.

Flexible commissioning models serve to ensure that providers are agile enough to provide the right level of support in line with the emergent needs of service users. We are working in partnership with our providers to ensure that support is delivered in the most effective and responsive manner, this has enabled us to move a greater number of individuals through the pathway, stepping down more quickly to lower support services or complete independence. This has enabled us to review our supported housing provision and decommission less suited or lower quality accommodation.

### 6.6. Carers Service

Over the past six months, the carers service has continued to receive high rates of referrals, both from professionals and self-referrals. We have also increased the variety of services we offer.

Areas of focus for the Carers Service over the past six months include:

- increased training and guidance around joint assessment work with the Adults Care and Support fieldwork teams. This will enable clients and carers to experience a more holistic 'whole family approach' to Care Act assessments.
- development of new peer support groups with a focus on parent carers and minority ethnic groups.

The Carers Service continues to see high levels of demand for services which is reflected in the increased spend in some areas, particularly the sitting service, although the budgetary position has improved with a reduction in the forecasted overspend for sitting service in 2023/24. We have also seen challenges resulting from the cost-of-living crisis.

We are starting to consider the transition model for young carers coming into the adult carers service both via the young adult carers transition pathway and through direct referral into the service.

Recognising the vulnerability of lone carers, we are developing a model for recording carers contingency plans in conjunction with NHS England which utilises the summary care record to increase visibility of these plans.

Here is a wonderful piece of feedback from one of the carers who regularly uses the service:

*'As a 71-year-old man with the sole carer responsibility for my physically disabled wife and 50-year-old daughter with severe learning difficulties, day to day life is challenging. It is no surprise that the demands have contributed to a deterioration in my own health both physically and mentally. Some years ago, I became aware of the existence of the Carers Centre, and since then it has become something of a beacon in my otherwise quite depressed existence. The cookery sessions provide a lovely opportunity to learn new skills with a comfortable sized group invariably led by really nice caring people. In addition, the opportunity to attend the health and wellbeing sessions, at the allotment, have been delightful. The very location is tranquil and the opportunity to escape the caring role, in such comfortable surroundings is so very therapeutic.*

*It would not be an exaggeration to say that the provision of the carers breaks sessions at the allotment and carers centre for me have been a life saver.'*

### 6.7. Independence and Wellbeing Team

The work of Independence and Wellbeing Team (IWT) remains core to our strategic approach in terms of co-producing solutions with a focus on strength-based practice to arrive at personalised, local and sustainable solutions. The focus remains on supporting the people of Portsmouth to

- retain their independence and quality of life.
- keep well.
- avoid social isolation and loneliness.
- have a sense of purpose.
- build and promote community.

The information below is taken from the data report for Community Development Service for period April - October 2023:

- 408 Portsmouth residents participated in 13 separate projects delivered by the IWT:

| | | |
|---|---|---|
| Chop Cook Chat | Reading Friends | Community Allotment |
| Yoga in the Park | Diversi-Tea Lounge | Autism & Neurodivergence Group |
| Refugee Badminton | Ethnic Grow Project | |
| Rock Out | Paulsgrove Men's Group | Extra Care Housing |
| Naturewatch | Treadgolds | |

## EDI Data

| Disability of service users | | |
|---|---|---|
| **Disability Type** | **Number** | **%** |
| Learning Disability | 9 | 2% |
| Physical Disability | 50 | 12% |
| Neurodivergence | 3 | 1% |
| Hearing Impairment | 4 | 1% |
| Sight Impairment | 4 | 1% |
| Cognitive Impairment | 2 | 0% |
| Mental Health | 10 | 2% |
| Multiple Disabilities | 41 | 10% |
| No Disability | 196 | 48% |
| Not Specified | 89 | 22% |
| Total | 408 | |
| | | |

| Age of services users | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Age** | **18+** | **20+** | **30+** | **40+** | **50+** | **60+** | **70+** | **80+** | **90+** | **Not Specified** | **Total** |
| **No.** | 6 | 26 | 31 | 59 | 57 | 61 | 39 | 30 | 8 | 91 | 408 |
| **%** | 1.5% | 6.4% | 7.6% | 14.5% | 14% | 15% | 9.6% | 7.4% | 2.0% | 22.3% | |

| Gender of service users | | | | | | |
|---|---|---|---|---|---|---|
| **Gender** | **Female** | **Male** | **Transgender** | **Non-Binary** | **Not Specified** | **Total** |
| **No.** | 246 | 108 | 0 | 0 | 54 | 408 |
| **%** | 60.3% | 26.5% | 0% | 0% | 13.2% | |

| Ethnicity of service users | | |
|---|---|---|
| **Ethnicity** | **Number** | **%** |
| Arab | 1 | 0.2% |
| Asian - Chinese | 6 | 1.5% |
| Asian - Bangladeshi | 56 | 38.2% |
| Asian - Indian | 4 | 1.0% |
| Asian - Pakistani | 2 | 0.5% |
| Asian - Other | 29 | 7.1% |
| Black - African | 1 | 0.2% |
| Black - Caribbean | 0 | 0.2% |
| Black - Other | 1 | 0.2% |

| | | |
|---|---|---|
| Mixed or Multiple Ethnicities | 2 | 0.5% |
| White - British | 196 | 48.0% |
| White - Irish | 1 | 0.2% |
| White - Gypsy or Irish Traveller | 0 | 0.2% |
| White - Roma | 0 | 0.2% |
| White - Other | 18 | 4.4% |
| Any Other Ethnic Group | 11 | 2.7% |
| Not Specified | 86 | 21.1% |
| **Total** | **408** | |

**Action:**

The service continues to monitor EDI data, with ongoing work to improve quality of recordings to reduce the number of unspecified responses. Also, Community Development Officers will be undertaking focused community outreach work to address low take up by residents with a protected characteristic.

**Wellbeing Evaluations - Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWS)**

| | Before Intervention | After Intervention | Change | Positive change? | Statistically Significant | Wilcoxon signed rank test P value |
|---|---|---|---|---|---|---|
| **% Low wellbeing** | **37%** | **21%** | | | | |
| **%Moderate wellbeing** | **44%** | **57%** | | | | |
| **% High wellbeing** | **20%** | **21%** | | | | |
| | | | | | | **P<0.0** |
| **Mean score** | **24.4** | **26** | **4.23** | **Yes** | **Yes** | **5** |
| **Standard deviation** | **6.3** | **4.5** | **6.6** | | | |
| **By age** | | | | | | |
| **16-24** | **15.4** | **19.0** | **3.60** | **Yes** | | |
| **25-39** | **24.9** | **30.5** | **5.64** | **Yes** | | |
| **40-54** | **23.4** | **27.7** | **4.32** | **Yes** | | |
| **55-64** | **23.8** | **26.8** | **3.07** | **Yes** | | |
| **65+** | **25.5** | **23.8** | **-1.77** | **No** | | |
| **By gender** | | | | | | |
| **Male** | **24.5** | **25.0** | **0.49** | **Yes** | | |
| **Female** | **24.4** | **26.8** | **2.39** | **Yes** | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **No. of people with a meaningful positive change (%)** | | | | **15** | **53.6** | **%** |
| **No. of people with a meaningful negative change (%)** | | | | **2** | **7.1** | **%** |

**Action**
The above figures do not include all post engagement evaluations as the service undertakes post engagement reviews at 6 months; a more complete data set will be available at the end of Q4 2023/24.

For Q1 and Q2 Community Connectors full reports please see Appendix 2 of the report.

### 6.8. Participation and Engagement

We believe, that to meet the challenges of delivering on our vision and strategy for Adult Social Care in the city, power must be distributed more evenly between people who use services, those with lived experience, people providing assessment/support and leaders. We continue to move to a language of involvement and shared power which will help to achieve the required shift in culture.

Achievements over recent months include:

- Strength-Based practice - phase one of this work is now complete following an independent stock take of our practice, focussed on how embedded the principle is of working to people strengths and maximising opportunities for independence; with an approach focussed on co-producing person-centred support plans with people requiring support.

  The stocktake included engagement sessions with carers, people with lived experience across all customer groups and practitioners. Evidence showed there are pockets of good practice, however we want to support consistency across all practice, including clear recording. The recommendations will form a delivery/improvement plan for phase two of the project.

Although we engaged with stakeholders, we recognised this is an area we need to develop further and have committed to develop a clear approach to engagement across the Directorate.

- From mid-October the Directorate has funded resource, from the Corporate Engagement Team for a year, to support us to develop an engagement strategy and draw on their expertise to engage with key stakeholders so our business, our priorities and any changes are at a minimum based on inclusive feedback from engagement, and ideally are co-produced.

- To support our preparation for regulation of ASC by the Care Quality Commission, in October we held an engagement event with formal stakeholders (including Public Health, ICB, Hampshire Care Association, Age UK Portsmouth, Police, The Hive and voluntary sector organisations). Our vision and several quality statements were shared and discussion, linked to areas of the assessment. A further virtual event is planned in November, the outcomes from both will be feed into our self-assessment.

### 6.9. Management Information Service

Following the previous HOSP report ASC have now implemented the Requests element of Client Level Data (our new statutory collection report mandatory from 1st April 2023)[5]. We are currently developing the Assessment and Reviews element, due to go live late November 2023.

We have made 2 successful submissions of CLD to DHSC (Q1 and Q2), with each submission improving on the previous, following the implementation of each new element. This will enable us to improve analysis of our service delivery and performance.

We will shortly be implementing the final phase of CLD, Support Planning, and will be completing and submitting full returns from April 2024.
To meet the requirement to support our data and information needs and to develop our business processes, we have recruited to two new posts, with recruits joining the team in November. This should reduce the reliance on external agency resource for specific skills, such as those needed for 'Python' software.

Our data warehousing project is due to start in November, improving our management information capabilities in the service.

[5] Client-Level Adult Social Care Data (No. 3) - NHS Digital

## 6.10. Regulated and Provider Services

Portsmouth City Council is regulated by the Care Quality Commission (CQC) for the delivery of three residential services; Harry Sotnick House, Russets and Shearwater are registered for the delivery of accommodation for persons who require nursing or personal care.

Each unit has a management team, consisting of a registered manager, deputy, and assistant unit managers as well as care and ancillary staff relevant to the service provided.

All services are subject to inspections from the CQC in line with their registered activity.

Harry Sotnick House was inspected by CQC in May 2022, and received an overall rating of Good, this was reviewed in July 2023. The unit has 46 bedrooms, 3 lounge areas with kitchenettes and accessible garden and patio areas. The care and nursing team specialise in offering long term dementia care and bed based reablement for older people with mental health and physical health needs, provided in a homely and caring environment.
A recent development is an offer of respite to informal carers requiring a break from their loved one, this is in partnership with the Carers Centre, demand for the service is extremely high, running at over 90% capacity and feedback on outcomes is positive.

Shearwater was inspected and rated overall as Good in March 2021; this was reviewed in July 2023. The unit specialises in dementia care for older people, offering long term accommodation and support in an enabling way to maintain independence, choice, and control. The top floor of the unit was closed in 2021, reducing the capacity from 60 to 40 residents. Consequently, the service was reviewed, and following consultation significant changes were made to the staffing establishment; there is a smaller management team, new team leader posts to support career progression and an increase in the number of care staff. The residents can choose from a range of activities, take part in seasonal events, and enjoy outings with staff and volunteers.

Russets was last inspected in December 2022 and is rated as Requires Improvement. The unit manager and Head of Service met with the CQC inspector in August 2023 to discuss the action plan and provide evidence of improvements. The service also completed a Provider Inspection Return (self-assessment) in August 2023. Russets is part of the offer to adults with a learning disability in Portsmouth, providing short breaks and longer-term accommodation with care and support. The staff team aim to create a positive environment which promotes independence and choice, where people are

offered experiences and opportunities to assist them with achieving their aspirations, and goals in life.

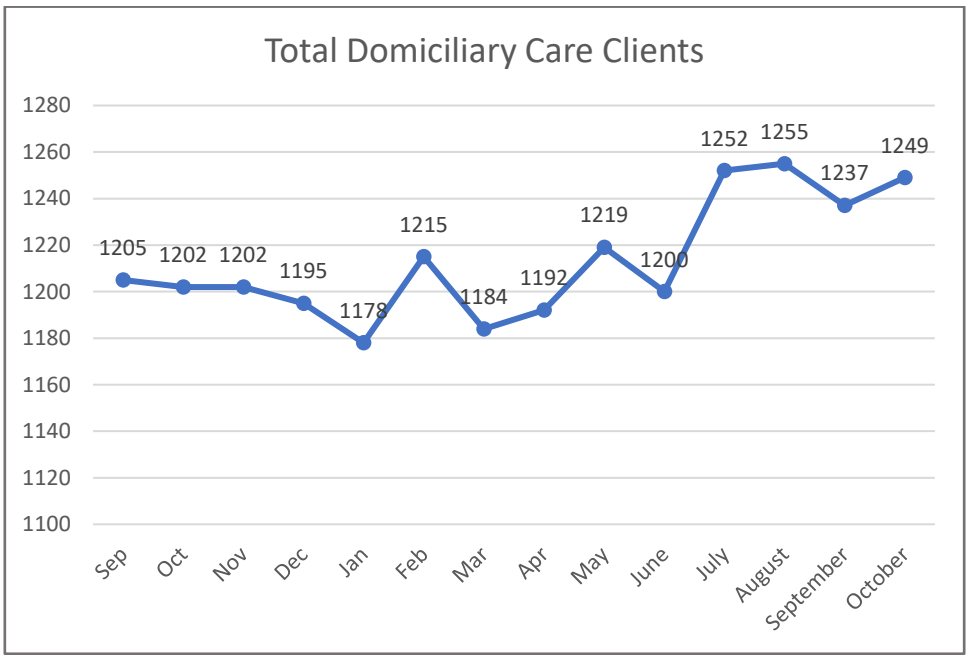
N.B. CQC are currently trialling their new single assessment framework across their Southern region, which includes Portsmouth. Consequently, this may mean a delay to inspections where there are no significant risks meaning ratings could remain unchanged for a longer period, but this will not stop services continuing to deliver to their action plan.

