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Notice of a Meeting

Adult Services Scrutiny Committee
Monday, 13 June 2011 at 2.30 pm
County Hall

Membership

Chairman -
Deputy Chairman -

Councillors:	Anda Fitzgerald-O'Connor	Larry Sanders	Alan Thompson
	Jenny Hannaby	Don Seale	David Wilmshurst
	Ian Hudspeth	Dr Peter Skolar	
	Peter Jones	Richard Stevens	

Notes:

Date of next meeting: *6 September 2011*

What does this Committee review or scrutinise?
- Adult social services; health issues;

How can I have my say?
We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Don Seale E.Mail: don.seale@oxfordshire.gov.uk
Committee Officer	-	*Sarah Carter, Tel: (01865) 894844* *E.Mail: SarahD.Carter@oxfordshire.gov.uk*

Peter G. Clark
County Solicitor

June 2011

About the County Council
The Oxfordshire County Council is made up of 74 councillors who are democratically elected every four years. The Council provides a range of services to Oxfordshire's 630,000 residents. These include:

schools	social & health care	libraries and museums
the fire service	roads	trading standards
land use	transport planning	waste management

Each year the Council manages £0.9 billion of public money in providing these services. Most decisions are taken by a Cabinet of 9 Councillors, which makes decisions about service priorities and spending. Some decisions will now be delegated to individual members of the Cabinet.

About Scrutiny

Scrutiny is about:
- Providing a challenge to the Cabinet
- Examining how well the Cabinet and the Authority are performing
- Influencing the Cabinet on decisions that affect local people
- Helping the Cabinet to develop Council policies
- Representing the community in Council decision making
- Promoting joined up working across the authority's work and with partners

Scrutiny is NOT about:
- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?
The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the Cabinet, the full Council or other scrutiny committees. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

recycled paper

AGENDA

1. Election of the Chairman for the 2011/12 Council Year

2.30

2. Election of the Deputy Chairman for the 2011/12 Council Year

2.35

3. Apologies for Absence and Temporary Appointments

4. Declarations of Interest - see guidance note

5. Minutes (Pages 1 - 8)

2.40

To approve the Minutes of the meeting held on Tuesday 26 April 2011 (**AS5**) and Monday 9 May 2011, to be circulated separately, and to receive information arising from them.

6. Director's Update

2.45

The Director of Social and Community Services will give the Committee a verbal update on current issues and answer questions. The Cabinet Member for Adult Services will also be present to respond to questions from the Committee.

SCRUTINY MATTERS

7. Continuing health care

3.30

This item follows on from discussions at meetings in October of last year and March this year. There is an opportunity to discuss issues around Continuing health care – looking at the responsibilities of the NHS and the Local Authority for the assessment and provision of care.

There will be a question and answer session with the Director of Social and Community Services and Nick Graham, Deputy Head of Law & Governance in attendance to respond to questions from the Committee.

recycled paper

8. NHS Health Reforms

3.45

This item will provide a briefing on the current progress of the Health and Social Services Bill and provide an update on the proposed relationship between Oxfordshire County Council and the NHS in the light of the revised Bill. This will be an oral update and so there is no paper attached for this item.

The item will be presented jointly by The Director for Social and Community Services and Jonathan McWilliam, Director of Public Health.

There will be an opportunity for the Committee to ask questions following the presentation.

9. Oxfordshire Care Partnership

4.15

John Dixon, Interim Deputy Director, Adult Social Care will give a presentation giving the current progress on this strategy. The item will provide an overview of the broad policies under which this strategy is being taken forward. The presentation will be followed by a question and answer session. The Director of Social and Community Services and the Cabinet Member for Adult Services will also be present to respond to questions.

10. LINk Update (Pages 9 - 12)

4.45

An update given by members of the Oxfordshire LINk summarising current and future areas of work. (A report is attached at **AS10**).

11. Report on visits to care homes (Pages 13 - 26)

5.00

A report from the Oxfordshire LINk giving feedback on the visits that have taken place to assess the standards of care homes funded by Oxfordshire County Council. The report has previously been presented to the Oxfordshire Joint Health Overview and Scrutiny Committee on 19 May.

The report (a copy of which is attached at **AS11a**) will be presented by the LINk Liaison members who conducted the visits.

A report giving a response to the LINk report is attached at **AS11b** will be summarised for the Committee by the Director for Social and Community Services. Andrew Colling Adult Services Contracts Services Manager will also with the Director to respond to questions from the Committee.