## 7. Demand

The figures below are snapshots of Portsmouth residents with care and support needs who are in receipt of care and support in the month.

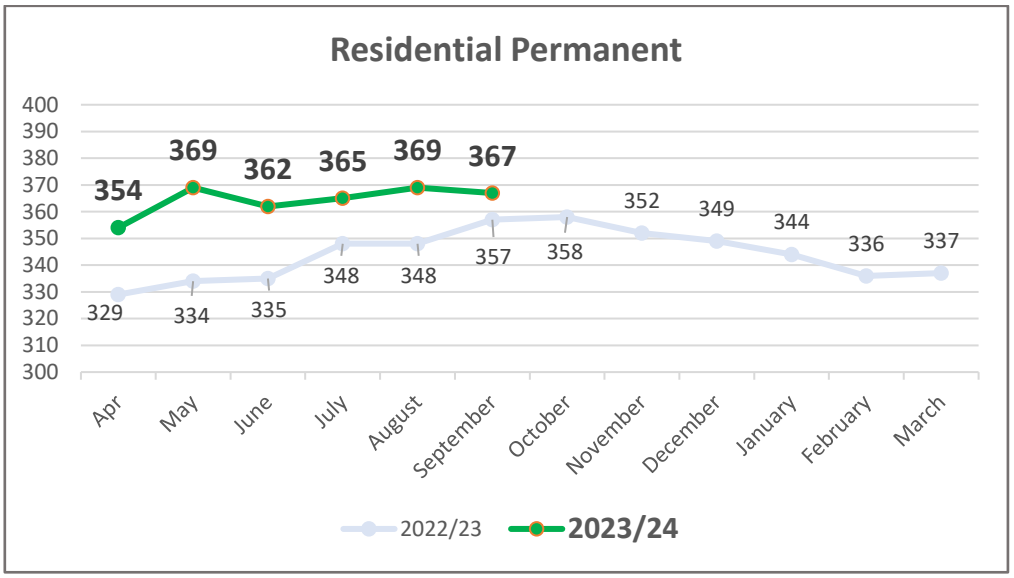
### 7.1. Domiciliary Care Services (including Day Care)

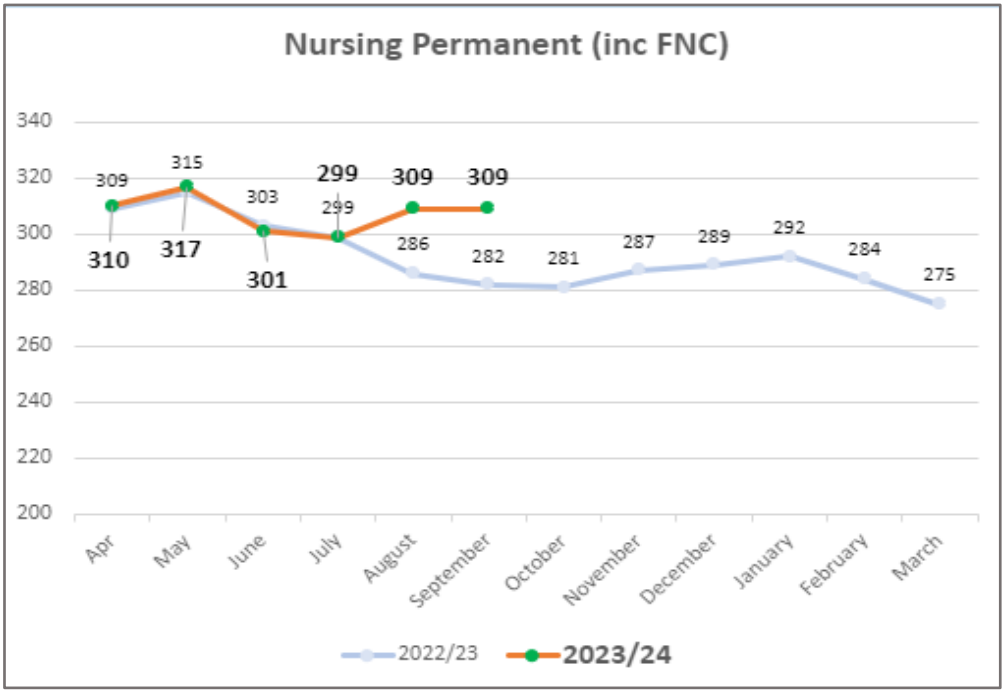
The number of people receiving care in their own home has gradually increased over the past 12 months. This is reflective of the increase in demand upon Adult Social Care referrals and service demand coming through our 'front door'.




### 7.2. Residential and Nursing Care

Apart from occasional fluctuations the number of residents in Residential and Nursing Care has remained broadly the same for the last six months, however significant increase on 22/23 demand.




## 7.3. Deprivation of Liberty Safeguards (DoLS)

Assessments are allocated by the administration team in line with timescales of the Act to Doctors, Best Interests Assessors, and Independent Advocates, we also utilise a triage process at times.

| Descriptor | No. | Change against previous |
|---|---|---|
| Referrals Received (all Referrals) | 446 | 33% fewer |
| Referrals Received (excluding Furthers & Reviews) | 304 | 38% fewer |
| DoLS Granted | 156 | 12% increase |
| Average Time between Referral & Authorisation | 56 days | Increase of 28 days |

| Status of referrals 31/08/2023 | No. | Change against previous |
|---|---|---|
| With Triage | 14 | Increase of 9 |
| To be Allocated | 26 | Increase of 3 |
| To be Triaged | 6 | Decrease of 7 |
| Total to be Allocated | 46 | Increase of 5 |

The data for the period 1st May - 31st August 2023 when compared, on a pro rata basis, to the figures submitted in the April report to HOSP show a slight reduction in referrals over the period.

The team have run workshops to update ASC staff on how to record when carrying out mental capacity assessments and best interest decision making; all staff have now completed this.

Also, the team are working with Childrens Services to support understanding of the implications of a Supreme Court ruling in January 2023 that prohibits parents from making decisions for children aged 16 or 17 who lack capacity to make a decision about where they reside, or aspects of their care and education plans. The feedback from this work has been positive and has identified that this needs to be further developed.

DoLS is expected to continue until 2025 as a minimum; meanwhile DHSC are re writing codes of practice and other aspects of proposed legislation.

### 7.4. Mental Health Act Assessments

The Approved Mental Health Professional (AMHP) team are providing proportionate deployment of staff to respond to formal requests for Mental Health Act assessments.

Delays are a common theme for this process and some of these are documented below. An Assessment requires 2 doctors (psychiatrists) and it has become more challenging to locate doctors to carry out assessments from Solent NHS Trust. There is a recruitment challenge for most NHS Trusts at this time and those doctors who are working in the trust are mostly reluctant to assist us, as the task is not part of their contracted work. This leads to delays in response to requests.

The team are continuing to monitor issues of obtaining warrants, due to the online system introduced by Her Majesty's Court Service (HMCS), that has delayed access to urgent warrants due to reduced spaces. This can have an impact on assessment timescales, with the potential impact of creating delays to admissions. The AMHP team have also reviewed their use of warrants seeking to reduce the need for applications.

There are additional complications due to delays in accessing private ambulance cover; consequently, this can (and sometimes does) delay admissions and create additional pressures. These issues are monitored by the Integrated Care Board (ICB) who are responsible for the management of the contract with Secure Care UK. The MHA lead attends a bed resilience meeting each week that monitors the bed situation as a well as the response times by Secure Care UK.

The recent publicity in regard to Right Care, Right Person[6] that the Police have brought to national attention has led to a new focus on a regular 2 weekly meeting to focus on the operational processes for those arrested on s136 in suites across Hampshire and in QAH when suites are full. This work is being led by the ICB.

Our Solent NHS Trust partner continues to experience challenges in managing the inpatient wards to ensure the flow of admissions and discharges. They have been affected by the national Registered Mental Health (RMN) nurse and psychiatrist recruitment challenges. This has resulted in transfer delays from QA Hospital while a mental health bed is sourced. The situation is being monitored closely by the Trust.

[6] **National Partnership Agreement: Right Care, Right Person (RCRP)**

As a result of the many delays that were occurring the MHA lead approached DASS sharing the AMHPs were unable to undertake their role in a timely manner as required by the Act leading to risks for PCC by way of legal challenge. Examples include someone waiting over a week for the execution of a s135(1) warrant due to police and ambulance services not being available, the AMHP not being able to make an application to detain to hospital due to no bed being available. As a result of this a decision was taken to add the AMHP team to the Risk Register for ASC and Corporate. This issue has now been taken to the Board and a decision made to write to the ICB formally and to collect relevant information about delays experienced by the residents of Portsmouth who require mental health act assessment.

Referral rates increased during the summer but generally remained steady over the course of each month although the AMHP service experiences increases at times. Where required the service deploys AMHPs on a supernumerary basis which supports a flexible response to meet increased demand on the service. There has been an increase in referrals for individuals under 18.

The team are often thanked by relatives for their work in enabling those who are unwell to be admitted to hospital. For those subject to assessments feedback is more difficult to obtain mostly because people are so unwell at the time of the assessment; the team have attempted other methods such as seeking feedback from care coordinators and other services that support the person with limited success.

The AMHP team have received no referrals for the Treasury's "Mental Health Crisis Breathing Space"[7] programme during this reporting period; additional guidance for AMHPs was issued following a legal judgment on eligibility. The programme helps take the pressure off people with debt issues while they are receiving crisis treatment and up to 30 days post treatment. This low take up is reported in regional and national AMHP leads networks and reflected across the country.

### 7.5. Adult Safeguarding

Adult MASH received over 600 referrals per quarter for a consecutive four quarters, an unprecedented level of demand for the team. Of the referrals received in Q1 and Q2 2023-24, over 50% met the Section 42 statutory criteria.

Where enquiries concluded in Q1 and Q2, the outcomes were:

- In 99% of cases, risk identified during the enquiry was reduced or removed on conclusion.

[7] Guidance on mental health crisis breathing space

- 75% of adults were asked for their desired outcomes for the enquiry, and when desired outcomes were expressed, 97% of these were fully or partially achieved.

This year, outside of statutory duties, the focus of the team has been on providing education and outreach to care providers and partner agencies in the city, helping to reestablish relationships and networks post-Covid. This outreach has taken the form of 'Meet the Adult MASH Workshops', offered to care homes, homeless services, supported living providers, PHUT, domiciliary providers, charities, and colleagues in partner agency safeguarding teams. The outcomes of 'Phase 1' of the workshops:

- Over 90 members of staff reached from 29 services
- 95% found the workshop to be 'more than satisfactory'
- 94% found the content to be 'very relevant' to their role

Much of the feedback from the workshops thus far has expressed how useful these sessions have been and requested that these are repeated and rolled out to further members of staff, something that the team is keen to do, should resourcing allow.

In addition, the team continues to offer safeguarding clinics for colleagues in adult social care, to carry out internal audits and participate in multi-agency audits organised by the PSAB, and to contribute towards care provider monitoring in conjunction with the HIOWICB and PCC contracts and commissioning.

## 7.6. Complaints

The Complaints Managers have continued to operate in a hybrid way, offering in-person, telephone, and online support. The complaints team handle complaints about Adult Social Care (ASC), Childrens Social Care (CSC) and the Integrated Care Board (ICB). We have recently experienced a significant number of complex complaints across the services.

For Adult Social Care, monthly exceptions reports are now taken to the ASC Governance Board, in addition to the quarterly and annual complaints [8]reports. This ensures the Senior Management Team are aware of the nature of concerns being raised in the service and the themes and trends affecting their business areas, to support learning and improvement. Regular reports also go to the senior managers in CSC and the ICB.

As well as the Complaints Team being in contact with regional and national complaints groups, we also have good working relationships with other departments of the council, such as housing, and across other agencies.

[8] Adult Social Care Annual Complaints Report

For the detail of Complaints Report for the period 11 May 2023 to 13 October 2023 see Appendix 2.

Over the next period we are reintroducing face to face complaints training and mobilising a new weekly clinic where staff can seek 'in person' advice on complaint related questions.

### 7.7. SystmOne Support

Since May 2023, the SystmOne Support team have:

- Developed the system to support completion of the new mandatory Client Level Data (CLD) return for DHSC; phase one development has seen functionality implementation, upskilling, training, and support to practitioners.
- Submitted CLD Q1 return in July, (this includes data from another SystmOne Unit used by Solent and Integrated Learning Disability Service).
- Supported the mandatory monthly Patient Level Data Set submission for Continuing Health Care (CHC) for NHS England
- Introduced lean processes and functionality e.g., electronic referrals, updated SystmOne word templates to auto allocate 'sensitivity labels' introduced with share point, with a focus on saving practitioners' significant time.
- Developed a SharePoint reporting structure for the Directorate to enable migration
- Developed approaches to pull data and successfully complete and submit statutory returns to DHSC including SaLT return 22/3, including follow up analysis on measures outside of range to inform service improvement, input into the SE ADASS Performance dashboard to facilitate benchmarking and follow up learning.
- Generated the data required for the ADASS Spring and Autumn surveys; this is important as this contributes to a national picture of the key pressure on ASC in terms of increasing demand, increasing unit costs and budget pressures, changes in demography which supports the narrative to DHSC and Treasury in terms of the need for a review of long-term funding for Adult Social Care.

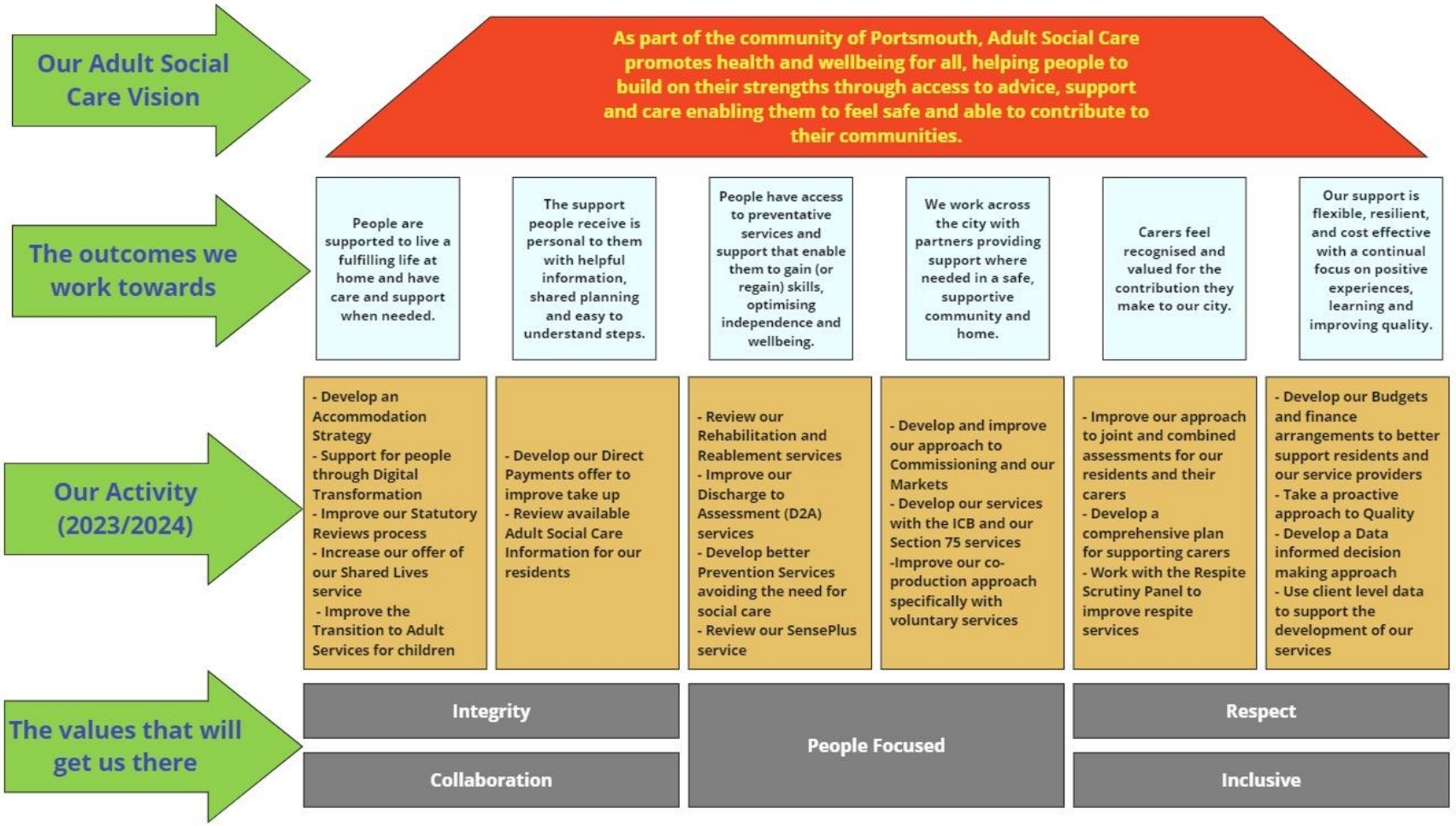
## 8. ASC Strategy

Adult Social Care have updated our strategy to include the corporate values and have been working to the result 23/24 Business Plan.

Our updated 'strategy on a page' which summarises our strategy into an infographic (is shown below).

We are in the process of reviewing our business plan, our delivery against it and will be starting the planning process for 24/5 aligned to the MTFS and

developing an updated business plan supported by an improvement plan to focus on areas where we know from a business, performance and customer perspective that delivering change will bring improved outcomes for residents in Portsmouth, within an optimal business structure.


Our Adult Social Care Vision
As part of the community of Portsmouth, Adult Social Care promotes health and wellbeing for all, helping people to build on their strengths through access to advice, support and care enabling them to feel safe and able to contribute to their communities.
The outcomes we work towards
People are supported to live a fulfilling life at home and have care and support when needed.
The support people receive is personal to them with helpful information, shared planning and easy to understand steps.
People have access to preventative services and support that enable them to gain (or regain) skills, optimising independence and wellbeing.
We work across the city with partners providing support where needed in a safe, supportive community and home.
Carers feel recognised and valued for the contribution they make to our city.
Our support is flexible, resilient, and cost effective with a continual focus on positive experiences, learning and improving quality.
Our Activity (2023/2024)
- Develop an Accommodation Strategy
- Support for people through Digital Transformation
- Improve our Statutory Reviews process
- Increase our offer of our Shared Lives service
- Improve the Transition to Adult Services for children
- Develop our Direct Payments offer to improve take up
- Review available Adult Social Care Information for our residents
- Review our Rehabilitation and Reablement services
- Improve our Discharge to Assessment (D2A) services
- Develop better Prevention Services avoiding the need for social care
- Review our SensePlus service
- Develop and improve our approach to Commissioning and our Markets
- Develop our services with the ICB and our Section 75 services
-Improve our co-production approach specifically with voluntary services
- Improve our approach to joint and combined assessments for our residents and their carers
- Develop a comprehensive plan for supporting carers
- Work with the Respite Scrutiny Panel to improve respite services
- Develop our Budgets and finance arrangements to better support residents and our service providers
- Take a proactive approach to Quality
- Develop a Data informed decision making approach
- Use client level data to support the development of our services
The values that will get us there
Integrity
Collaboration
People Focused
Respect
Inclusive

## 9. Quality Assurance and CQC (Care Quality Commission) Assessment of ASC

As updated in Section 4 of this report the pilot assessments with 5 local authorities have now concluded; these started slightly later than initially communicated, similarly the start of formal assessment has been delayed from the original date of September to later in 2023; at this time, we await a formal announcement confirming this which will follow the passing of the secondary legislation which we are led to believe is imminent.

Over the six months to November, we have gathered evidence against each of the 9 quality statements, to understand how compliant we are in meeting out statutory duties under Part One of the Care Act 2014, the legislative framework against which councils will be inspected. This process has involved team, managers, and senior managers across the Directorate. To share emerging information from CQC and the pilots and allow space to co-produce our approach to preparing for assurance we have has monthly ASC managers meeting; this has supported joint and several ownership of our approach across the business. We have invited colleagues from PCC owned and run registered care homes and colleagues from Childrens' Services who are familiar with regulation by Ofsted to present and work with us so we may learn and build on good practice.

In September surveys were shared with customers by post and in person to invite feedback on how well they felt we were delivering services these were set out in terms of 'I' statements. Further we invited formal stakeholders and partners to an in-person event on 17 October sessions to sense check ‘how we are doing, against a set of focussed statements including sector leadership, governance, living our vision and values’, and presence in the city. We have a further virtual event planned, once this has concluded the combination of the feedback will support as to check and refine our self-assessment and inform our improvement plan.

With support from the Engagement Team across November we are actively seeking input from residents, we regard this as being the most important element to inform future priorities and plans. Drop ins to existing groups, forums, meeting places and key places across the city will present an opportunity to get realistic feedback from carers, customers and resident of Portsmouth who may be thinking about or may have a need for support from ASC in the future.

We are using the information coming from the pilots and the summary of the remote review of all 153 CASSRs, against quality statements of quality

statements of assessing needs and care provision, integration and continuity to refine and shape our self-assessment and resulting improvement plan.

As a Directorate we have continued work, through briefings, newsletters, ASC live events and meetings to involve and inform staff on the evolving process.

## 9.1. Service Assessments

### Stroke Association Update

The Health Overview & Scrutiny Panel were updated in September 2023 on the decision to withdraw from commissioning the Stroke Information and Support Service.

In summary as of September, with the awareness that the Stroke Association would need to begin the processes to close the service from September 2023, the Leader of the Council and Cabinet member for Community Wellbeing, Health & Care confirmed to the Stroke association that the Council had identified non-recurrent funds to maintain the service until the end of December 2024.

This is not a recurrent source of funding and therefore at this time no funding will be available from the Council after December 2024. The Council has prioritised extending this service with the expectation that the ICB will implement an ICSS model in Hampshire & the Isle of Wight during 2024.

A report is being presented to this HOSP with an update.

### Review of Principal Social Worker [9](PSW)

Review of the pilot for the Post Qualifying Supervision Standards training has been completed. This was a successful programme for adult social care. Supervision is important as it supports practitioners to reflect and develop their practice. PSW has requested 5k from current training budget to roll out a cohort of 10 practitioners within this financial year, with a further 5k for 2024-2025. This training will be in collaboration with 2 other LAs to spread the cost of the budget.

The Principal Social Worker and Principal Occupational Therapist have designed and launched a framework to assess the quality of the case work through audits. This is objective and can be applied consistently, so we may hold up good examples, learn and prioritise work and support to understand

[9] PSWs lead on quality assuring social work practice and are a statutory requirement (ref in 2016 revised Care Act guidance).

why practice may not meet the required standard. The expectation is for each worker to undertake a minimum number of audits per year.

A number of audit tools have been introduced to practitioners to support them to ensure their work is legally compliant and to enable managers to quality assure their work. Principal Social Worker and Principal Occupational Therapist are overseeing audits and acting where necessary, to improve areas of practice that needs to be developed.

Preparing for inspection, we have developed a tool to support managers to identify cases in preparation for inspection. We have developed a chronology template to support tracking a person's journey across a year supported by adult social care.

Whole family approach workshops have been implemented. The workshops are designed to help practitioners to recognise the support systems in a person's life, which will support a strength-based approach to practice. It is also important to capture the needs of carers under our Care Act duties.

**Modern Slavery**

The Directorate with colleagues in corporate Procurement have supported research into Modern Slavery in the ASC Supply Chain. This was a national piece of work with Nottingham Rights Lab with the Local Government Association and two other local authorities. This has informed a publication, 'Establishing modern slavery risk assessment and due diligence in Adult Social Care: A commissioning officer's guide'[10], which has been published nationally, but more importantly has supported the Directorate to develop a plan of how we can take this forward in Portsmouth.

## 9.2. Updated Strategies

The Directorate continues to update, review, and introduce strategies to drive areas of work forward, provide clarity on intended outcomes and enable us to priorities key areas of work.

In June we submitted a capacity plan in response to meeting DHSC conditions for funding into ASC to support increases in fees paid to care providers, the Market Sustainability and Improvement Grant (MSIF) which we received for 2023/24. We outlined how capacity gaps would be addressed including initiative such as Portsmouth City Council partnering with HIOW ICB to develop a cohort of 10 Heath and Care Support workers apprentices, and stock take of strength-based practice: with a focus on prevention and a move

[10] Establishing modern slavery risk assessment and due diligence in Adult Social Care: A commissioning officer's guide

from deficit models, leading to the release of some capacity of formal care over time alongside developing strength-based commissioning.

We continue to work on other strategic approaches including accommodation related support, our Medium-Term Financial Strategy, and our workforce.

### 9.3. Quality Assurance

In previous reports to HOSP we outlined four key areas of focus of assurance as:

- feedback and the experiences of users, carers, and other stakeholders
- operational processes including quality supervision and practice observation.
- performance management using a set of key performance indicators. (based upon national and local reporting requirements)
- external assessment (including peer review, assessment and audits).

The update below talks to the above focus areas.

A summary of some of the things we have done in the last six months:

- Agreed funding for 12 months to secure a dedicated 0.4FTE for resource to support developing an ASC engagement strategy, to support the Directorate to engage with customers, carers, and residents consistently and meaningfully; this follows an initial piece of engagement work across the city, in November, to inform improvement.
- Introduced a new case audit tool.
- Developed a process to sign off statutory returns, ahead of submissions, by allocating a member of the Senior Management Team (SMT) to each of the returns with the responsibility of overseeing the return. The SMT member presents a summary of the return to Governance Board which gives the opportunity to understand any anomalies or data outliers, consider any impact this may be highlighting on service delivery or people receiving services. From this a plan is agreed to address the issue (be that data quality e.g., recording or a practice issue) with an update on progress and impact scheduled for a future meeting.
- Made our first submission to SE ADASS Performance dashboard so we may benchmark and learn.
- Participated in an ASC Leadership Review, by Partners in Care (Local Government Association (LGA) and Association of Directors of Adult

Social Services (ADASS) DASS [11]sector led improvement offer), due to report to the DASS and Chief Executive during November.

- Recruited to 2 new posts, data analyst and business analyst to resource the Directorate to support the Directorate in its vision of data informed decision making; this is an area that has not been resourced for a number of years.