INFORMATION SHARE

Link to Law Commission Report on Health and Social Care
http://www.justice.gov.uk/lawcommission/publications/1460.htm

12. Close of Meeting

5.25

Declarations of Interest

This note briefly summarises the position on interests which you must declare at the meeting. Please refer to the Members' Code of Conduct in Part 9.1 of the Constitution for a fuller description.

The duty to declare …

You must always declare any "personal interest" in a matter under consideration, ie where the matter affects (either positively or negatively):

(i) any of the financial and other interests which you are required to notify for inclusion in the statutory Register of Members' Interests; or

(ii) your own well-being or financial position or that of any member of your family or any person with whom you have a close association more than it would affect other people in the County.

Whose interests are included …

"Member of your family" in (ii) above includes spouses and partners and other relatives' spouses and partners, and extends to the employment and investment interests of relatives and friends and their involvement in other bodies of various descriptions. For a full list of what "relative" covers, please see the Code of Conduct.

When and what to declare …

The best time to make any declaration is under the agenda item "Declarations of Interest". Under the Code you must declare not later than at the start of the item concerned or (if different) as soon as the interest "becomes apparent".

In making a declaration you must state the nature of the interest.

Taking part if you have an interest …

Having made a declaration you may still take part in the debate and vote on the matter unless your personal interest is also a "prejudicial" interest.

"Prejudicial" interests …

A prejudicial interest is one which a member of the public knowing the relevant facts would think so significant as to be likely to affect your judgment of the public interest.

What to do if your interest is prejudicial …

If you have a prejudicial interest in any matter under consideration, you may remain in the room but only for the purpose of making representations, answering questions or giving evidence relating to the matter under consideration, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise.

Exceptions …

There are a few circumstances where you may regard yourself as not having a prejudicial interest or may participate even though you may have one. These, together with other rules about participation in the case of a prejudicial interest, are set out in paragraphs 10 – 12 of the Code.

Seeking Advice …

It is your responsibility to decide whether any of these provisions apply to you in particular circumstances, but you may wish to seek the advice of the Monitoring Officer before the meeting.

ADULT SERVICES SCRUTINY COMMITTEE

MINUTES of the meeting held on Tuesday, 26 April 2011 commencing at 10.00 am and finishing at Time Not Specified

Present:

Voting Members:	Councillor Don Seale – in the Chair
	Councillor Mrs Anda Fitzgerald-O'Connor (Deputy Chairman)Councillor Jenny HannabyCouncillor Larry SandersCouncillor Dr Peter SkolarCouncillor Alan ThompsonCouncillor David Wilmshurst
Other Members in Attendance:	Councillor (for Agenda Item)

By Invitation:

Officers:

Whole of meeting	Sean Gibson
Part of meeting	
Agenda Item	**Officer Attending**
	John Jackson John Dixon Alan Sinclair Varsha Raja Suzanne Jones

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting [, together with a schedule of addenda tabled at the meeting/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and schedule/additional documents] are attached to the signed Minutes.

125/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received on behalf of Councillor Anthony Gearing.

126/11 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE

(Agenda No. 2)

None

127/11 MINUTES
(Agenda No. 3)

The minutes for the meeting held on 8 March 2011 were agreed and signed.

116/11 Councillor Larry Sanders referred to the briefing on 'continuing health care' circulated to the committee by the Director for Social & Community Services. It was AGREED that the briefing would be added to agenda for next meeting. Nick Graham (check) to be invited for this item.

Sean Gibson reported that the record of attendance at meeting had been updated.

128/11 DIRECTOR'S UPDATE
(Agenda No. 4)

The Director for Social & Community Services gave an update on:

Interim Deputy Director, Adult Social Care

The Head of Adult Social Care, Paul Purnell, left his role in March 2011. Given the current uncertainly surrounding the future of health and social care, it was considered sensible not to recruit a permanent replacement until direction of travel had firmed up.

With this in mind, John Dixon has been appointed as Interim Head of Adult Social Care. John Jackson said that John Dixon is a person of great experience and knowledge in this area having been Director of Adult and Children's Services at West Sussex for several years , and past President of the Association of Directors of Social Services. He is expected to be in post for several months.

The Chairman noted that there is a high proportion of older people in West Sussex. John Dixon agreed, and hoped that his experience in West Sussex would inform policy development in Oxfordshire.