### 9.4. Other Activities

- The Social Care Sector Operational Group following review and reset is now established. This monthly meeting brings together representatives from across health and social care in Portsmouth and CQC, to understand emerging issues, risks, and themes. This supports rounded understanding of where quality and improvement support may be required and who is best placed to lead. This forum has supported is to be both more proactive and responsive to quality concerns and have enabled us to highlight areas the system needs to come together to coproduce solutions, a recent example of this is guidance for the sector on covert medication and mental capacity; a welcome resource in response to a quality theme identified across a number of health and social care providers.
- The Quality Improvement Team, hosted by the ICB, has moved to line management of PCC and aligned to work alongside the ASC Contracts Team and Training Partnership resource; building on existing relationships and strengthening our oversight and support offered to providers.

## 10. Governance

ASC have an established monthly Governance Board that focusses on 'Management Insights', data that focus on key areas of the business including waiting lists, assessments, reviews, safeguarding etc. which supports driving performance. The data is reviewed and has supported us to improve on areas such as timeliness of reviews, assessments and better understand risk including safeguarding referrals into the MASH and how risks are managed.

The risk register continues to provide an overview of risks and issues.

Some of the current risks being monitored fall into the following themes (with some examples provided):

[11] The Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) are Partners in Care and Health (PCH), working with other well-respected organisations.
PCH helps councils to improve the way they deliver adult social care and public health services and helps Government understand the challenges faced by the sector.

- Demand
  Increasing demand for learning disability services, in particular 'transition' cases moving across from Children's Services as people become adults.
- Training
  Lack of corporate training database and gap in corporate resource to commission training into 24/5 for ASC, presents a real risk in terms of oversight and delivery of Directorate training.
- Cost
  Increased unit costs for care provision set against increased demand for Adults Care and Support is placing significant pressure on the service budget.
- Restructure of ICB
  Following establishment of ICBs in June 2022, where effectively CCG structures were moved across to the newly established ICB entities, since early summer ICBs have been reshaping and going through a series of Mutually Agreed Redundancy phases, which are likely to continue into 2024. This is having an impact on the shape of Health and Care Portsmouth, and there is a high likelihood that as funding is redirected, reduced, or stopped this could create a new cost pressure for ASC.

In reviewing risk consideration is given to any that may need to be escalated corporately.

ASC has a clear governance framework, project management tools and resources with a monthly scheduled Portfolio Board to maintain oversight and assurance around current ASC projects.

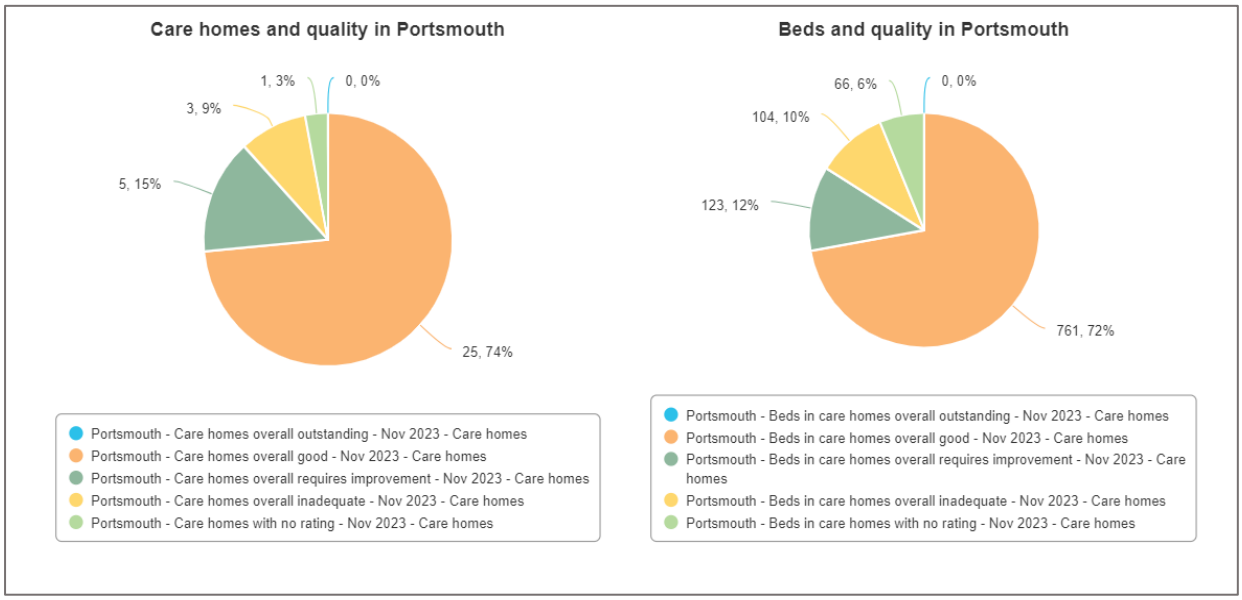
The ASC Contracts team has two posts funded through invest to save; across the team they have delivered a mix of cashable, non-cashable and cost avoidance measures which are on track to exceed the costs of the posts. This has been through identifying opportunities in existing contracts, renegotiating contracts, and tendering for new services including supporting the development of specifications. A report will be produced following end of 23/4 financial year.

On a quarterly basis, the data from savings plans updates are aggregated and shared with the Leader of the Council, S.151 Officer and cabinet member to ensure financial governance.

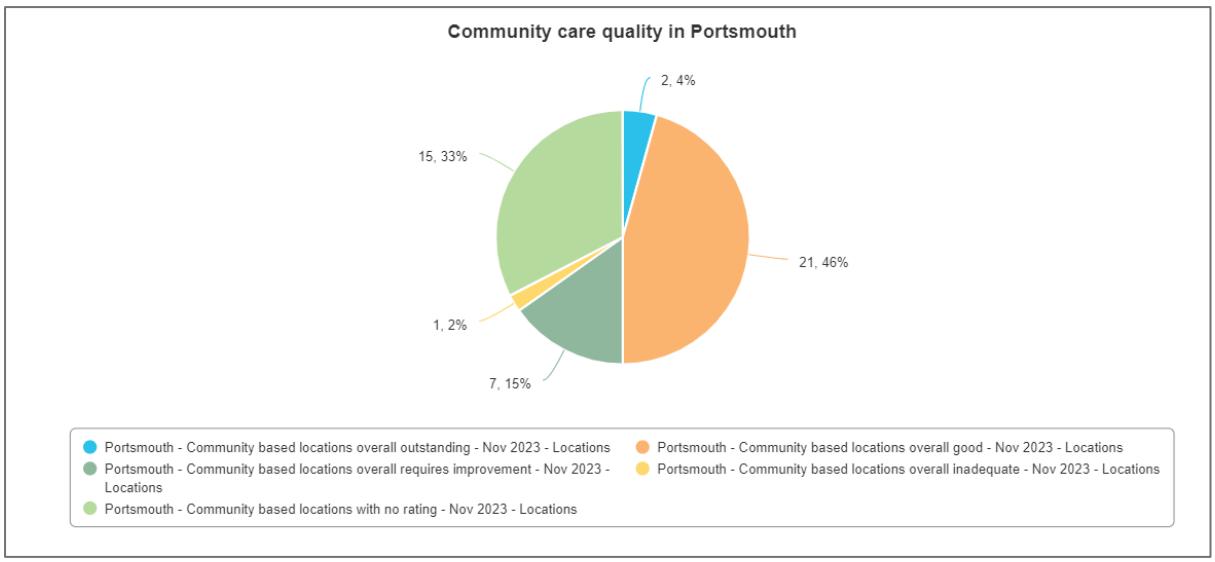
The service publishes regular papers to the Cabinet Member Decision Meeting and briefs opposition spokespeople monthly.

## Market Sustainability and Quality

Sustainability of the Care Market - in Portsmouth 74% of care homes (includes care with nursing)/72of beds in homes are rated good (an improvement of 9% since the last report). 2 of the 3, care homes rated inadequate are not currently operational, the true figure for inadequate service then reduces to 3%.




46% of registered community care provision (home care/domiciliary care) are rated good or outstanding (a 6% reduction since the last report). This is due to a previously unrated service being rated inadequate on its first inspection; as our care market is relatively small a change to one or two service ratings makes a noticeable difference overall.




Taking account of quality, CQC rating, workforce challenges, and cost pressure there remains a risk of capacity in the city not being sufficient to

meet need, and where there are pockets of capacity in the city having to pay a higher unit cost to commission services, is creating additional budget pressure.

Compared with nearest statistical neighbours Portsmouth has the highest numbers of small and medium sized care home, with only 1 care registered for 60+ beds - this is likely to impact on operating costs (i.e. higher unit costs) and may impact on the ability of providers to leverage investment to turn around a service in need of improvement; this is borne out when comparing overall ratings in a range of 58.6 to 98.1 for % of services rated good or outstanding Portsmouth, as above, falls at 74%.

The table below compares Portsmouth to England and SE Councils.

Portsmouth & England (Quantiles of All English single tier and county councils)

| Area | Care homes, good or outstanding, % | Beds in care homes, good or outstanding, % | Care homes with nursing, good or outstanding, % | Beds in care homes with nursing, good or outstanding, % | Care homes without nursing, good or outstanding, % | Beds in care homes without nursing, good or outstanding, % | Community based locations, good or outstanding, % |
|---|---|---|---|---|---|---|---|
| | Nov 2023 | | | | | | |
| | % | | | | | | |
| England | 78.8 | 76.2 | 76.1 | 74.9 | 79.9 | 77.5 | 62.3 |
| Portsmouth | 73.5 | 72.2 | 77.8 | 73.4 | 72.0 | 71.4 | 50.0 |
| Mean for South East (ADASS Region) | 77.5 | 73.3 | 71.7 | 71.3 | 79.6 | 75.5 | 60.7 |

1 Quartiles within All English single tier and county councils | 2 Quartiles within All English single tier and county councils | 3 Quartiles within All English single tier and county councils | 4 Quartiles within All English single tier and county councils

Some of areas we will be focussing on going into 2024 to support quality are:

- the training and support offer for care providers in Portsmouth and how it aligns to safeguarding themes
- take up of the current PCC commissioned training offer for the private, voluntary, and independent sector
- a review of the provider forums, informed by consultation with providers
- how we share resources and comms, with a view to developing our web offer to share/ store resources and messages for providers.

As a Directorate we value the relationship we have with providers and partners in the city and recognise the importance of building on this to ensure good quality outcomes for our residents.

**End note**

Following feedback from HOSP members, this report has been restructured around outcomes for our residents and the plans to improve outcomes. The appendices provide more detailed information in two areas and there is much

more detailed information available around the structure and functions of individual services if required.

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**Appendix 1**

## Portsmouth Community Connector Service

## 2022-23 - Quarter 1 (April, May, June 2023)

### Aims of the Project

To reduce loneliness and social isolation amongst vulnerable adults by connecting individuals to existing community-based resources appropriate to their needs and interests and by identifying and addressing access issues. This in turn will reduce/ delay the need for health and social care services.

### Anticipated Outcomes

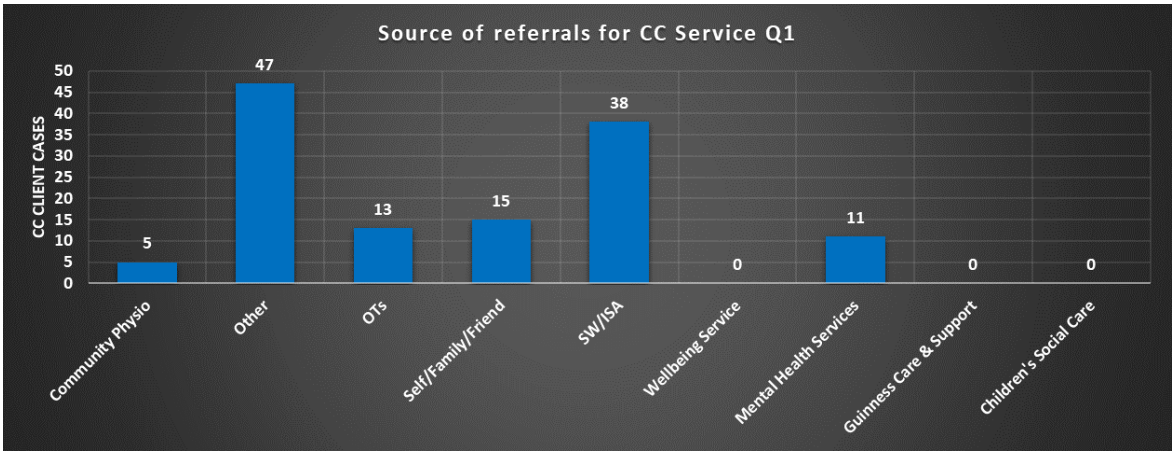
Short Term:

- Successful signposting to appropriate agencies and services within the local community
- An enhanced sense of wellbeing
- Inclusion in the local community and increased socialisation
- Prevent or delay the need to access mainstream health and social care services

Long Term:

- Clients feeling less lonely/socially isolated
- Improving independence and self-resilience
- Established friendships/extended networks of support

### Data for Quarter 1




This quarter the chart shows 129 referrals were received - 41 have been carried over from 2022/23 which would include those being currently worked with. 88 is the number of referrals received this quarter.

This evidences that from last quarter when 70 referrals were received and this quarter where 88 referrals have been received, the demand for the service is increasing quickly.

Previously, the average was around 50 referrals per month.

There were 47 'other' referrals however, again this would include what was carried over from 2022/23.

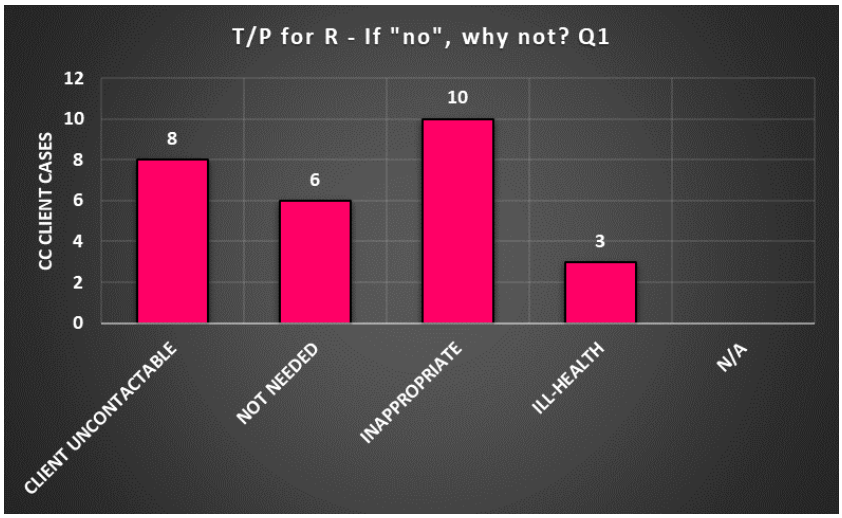
There are 47 'other' referrals for this quarter.

| | |
|---|---|
| Social Prescriber | 11 |
| Society of St James Recovery Hub | 5 |
| Job Centre | 4 |
| Independence and Wellbeing Team | 3 |
| Early Intervention Project - NHS | 2 |
| Stroke Association | 2 |
| Neuro Physio | 1 |
| Two Saints | 1 |
| You Trust | 1 |
| Parkinson's Nurse | 1 |
| Sheltered Housing | 1 |
| Speech and Language Therapist | 1 |
| Refugee Hub | 1 |
| Stop Domestic Abuse | 1 |
| Frailty Co-ordinator | 1 |

**Triage**

From the 88 referrals that were received and triaged, 27 didn’t progress to an assessment. The below chart shows the reasons why.

**Appendix 1**

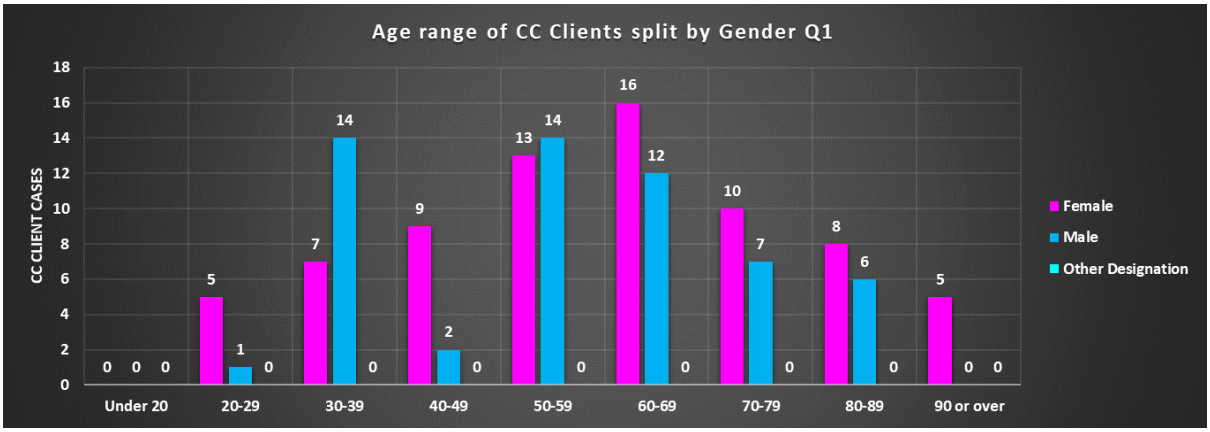



Where a pattern emerges of some inappropriate referrals coming from the same service, agency, a community connector overview is offered to clarify what the service offers and the opportunity for professionals to ask a any questions.

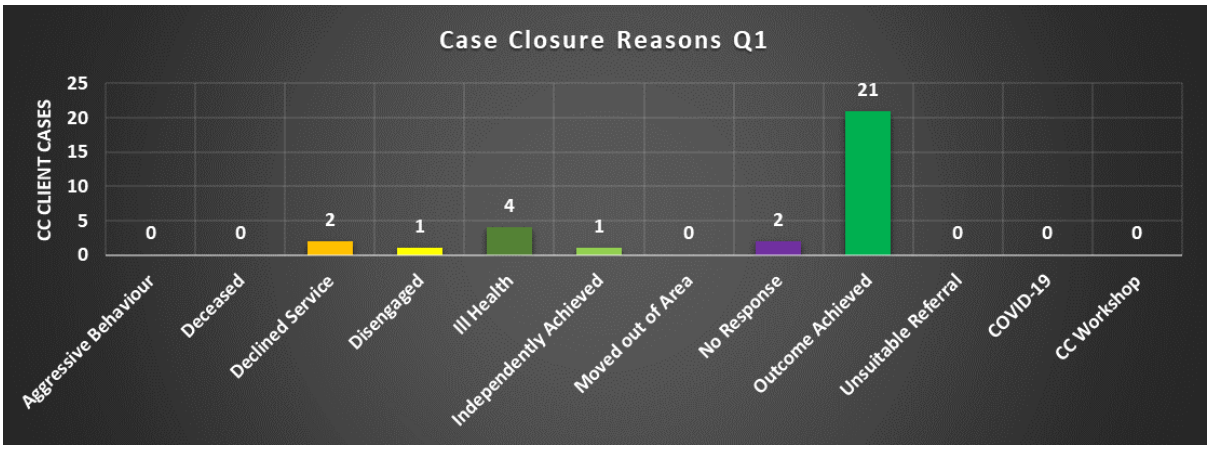
## Waiting List

27 - this has increased considerably since the last quarter due to the increase in referrals. Waiting list time has increased from two weeks to 4-5 weeks. Due to the extended wait - people may not be seen whilst they are motivated. This could mean for some that their goals are not achieved as the window of opportunity has been missed.

## Age Range of CC Clients by Gender




## Case Closure Reasons

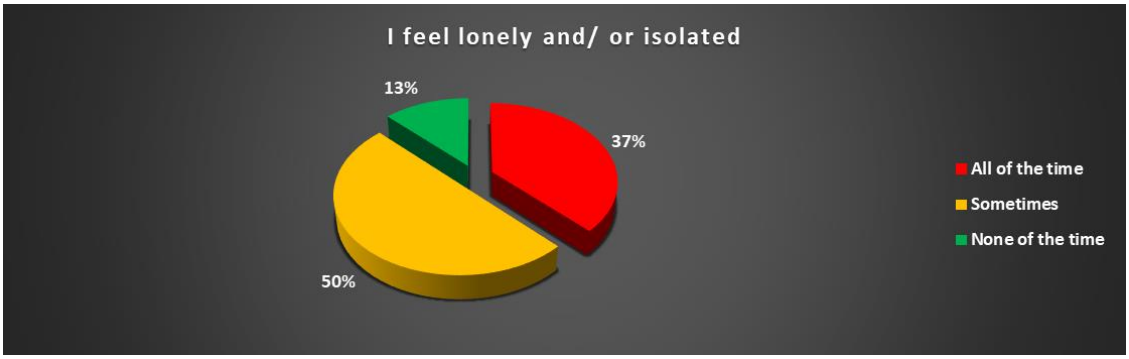



2 clients declined the service at point of assessment -

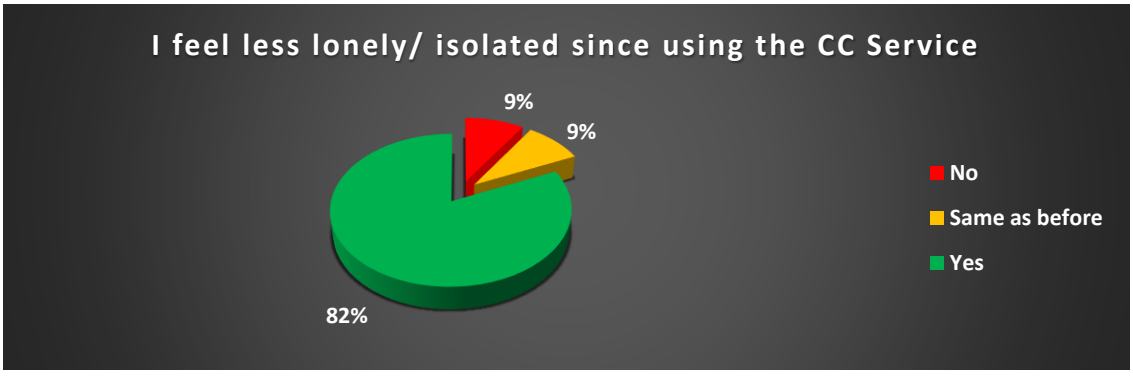
- One client did not have any goals to achieve.
- One client felt the time wasn't right for them

### Outcomes Achieved - Loneliness/ Isolation

### Before intervention

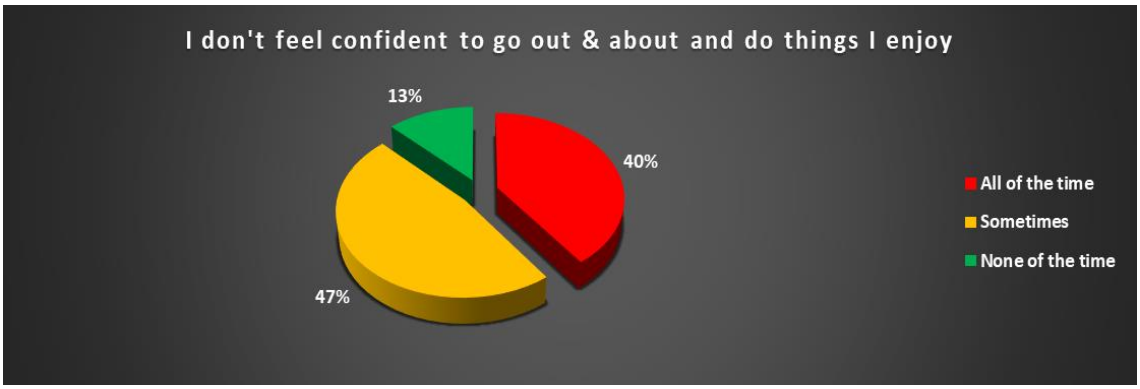



### After Intervention

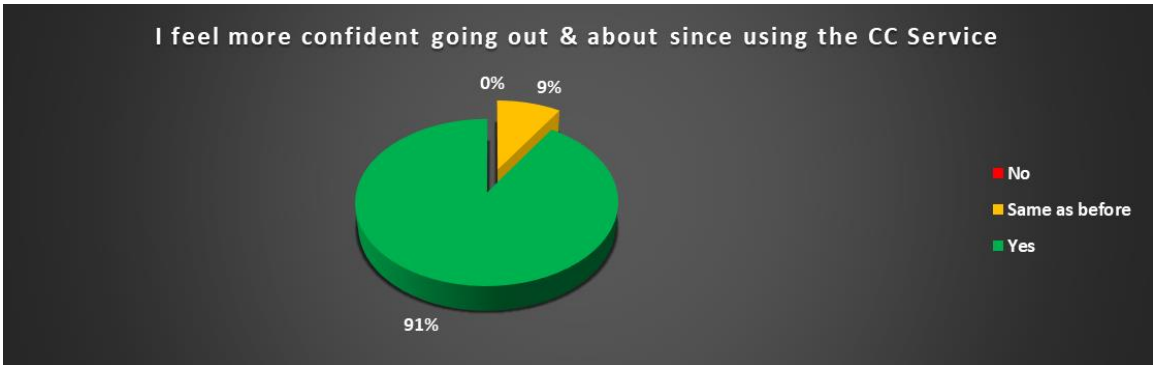



### Before Intervention

**Appendix 1**




### After Intervention




It is clear from the above before and after charts the positive impact the Community Connector Service has had on the individuals who have been supported and this is shown clearly in every quarterly report.

It is also important to note that the 'same as before' results will have resulted in some clients not feeling lonely or lacking in confidence, some clients need only to work on one or the other.