Day Opportunities for Older People

On 16 November 2010 the Cabinet approved the implementation of the strategic commissioning framework to move to day opportunities for older people and carers within Oxfordshire. The model is based on three tiers reflecting the range of universal services, specific support, and specialist social and health care provided to individuals and their carers:

1. Community Engagement
2. Community and low level support
3. Specialist Health & Wellbeing Resource Centres

Community Engagement:

The fund which allocated small scale grants for community-based options has been transferred to the Big Society Fund.

Community and low level support

Tier 2 is supported by voluntary sector, and includes important initiatives such as, for example, lunch clubs. Existing contracts have been extended to September 2011. As Tier 2 services will be decided at a local level, there will be a clear accountable process on allocating resources. The way forward is to locality boards, an approved provider list, and a simplified procurement system.

Best practice is to work with providers in order that they are in the best position to complete. As part of this support, a commissioning conference will be held in May 2011. It was noted that Age Concern were a major provider in this area.

Regular monitoring of the performance of providers will be ensured with monthly reports being put in place.

Councillor Arash Fatemian (Cabinet Member for Adult Services) stressed the importance of simplifying the procurement process to reduce the burden placed on providers. He added that the locality boards will include local Members, and that the committee will see detail proposals when ready.

Specialist Health & Wellbeing Resource Centres

Initially seven centres were proposed, but eight have now been included. This is due to the Wallingford centre successfully arguing to provide an overflow service which will only work if people are willing to use what is on offer.

Specialist Health & Wellbeing centres are likely to be run by larger organisations who have an understanding of complex procurement procedures. Interest in running the centres has been shown by internal providers, Leonard Cheshire (who currently run the centre in Witney), Age UK, and the British Red Cross. Partnerships may be formed between organisations.

Simon Kearey (Head of Strategy & Transformation, Social & Community Services) will lead on the internal provider preparation.

A decision to be made in September 2011 for a June 2012 start.

Transport

The Director reported that plans for transports were at an early stage, and focused on identifying those with complex transport needs (particularly electric chairs). Once the issue is clearer then options will be developed.

The framework should include using voluntary drivers, for example, a neighbour giving someone a lift.

Councillor Arash Fatemian added that he would circulate guidance on car insurance for those offering lifts. It was an ‘urban myth’ that this was an insurmountable problem.

Members welcomed the update but raised concerns around the reach of Age Concern in providing social care, and suggested aligning work of Dial-A-Ride with that of Octopus in order to support transport for day care services.

Changes to NHS locally

Sonia Mills had been appointed Chief Executive of the NHS Oxfordshire and NHS Buckinghamshire Cluster, and she is in the process of appointing Executive board members.

GPs in Oxfordshire have elected Dr Stephen Richards, a GP from Goring, as the Lead of the developing Oxfordshire GP Consortium (OGPC). Dr Richards will work with the six GP locality representatives.

Councillor Peter Skolar added that OGPC is still scheduled to replace the PCT in 2013, and that changes listed for 2012 (eg, abolishment of the Strategic Health Board and the establishment of HealthWatch England) will still take place.

129/11 UPDATE ON DELAYED TRANSFERS OF CARE

(Agenda No. 5)

The Chairman began this item by referring to the recent news reports which argue that the issue of ‘bed blocking’ was getting worse due to the social care element.

John Dixon responded by stating that Oxfordshire’s approach to this issue is similar to that of other areas, and that improvement can only be achieved by NHS, voluntary sector, families and the council working together. He stressed that Oxfordshire has all the ingredients in place to make a positive impact, and that the media reports are wrong.

Commenting on the medium term strategy to address Delayed Transfers of Care (Adult Services Scrutiny Committee meeting, 8 March 2011, item 7, para 13), John Dixon emphasised the importance of keeping the process simple so

everyone knows how it works, and the need to further develop pooled budgets (especially for older people services).

He added that it is vital to have reliable and timely data, and acknowledged that there are some delays in reporting data, but that the recent trend is downwards though remains well above a satisfactory level. Analysis shows that the there are a number of pinch points in the process, and understanding the whole pathway is crucial in dealing with these pinch points, that is; the lead up to a hospital referral, the hospital experience and leaving hospital.

Discussion by members highlighted the importance of reablement working effectively, and the recognition that DTOC is more a managerial issue than financial. The financial aspect of delays on a person's quality of care should not be underestimated, but for the process to work smoothly requires good management.

Cllr Peter Skolar said that HOSC should be asked to consider the aspect of how consultants decide on when a patient is to leave hospital.

A vote was taken on the Chairman's proposal to inform Cabinet that: 'The financial basis for delayed transfers of care is adequate, any improvement will depend on the efficiency and effectiveness of the different organisations working together'.

8 voted in favour, 1 against.

130/11 REPORT ON TURNAROUND PROJECT

(Agenda No. 6)

John Dixon (Acting Head of Adult Social Care) reported on the progress of the Turnaround Project. He stressed that it is key to the improvement of Delayed Transfers of Care (DTOC), but highlighted the difficulty in identifying those who are at risk of being overly dependent on Adult Social Care services.

The aim would be to provide support to people at the beginning rather when they have fallen into difficulties. Like DTOC this would require an understanding of the whole system in order to target intervention effectively.

The Chairman was concerned that the project may be considered a 'nice to have' rather than an essential service which could be vulnerable if budget is under threat.

131/11 UPDATE ON PROGRESS IN RELATION TO THE NATIONAL DEMENTIA STRATEGY

(Agenda No. 7)

Varsha Raja (Assistant Head of Adult Services) and Suzanne Jones (Senior Commissioning Manager Older people, Directorates of Service Redesign – Oxfordshire PCT) reported on progress in

- Quality care in the community
- Improved dementia care in general hospital
- Early diagnosis for dementia and intervention in the community
- Community support

The Chairman asked about GPs handling of dementia patients, and noted the reluctance of individuals and families to admit to issues of dementia. During discussion of these points, Cllr Larry Sanders asked about the quality of memory assessment.

Varsha Raja explained that the introduction of Dementia Advisers in surgeries is helping with these matters, as well as raising awareness of dementia in general. Suzanne Jones added that early diagnosis and intervention was key to improving the care package for patients.

Councillor Anda Fitzgerald-O'Conner referred to reduction in the use of anti-psychotic medication noted in the report and asked how this is being managed. The Chairman suggested that training for carers to help with this, and Varsha Raja thought that this could be achieved via GP surgeries.

132/11 UPDATE FROM OXFORDSHIRE LINK
(Agenda No. 8)

Adrian Chant (Locality Manager, Oxfordshire LINk) and Anita Higham (member of Stewardship Group, Oxfordshire LINk) reported.

Dermot Roaf (Chair, Stewardship Group) would not be attending as noted in agenda.

Adrian Chant reported that Oxfordshire LINK will be located under the aegis of the Oxfordshire Rural Communities Council (ORCC) at its offices in Cassington with all current staff transferring to ORCC. There is an on-going review of finances and there may be some redundancies due to the transfer, but service continuity will not be affected.

Anita Higham (Board member) spoke about recent projects Oxfordshire LINk has been running:

'Have a Say' which she said is quite constructive in assessing the quality and access to food and drink in hospitals. It is intended to undertake some work on the patients experiences of the quality of leaving hospital.

A report is expected in June of the work into reaching out to Black and Ethnic Minority groups in order to collect views of using health services.

Anita reported that Oxfordshire LINk intends to apply to be a HealthWatch England pathfinder in order to be in at the start of the new initiative. This would put the local LINk in a strong position. It was noted that Aniata Higham is the South East LINks representative on the department Of health's Advisory Board in regard to the establishment of HealthWatch England.

Councillor Larry Sanders referred to the point on the quality of food, and reminded the committee that a major project was undertaken in 1999/99 in community hospitals.

133/11 FORWARD PLAN
(Agenda No. 9)

134/11 CLOSE OF MEETING
(Agenda No. 10)

.... in the Chair

Date of signing ....

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Oxfordshire Local Involvement Network
Update for Adult Services Scrutiny Committee
meeting 13th June 2011

Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following projects being taken forwards. Further Health and Social care issues will be prioritised during this year.

LINk Host Contract

Oxfordshire Rural Community Council has taken over as the 'Host' organisation for the Oxfordshire LINk from 1st May, following a tendering process that took place during the early part of the year. The contract will run until 31st March 2012, subject to new 'HealthWatch' arrangements being introduced at that time (implementation is now delayed until at least July 2012). Linda Watson, Chief Executive of ORCC, has warmly welcomed the opportunity to act as host. She says: "ORCC's staff team have a great deal of expertise about creative ways of involving communities and individuals, combined with an intimate knowledge of Oxfordshire. I am confident that our organisational strengths will mean we can provide a strong and supportive framework for the LINk to operate within".
The LINk office base has moved to Jericho Farm, near Cassington. Details of how to contact the LINk team has been published and sent to all LINk participants.