### Activities Clients Supported With

Chit Chat Club
Nexus Women's Group
Diversi-Tea Lounge
Spark Community Space
Copnor Coffee Club
Nexus Men's Group
Positive Minds Café
Cross Cultural Women's Group
Rock Out
LGBTQ+ 4 Me Group
Personal Choice Lunch Club
Spa 61

Confidence building in the community - Mobility
Mobility scooter, Electric wheelchair Bus

Volunteering at -
Cosham Larder
The

U3A French Group
Relaxation and Wellbeing Course
Med 3 Music
ESOL classes/assessment Room 1

Yoga in the Park
Wellbeing Walks
Walking Netball
Snooker

**Referrals Made to:**

- ESOL classes
- Citizens Advice Bureau
- Goodgym
- Digital Champions
- Serendipity Autism Group
- Portsmouth Interaction
- Gig Buddies
- Hampshire Fire Service - Safe and Well Visit
- Safe at Home
- Early Help and Prevention Service's LGBTQ+ Team

**Information Given**

As well as giving a wide variety of information to clients they requested this quarter 19 members of the public have enquired to the service and been given information on -

- A variety of social groups
- Wellbeing Walks
- Art group
- Singing for Wellbeing
- Community Connector Service overview
- Baby Basics
- Driving Miss Daisy
- Red Cross Wheelchair Service
- Ethnic Growing Group
- Digital Buddies
- NHS 111
- Mental Health Crisis Team
- GP
- Positive Minds
- Talking Change
- Online social groups
- Home Library Service
- Gigg Buddies
- Bowling Group
- Read and Grow
- Gentle Exercise Classes

The service has had enquiries from a variety of professionals -

- Social workers and Independent Support Assistants - ASC
- OT's

- Job Centre
- Community Development Officer
- Early Help and Prevention Services LGBTQ+ Team
- Parkinson Disease Nurse Specialist
- Physios
- Social Prescribers

and the following information has been provided -

- Community Connector Service Overview
- Portsmouth Interaction
- Goodgym
- HIVE Directory
- Personal Choice
- Wellbeing Walks
- Coffee mornings
- Variety of social groups
- Adult Social Care Help Desk
- Med 3 Music
- Pompey Pluckers
- Art workshops

**Comments from Clients**

Client A
*"The service totally made a difference because when I first arrived here (in this country) I was lonely and was afraid of going out on my own and now I can finally go out by myself."*

Client B
*"I am very grateful for all you did. I am learning new words and improving my English. When I attend the group, I have fun playing games and meeting others. I feel I have heart connections with others which I did not have before I met my community connector. Before I was just staying at home within my four walls. I now have more confidence and a purpose to my days. I have places to go when I feel lonely."*

Client C
*"You have been a great help. You have changed my life, and I can't thank you enough."*

Client D
*"I feel better for going out as I get fed up being indoors all day. I feel more confident."*

## Developments

Information Station

Along with the City of Sanctuary's Refugee Hub and a presence with them at the Royal Beach Hotel, which is currently housing asylum seekers, the Information Station is now also taking place at -

- Portsmouth Job Centre
- Southsea Library

It was also trialled at Room 1's Information and Support Service, but it became clear that this was more a group setting with the same people attending each session. It has been agreed with the facilitator that community connector service overviews can be given to the group on request when several new members have joined the group.

60 people accessed the 16 Information Station sessions in this quarter and have been signposted to community groups/ activities in the community based on their interests.

5 professionals also accessed the Information Stations.

## Case Studies

| **CASE STUDY 1 Background** |
| --- |
| The client is a 22-year-old male who lives in the south of the city and arrived in the UK in January 2023 seeking asylum.<br><br>Prior to arriving in this country, the client had been persecuted by his local community due to his sexual orientation and being openly gay. The client showed the Community Connector the implications of this persecution which included significant scaring to his face where he had been physically assaulted.<br><br>The client had found out about Community Connector Service when visiting the Community Connectors Information Station at the City of Sanctuary Refugee Hub. The client, after talking to one of the community connectors and learning more about the service completed a self-referral looking for support around joining a running group.<br><br>The client expressed at his initial assessment that alongside finding a running group he would like to engage with an LGBTQ+ social / support group and find support around his mental health due to his experiences in his home country.<br><br>Prior to our intervention the client shared that he did not leave the home very often due to having no funds as his asylum application had not yet been processed and was receiving no financial support from the UK Government. The client stated that due to his persecution in his home country he often felt anxious when around others and outside his home which |

had resulted in him feeling lonely and isolated. The client reported he would spend most days watching TV and sleeping.

Goals

- To find a running group
- To find a LGBTQ+ social / support group
- To find a support service around my mental health

Intervention

- CC supported client by providing information around different community opportunities that pertained to his goals.
- Client supported to complete referral form for the 4ME LGBTQ+ service.
- Client supported to attend the initial meeting with 4ME group facilitator and later attend his first group meeting with the service.
- Client given support to signup online to the GoodGym running group / volunteering service.
- As the client did not have the financial means to purchase appropriate running shoes / clothing, research around community grants completed and local running groups contacted by community connector.

Outcome

- The client now regularly attends the 4ME LGBTQ+ social group independently on a weekly basis.
- As a result of attending the 4ME group the client has been supported to engage with other local community opportunities and services such as Downtown Pompey which 'Brings together a variety of local communities in Portsmouth through queer art practices'
- The client now receives regular 1-1 support sessions from a 4ME worker to talk about his mental health and emotional wellbeing.
- The client has been invited to join the 4ME service and attend Portsmouth Pride this year which he is looking forward to as this will be his first time ever attending a Pride event.
- The client has received a donation of running shoes and clothing from members of the GoodGym service, so he was able to confidently attend the group.
- After initially visiting the Early Help and Prevention Services LGBYQ+ Teams 4 4ME group the client stated he felt more confident being out in the community and engaged independently with the GoodGym service where he has attended running sessions and volunteered at food banks and plans to continue to volunteer in the future. The client stated***, "I really enjoy the opportunity to help others."***
- The client reports he now feels confident to independently leave the home and travel in his local community.

At the end of working together the client expressed

***"Working with the Community Connector Service totally made a difference because first when I arrived here, I was lonely, and I was afraid of going out on my own and now I can finally go out by myself."***

**CASE STUDY 2 Background**

The client is a female client aged 70 living alone in the south of the city, she was referred to the Community Connector Service via her Independent Support Assistant.

The client lives with multiple health conditions, including Anorexia and Bulimia from a young age, which has resulted in many hospital admissions and long stays in rehabilitation

clinics in the past. Depression was also triggered by never feeling loved by her mother and her twin, thus impacting her own self-esteem and confidence.

The client's interests are swimming, knitting, and playing scrabble, which she finds calming and enjoys having something to focus on. She would also take pleasure from walking to the beach with her husband and swimming in the sea.

Sadly, after a terminal illness her husband passed away, thus leaving the client feeling alone, grieving for her companion and with no support to help her cope with her own illness and poor mental health. Her husband was her "rock and soul mate" they enjoyed spending every day together and felt no need for friends. At the point of referral, she found herself spending most of her time in bed, tearful, with low mood and unmotivated. Her health conditions had also deteriorated, and she was having little interaction outside of her home.

Since the loss of her husband the client finds herself more reliant on her family, waiting all day for that one important phone call from her twin sister, if the call is late her anxieties and stress levels increase which impacts on their conversation, leaving their relationship strained and blameful.

The client can drive; However, a recent diagnosis of emphysema has caused her to worry about accessing the community by car due to her shortness of breath. This impacts her significantly as she requires close parking options around the community and her home but finds parking very limited to this capacity. The health implications of being short of breath also limits her ability to complete everyday tasks around the home.

Goals

- To join a social group to meet new people and hopefully in time to make new friends.
- To feel less lonely.
- To be less reliant on her family.
- To rebuild her life without her husband.

Intervention

The community connector

- arranged a meeting with client to complete an initial assessment, to build a rapport in working together and help to identify clients' interests and goals around finding community opportunities.
- Explored and provided information on social groups and craft activities from information gathered at the assessment.
- supported the client to attend a meet and greet with the social for seniors' group. (A social group for people aged over 60 who live alone. The group meet up during the week, evenings, and weekends)
- Supported client to attend a Knitting Group.
- Provided information on a Bereavement support Group.
- With the client's consent, CC referred client to Age UK for support with completing an Attendance Allowance application. (Attendance Allowance is financial support if you need help with care or have an illness or disability)

| |
|---|
| • Supported client to explore and apply for a Blue Badge. (Blue Badges help people with disabilities or health conditions park closer to their destination). |
| Outcome |
| The client attends many of the groups run by Social for Seniors, enjoying spending time with new people, where she has now made some close friends. She also has arranged to meet her new friends outside of the group and communicates with them over the phone and via a What's app group. Now having a social circle, the client says she has more to look forward to and has less time to think about the telephone call from her sister and feeling alone. Her sister is important to her, and the relationship has improved, the conversation is less strained and more enjoyable.<br><br>The client attended the knitting group and has arranged to collect a couple of other people in her car to join her. She is also helping them with their own knitting projects and sharing her skills.<br><br>Due to her illness, she is unable to swim but enjoys being invited along for the company and spending time at the beach.<br><br>After much thought she didn't wish to attend the Bereavement group, she felt that during her lifetime she has attended many counselling sessions for her illness and did not wish to go down this path again, hoping that in time she will naturally rebuild her new life.<br><br>After an assessment, the client did not meet the eligibility criteria for the Blue Badge, but she has been awarded the Attendance Allowance, so is now able to use this financial support towards help around the home and to fund travel expenses, giving her the opportunity to continue to spend time with new friends reducing her anxieties. |

**Author - Julie Roberts, Community Connector Team Lead**

**Appendix 1**

## Portsmouth Community Connector Service

## 2022-23 - Quarter 2 (July, August, September 2023)

### Aims of the Project

To reduce loneliness and social isolation amongst vulnerable adults by connecting individuals to existing community-based resources appropriate to their needs and interests and by identifying and addressing access issues. This in turn will reduce/ delay the need for health and social care services.

### Anticipated Outcomes

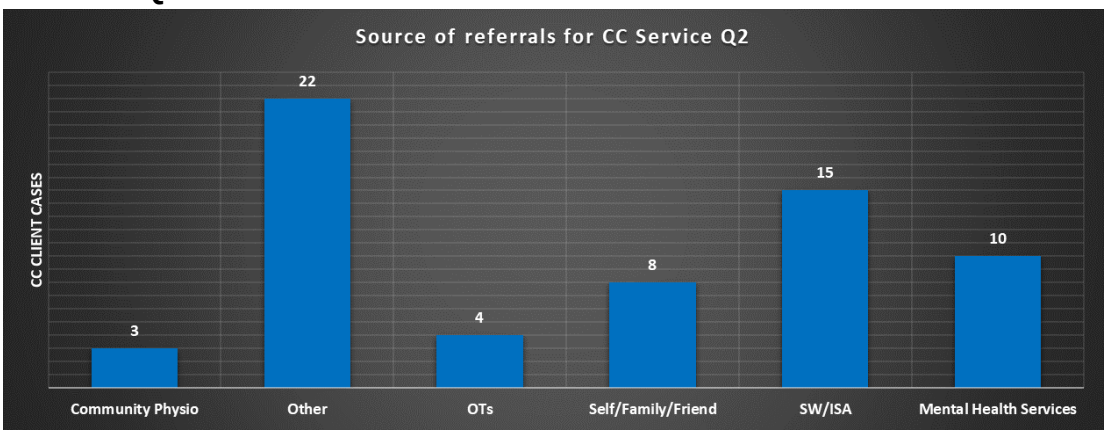
**Short Term:**

- Successful signposting to appropriate agencies and services within the local community
- An enhanced sense of wellbeing
- Inclusion in the local community and increased socialisation
- Prevent or delay the need to access mainstream health and social care services

**Long Term:**

- Clients feeling less lonely/socially isolated
- Improving independence and self-resilience
- Established friendships/extended networks of support

### Data For Quarter 1




This quarter the chart shows 62 referrals were received.

The average was around 50 referrals per month over recent years but the referrals coming in now are more than that each quarter and this has been the case for some time.

The 22 'other' referrals for this quarter came from the following -

| | |
|---|---|
| Social Prescriber | 6 |
| Society of St James Recovery Hub | 3 |
| ASC Community Link Worker | 2 |
| Stroke Association | 1 |
| You Trust | 1 |
| Speech and Language Therapist | 1 |
| Children's Services | 1 |
| Community Independence Service ASC | 3 |
| Frailty Co-ordinator | 3 |
| The HIVE | 1 |

**Triage**

From the 62 referrals that were received and triaged, 15 didn't progress to an assessment, the reasons would have been -

- Service was not needed.
- Referral inappropriate
- Ill health
- Unable to contact

All clients except inappropriate referrals, that didn't progress to assessment are sent a closure letter with the service overview and the invite to refer if they wish in the future.

Where a pattern emerges of some inappropriate referrals coming from the same service, agency, a community connector overview is offered to clarify what the service offers and the opportunity for professionals to ask a any questions.

**Waiting List**

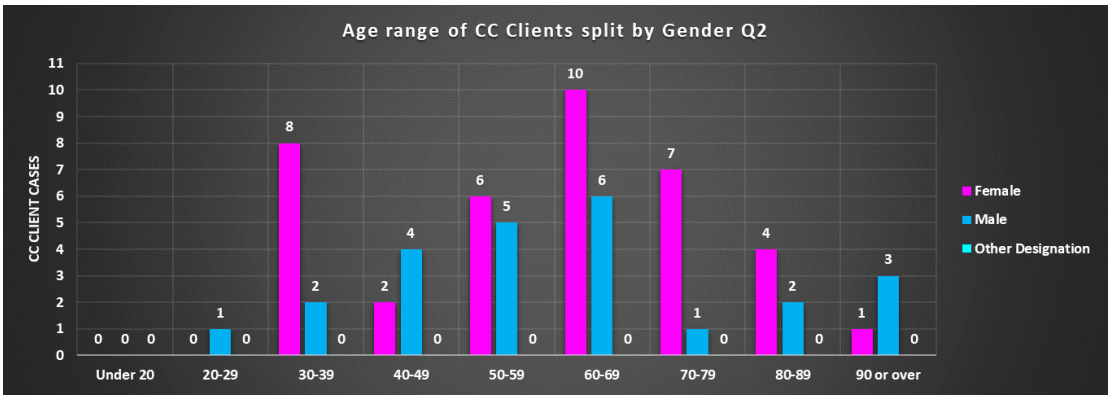
The waiting list at the end of September was 35 - This is due to the number of referrals being received and the only fulltime community connector being on shared parental leave for ten weeks for all of August and September. This means wait time is currently between 8-10 weeks.

Due to the extended wait - people may not be seen whilst they are motivated. This could mean for some that their goals are not achieved as the window of opportunity has been missed.

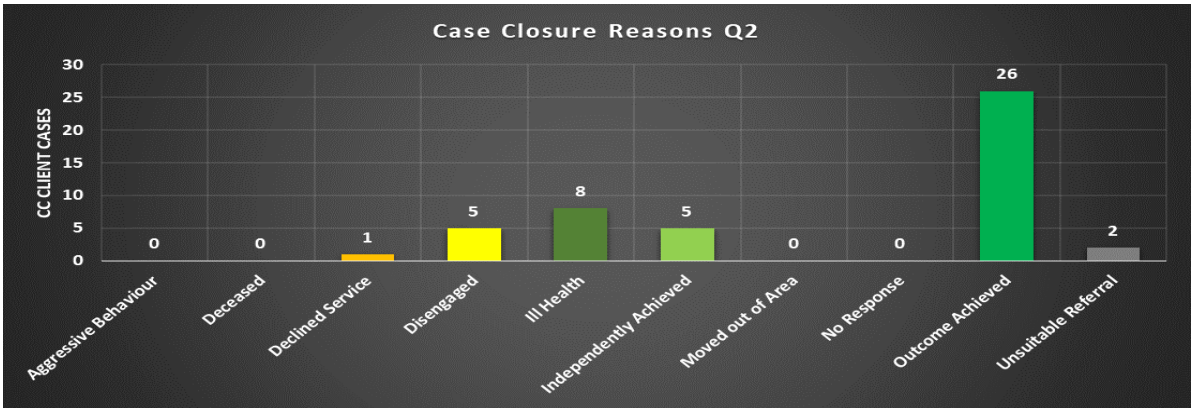
The ongoing challenge of a waiting list is evidence that more cc's are needed to deal with the demand and see people in a timely manner for them to be able to make a positive change.

**Appendix 1**

## Age Range of CC clients by gender




## Case Closure Reasons




One client declined the service at point of assessment as the felt they were unable to commit to the service at this time.

Two referrals were unsuitable.

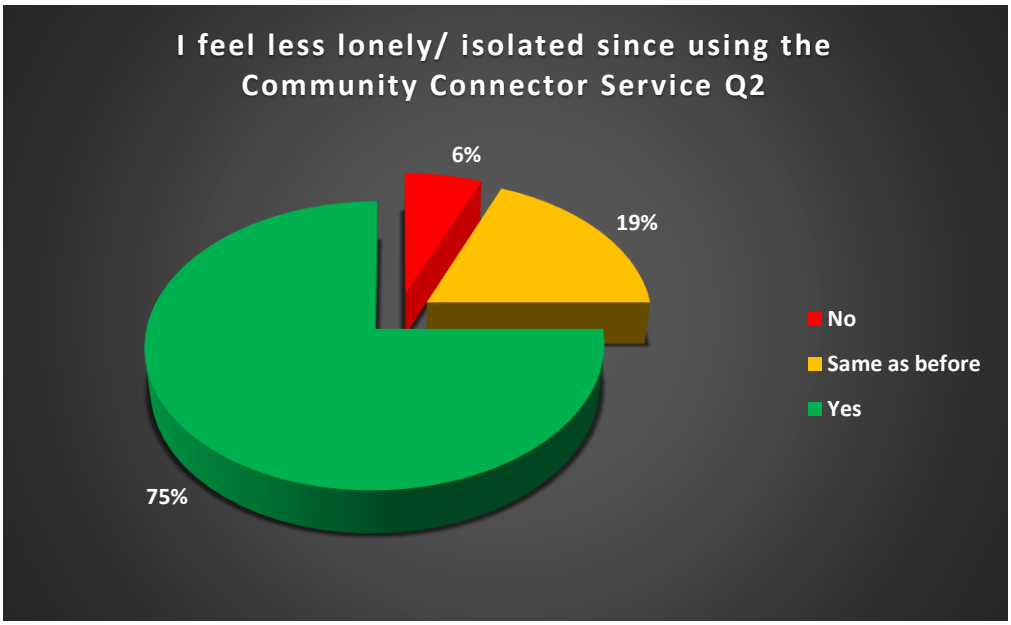
- One client said they needed physio before they were able to go out.
- One client was already on the Community Independence Service and was closed to avoid duplication.

## Outcomes Achieved - Loneliness / Isolation

## Before Intervention

**Appendix 1**


**After Intervention**




The above results are unusually low and have not been seen before in past quarters/years. However, looking at the clients' evaluations that have recorded 'same as before' or 'no difference' after being supported by the service, the comments clients have written include that their ill health had an impact on how they felt post working with the service and others had written positive comments in including -

*"Yes, it has, I now have gathered more confidence; it's made a real difference."*

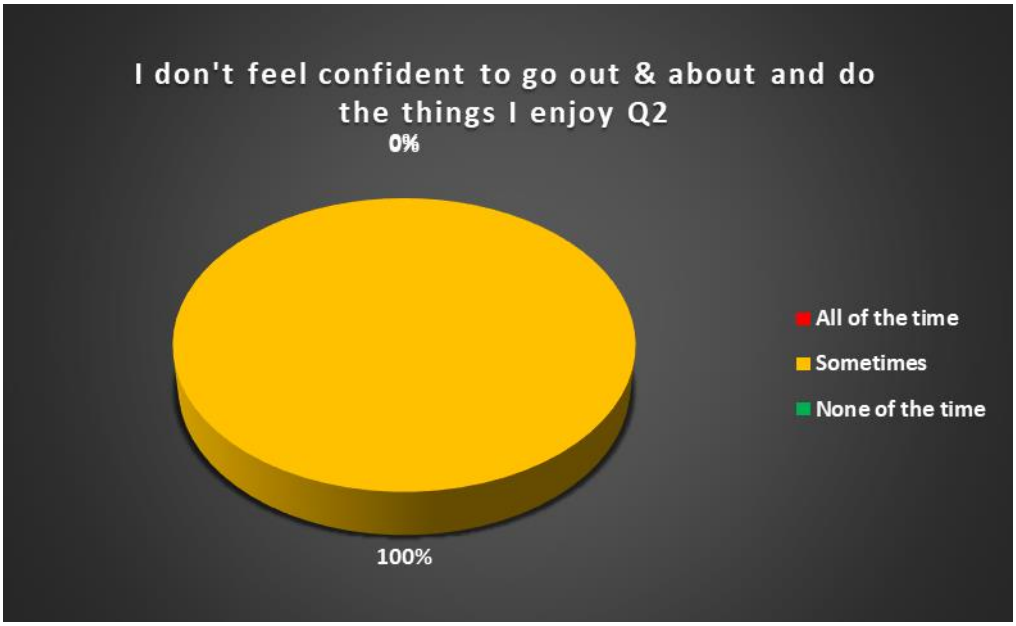
*"I was feeling more confident using the bus and getting out, but I have had a set back with my health which has made getting out harder."*

*"Yes, it totally made a difference because first when I arrived here, I was lonely, and I was afraid of going out on my own and now I can finally go out by myself".*

There seems to be inconsistencies of people answering "same" or "no difference" whilst giving positive feedback and scoring better on the WEMWBS survey.

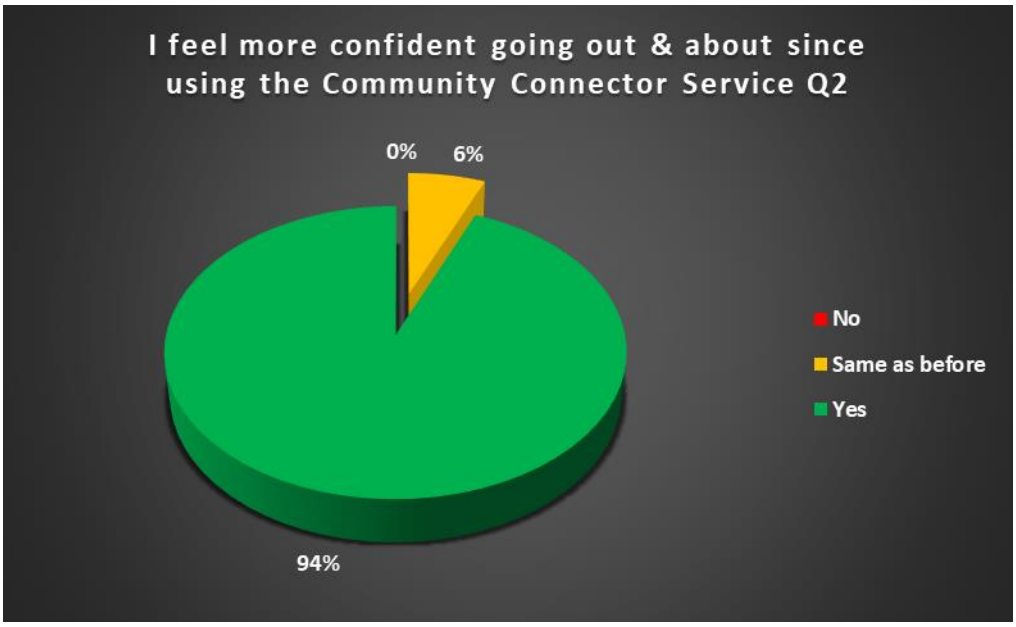
These concepts are also subject to change over time - people can report increased mental wellbeing whilst still feeling sometimes lonely or still lacking some confidence. It is the overall picture for an individual that is most important.

**Before Intervention**



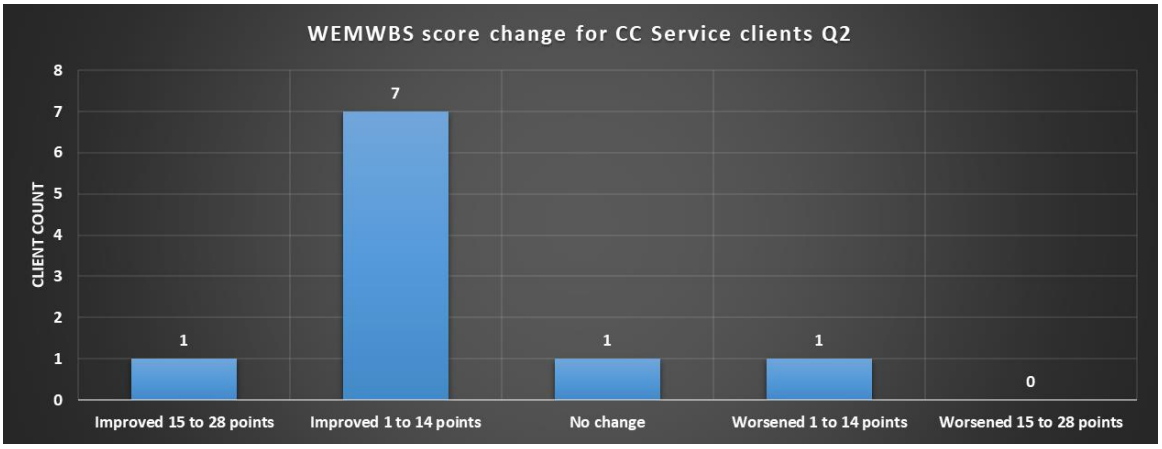

**After Intervention**

**Appendix 1**




It is clear from the above before and after charts, comments and the evidence with the following results from the Warwick Edinburgh Mental Wellbeing Scores (WEMWBS) the positive impact the Community Connector Service has had on the individuals who have been supported.

### Warwick Edinburgh Mental Wellbeing Scores




Of the clients that completed the evaluations including the WEMWBS scores the majority had a dramatic increase in their wellbeing at the end of working with the community connector service.

**Appendix 1**

## Activities Clients Supported With

**Numerous social groups including -**
Cross Cultural Women's Group
Spark Community Space
Men's Sheds
Various stroke support groups
Theatre group
Personal Choice - lunch club
Wellbeing Café
Health and Happiness Workshop

**Activities including -**
Mahjong
Power Sew
Crochet group
Art and craft group
The Learning Place

**Confidence building in the community with -**
Using a mobility scooter
Travelling on a ferry
Using the bus
Using the train
Using an electric wheelchair
Going to local shops

**And -**
Bereavement Support Group
The HIVE regarding volunteering
Portsmouth Interaction

## Referrals Made to -

- GoodGym
- Age UK - Digital Champions
- Age UK - Close Encounters Befriending Service
- Steps to Health
- Portsmouth Interaction
- OT's
- Advice Portsmouth
- Stroke Association
- WEA - learning opportunities
- A2i

## Information Given

As well as giving a wide variety of information to clients they requested this quarter 10 members of the public and 15 professionals have enquired to the service and been given information on -

- The Independence and Wellbeing Teams groups
- Community Connector Service
- Board game groups
- Cross Cultural Women's Group
- Chinese Lunch Club
- Chinese Association
- Art and craft groups
- Goodgym
- Age UK's Close Encounters Befriending Service
- Islamic provision
- Bangla Society

- Writers Group
- Loaves of Love
- IT classes
- Bingo groups
- Spanish lessons
- PCC's Cost of Living Hub
- Community Meals
- Food Pantries
- Food Banks
- Open University
- Changing Places - shower facilities
- Driving Miss Daisy
- Neurodivergent social groups
- Portsea Community Hub
- Local mosques
- Veterans' social groups

**Comments from Clients**

*"Knowing there is Room One and Autism Hampshire around I know there are places around if I need them. I definitely feel confident to now navigate the city."*

*"Previously to working with the CC service I was being admitted into the Emergency Department weekly, suffering from high anxiety and heart palpitations. I haven't been admitted in the last two months."*

*"I have been able to go out of my house and join groups, feeling more confident and in control. This service is excellent, and I have been recommending it. My cc was very supportive, friendly, and encouraging. Thank you for everything."*

*"I feel less lonely when I am attending groups because I am with other people as opposed to being on my own which makes me feel lonely. I have also noticed some positive changes and the progress when it comes to how I interact with others. I am more confident to go out to places I have not been before."*

**Information Stations**

Information stations are held across the city in a variety of venues. This is an opportunity for members of the public and professionals to come along to find out information, bespoke to them, that is available in the community. For this quarter the stations were held at -

- Portsmouth Job Centre
- Southsea Library
- City of Sanctuary's Refugee Hub
- The Royal Beach Hotel which is housing asylum seekers

46 people accessed the Information Stations this quarter, 7 of these were professionals.

## Case Studies

| **CASE STUDY 1 Background** |
|---|
| The client is 43-year-old women. She has had two heart attacks which have left her unable to walk long distances or complete physically demanding tasks. She has a care package in place to support her with household tasks. She acknowledges that the housework has got on top of her, and the flat has become cluttered. This is something she would like to work on.<br><br>The client has depression and anxiety, in the past she says that she struggled to control her emotions. "I used to hit and ask questions later" she says. In recent years she has worked on strategies to control her anger and now feels like it is the right time to meet new people. The client lives with her two cats, who are very important to her.<br><br>She has some family members nearby, but they cannot offer the level of social support that she needs. She says she feels lonely and bored. The client would like to get out more and access some social activities. The client is interested in learning new things. |
| **Goals** |
| • Leave the house independently.<br>• Find some social activities (ideally with an arts and crafts element).<br>• Find social opportunities that will support mental health.<br>• Access some learning opportunities. |
| **Intervention** |
| • The first goal was to leave the house and take short walks around the local community with the Community Connector (CC)<br>• The client was then able to consider social opportunities and attended Diversi-tea Lounge with the CC. This gave her a chance to meet people and do some crafts.<br><br>At this point in the process, due to maternity cover ending the Community Connector changed.<br><br>In the short break between the CCs the client made significant changes to support her independence. She had a stair lift installed and she purchased a mobility scooter. This meant the range of activities that she could access widened.<br><br>• The client had built confidence to get around in the local community and wanted to explore more social options. CC found options that had craft elements but also supported her mental health. With the CC she visited the Nextus women's craft group, Fratton Friends Craft group and the Chit Chat group. The client felt it would suit her to have options |

throughout the week, so she could pick and choose the groups doing the activities that most appeal to her. She found that if the activity did not interest her, she was not motivated to attend the group.

- The client and CC worked out a step-by-step plan for her to attend each group independently. Eventually she was able to go completely alone to each group with confidence.
- The CC introduced the client to the Learning place, which she felt confident enough to sign up to courses straight away. After a discussion with the CC, she also independently got in touch with the Recovery College.
- CC provided information on other groups based on conversations with the client. These are things she could try in the future with her newfound confidence. They included Positive Minds, Interaction, Helping Hooves and Nature Watch.

**Outcome**

The client reports feeling more confident and is leaving her house often. She is attending at least one social group a week and has started a maths course at the Learning Place. She also has signed up to a wellbeing course starting soon. She says the process has had a knock-on effect to the rest of her life as she now has more motivation to set herself realistic goals to start sorting the clutter in her home. The client mentioned the positive impact of the Nextus Women's group ran by the Good Mental Health Coop. As through attending she has really been able to recognise what affects her anxiety and what activities improve it.

Through reflecting on what she had achieved by using the Community Connectors service the client was able to see the skills she already possesses and the motivation that she is able to accomplish. Which means she feels more positive about her future.

***"I've got a lot to do but the things I really enjoy, I would like to say a really BIG THANK YOU to you for all your major support in my whole life, It was turned upside down till The Community Connector Service came into my life, and now look at my life, It's now up the right way & I'm going up those steps slowly but am up higher now than I was years ago".***

**CASE STUDY 2 Background**

The client is a 65-year-old male living in the PO4 area of the city.
When the referral was received from the stroke association, the client was experiencing severe depression since his wife had passed away and the relationship with his daughter had broken down.

The client shared with the Community Connector (CC), -

***"I am now just existing and waiting to die, I have no confidence in life anymore."***

The client had experienced a stroke which had left him unable to walk independently, he now relied on a walking frame but was only able to walk short distances. The stroke had also left him with long term speech problems and a limited ability to swallow without the use of a thickener, he also experienced extreme fatigue.

The client shared that he did not see anyone accept his carer once a day and spent his days sitting in the same chair watching T.V, opposite the sofa where his wife had died. He expressed that he felt people often attached a stigma to him because of his health

conditions and this affected his confidence, preventing him from attending social opportunities and accessing the community.

**Goals**

- To have the confidence to attend a social group once a week.

**Intervention**

The CC

- provided information tailored to the client's personal interests and needs.
-Spark community cafe, Rock Café, Socials for seniors, over 50's social groups, Stroke support groups. DISC, Stroke Squad.

- attended the Spark community cafe, Chit Chat club and DISC with the client, supporting him to build his confidence to walk in and sit down with new people, to speak to the volunteers and to support his confidence to use his thickener for his tea in public.

- provided confidence building by phone to support the client when he returned to Spark community cafe independently.

- provided confidence building by phone to support the client to attend the Stroke Squad for the first time. Asking scaling questions to help the client to identify how his confidence had improved in just one session.

**Outcome**

The client now attends the Spark Community Café every week and the Stroke Squad for their monthly meet up's. He is also confident to visit the DISC and Chit chat groups when he wishes.

His wellbeing score via the Warwick Edinburgh Mental Wellbeing Scale has improved and he now no longer feels socially isolated. The client shared that the CC had -

***"Built my confidence to go out and try new things. You have taught me to ignore the stigma."***

**Author - Julie Roberts, Community Connector Team Lead**

**Appendix 2**

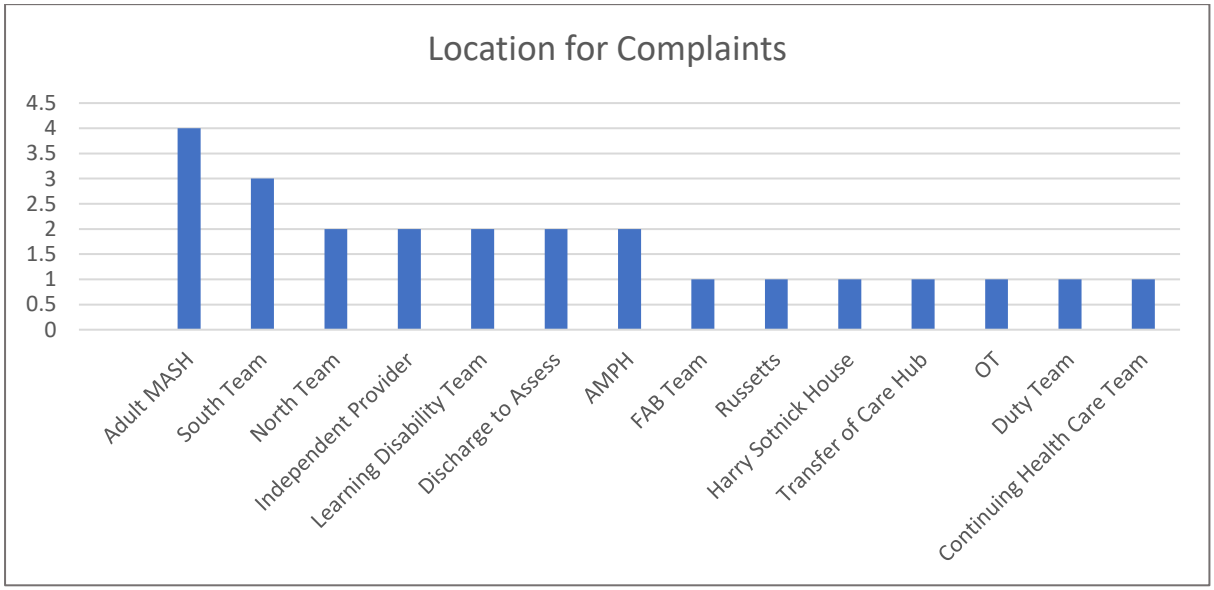
## Complaints Report

For the period 11 May 2023 to 13 October 2023, there were 24 new statutory complaints made about Adult Social Care, compared to 38 in the same period in 2022.

In addition to statutory complaints, there were 20 customer contacts, 10 possible complaints and 3 contacts that were responded to under different procedures.

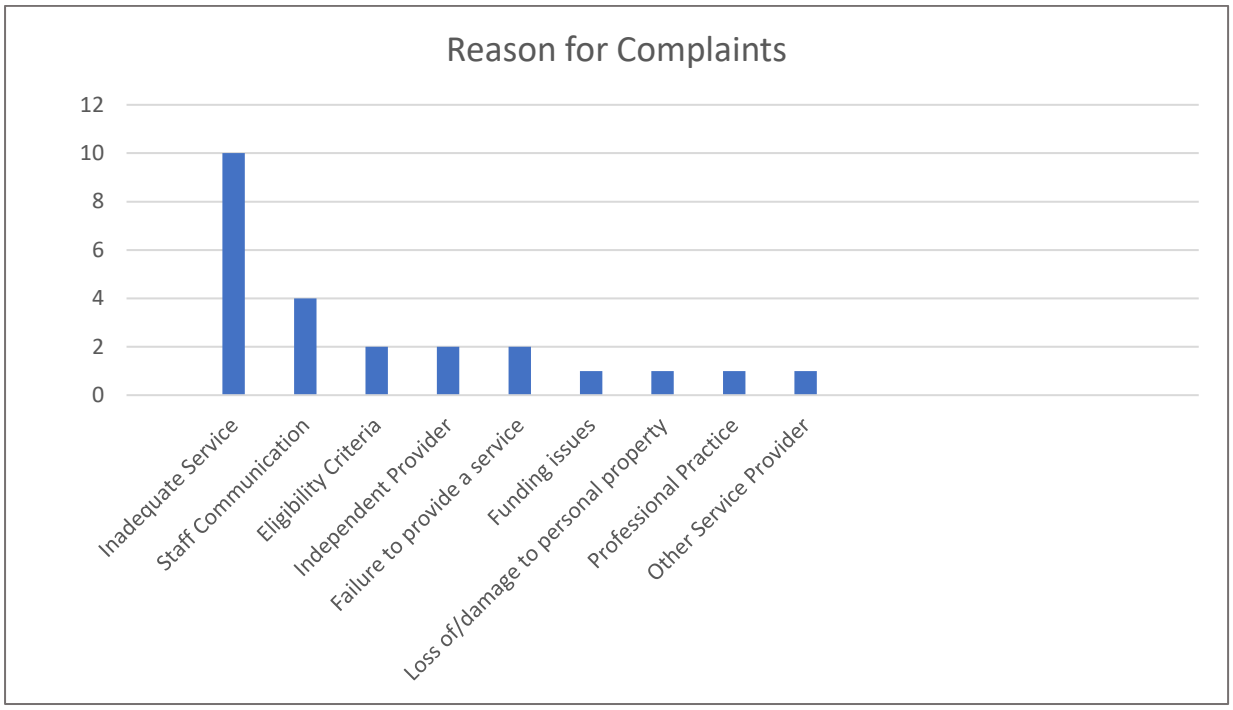
Based on number of service users open to adult social care on 5 December 2022 (8,362), the 24 complaints received represent less than 1% of all the people receiving a service from adult social care.

To set the complaints figures in context, the following chart outlines the number of complaints for each location/team.




It is also important to consider the reasons why complaints were made.

**Appendix 2**




New timescales were introduced (15 working days) during this period, with 85% of complaints responded to within this timeframe (with 15% in the ≥20 days); performance has increased from 59% (56% within 10 days) to 85%.

There is a continued focus on reviewing processes to support the improvement of response times, including the follow up with those leading the complaint response, their managers and also the submission of highlight reports for scrutiny at ASC monthly Governance Board.

**Local Government & Social Care Ombudsman**

Two complaints were investigated by the Local Government and Social Care Ombudsman (LGSCO).

We have received and accepted the draft decision for the first complaint and are waiting for the final decision. The draft summary is as follows:

'Mr X complained the Council placed his mother in a nursing home without giving her, or her family, opportunity to object. Mr X complained the Council is now asking for payment of care home fees for this placement. Mr X also complained the Council sent his mother for rehabilitation and respite care when it knew she would not be able to walk or live independently again.

On the evidence seen, we found fault with the Council delaying in referring Mr X's mother to a physiotherapist. We do not consider this fault caused a significant personal injustice to either Mr X or his mother. Mr X's mother spent

nearly two months in a care home. Mr X and his mother both knew the time spent in this care home would come at a cost.

The Council has completed a suitable financial assessment, at a suitable time given Mr X's wishes, and presented a bill detailing the assessed cost. The Council has acted in line with the guidance and legislation in billing for Mr X's mother's stay in the care home and I do not find fault. Subject to further comments by Mr X and the Council, I intend to complete my investigation as there is no evidence of fault by the Council causing a significant personal injustice to Mr X or his mother.'

The second complaint is still in the information gathering stage.

**Upheld complaints**

34% of complaints were upheld to some degree.

**Councillor/MP Enquiries**

In total for this period, we recorded 15 Councillor/MP Enquiries for Adult Social Care.

**Learning**

A complaint was made following a visit to conduct a financial assessment. The complainant was unhappy with how the member of staff behaved; the team manager therefore met with the complainant to resolve. As a result, there was a meeting with the staff member and management will temporarily shadow officers to support learning and ensure a consistent approach moving forward.

The Complaints Managers will continue to support operational staff and managers in handling and responding to complaints in the future. Complaints provide invaluable research for the directorate, with an aim to continue to increase learning from complaints, to disseminate good practice, learn from mistakes and to achieve service improvement as a result.