Ongoing projects and engagement:

Second 'Social Care' Hearsay event – 11th March 2011

This event was for people who use Adult Social Care services with their carers, friends and family members being given the opportunity to give their views directly to the Director and Senior officers in Social and Community Services. The 2011 event was very successful and substantially oversubscribed with approximately 50% of the audience who came last year and 50% of new clients. Service Users and their companions heard if the quality of services people receive has improved, were given an update from the 2010 key recommendations, explored what further the LINk working in partnership with Social and Community Services can do to change or improve services and to set further goals and made recommendations for 2011-12. The report detailing this year's action plan with the priorities taken from the event was presented to the directorate leadership team in Social and Community Services on 12th May. The final report has now been agreed and is about to be distributed. Copies will be available at the meeting.
There is a proposal to hold additional Hearsay events to cover different parts of the county during this year subject to resources.

Self Directed Support (Personal Budgets)

Following the first phase of LINk-sponsored research into the experience and perceptions of clients of traditional social care services and Self Directed Support which was carried out in June 2010 and reported in September 2010, this additional piece of

Oxfordshire LINk Your voice on local health and social care

qualitative research will involve a small group of SDS clients from Black and Minority Ethnic groups.

The main questions for this research are:
1. What are the benefits to clients of SDS, what are the drawbacks?
2. How does the type of service available under SDS compare with previous experience of traditional support services?
3. Are there any specific issues with accessing Self Directed Support services that have been encountered by people from BME groups?

The sample for the research is being provided via the Council's Taking Part team, who have identified BME clients of SDS and have written to each asking permission to pass on their contact details to the LINk. We have contacted those willing to be interviewed to set up a discussion. The interviews may require the use of translators.

As in 2010 and where appropriate, the views of the client will be supplemented by (or provided by) a proxy such as a carer, family member or caring professional. The LINk budget for this work allows for 8 face-to-face interviews. If there are fewer than 8 Oxfordshire County Council BME clients willing to be interviewed then we will re-contact people who were interviewed in the 2010 research project for a follow-up discussion – as many as the time will allow. The findings and report will be available by the end of July 2011.

'Enter and View' visits to Care Homes

The LINk has carried out a series of visits to 36 Care Homes, the criteria being size, locality to evenly cover the County and a range of service providers. The first report is included to follow this update. A second series of visits is being planned.

Other projects (ongoing or concluding):

Podiatry

An information resource, comprising an attractively designed booklet, website pages and other means of communicating comprehensive information about Foot Care is about to go to print. This will be available during June and widely circulated. The PCT, Age UK and local Podiatry & Chiropody practitioners are supporting the project.

LINk Partnerships:

Alongside the main project programme, the LINk is working alongside several Oxfordshire groups and organisations in order to improve or develop services and to provide the LINk with a wider base of interested participants:

Oxfordshire LINk
Your voice on local health and social care

Oxfordshire Unlimited
The six month membership project has now completed and has helped develop this User Led Organisation for those with physical disabilities in Oxfordshire. This project provided Unlimited with the ability to increase its membership and become better known in the county and hence to offer to the community a key reference base for information and services in the future.

Oxfordshire Neurological Alliance
LINk is providing ongoing support for the local branch, supporting ONA to publicise its work and raise public awareness, the LINk has helped to produce promotional materials, publish a website and to provide additional channels of contact with local people. LINk has funded the facilitation of a successful business planning workshop, from which a plan for the next stages of development is being taken forward following their AGM at the end of March.

Adrian Chant (LINk Locality Manager)
01865 883488
Update 01/06/2011

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Oxfordshire LINk
Your voice on local health and social care

OXFORDSHIRE RESIDENTIAL CARE AND NURSING HOMES REPORT November 2010 – April 2011

Introduction

There are 142 homes in Oxfordshire. We planned to visit 36 in a first phase and hope to do more in future months. It may be appropriate at some stage to extend visiting to Community Hospitals. Volunteers visited in pairs, writing a short report from each visit. Twenty eight sets of notes have been received so far. Comments and views expressed were those obtained during discussions with managers, staff, residents and their relatives. They reflect the personal perceptions of the individuals.

Each volunteer was asked to undertake a CRB check, to have a short training to make sure that he or she understood the delegated powers under the Act, and each was interviewed for suitability by two members of the LINk Stewardship Group. Guidelines were agreed to ensure that visitors were looking at similar issues.

An e-mail letter was sent by Andrew Colling, Service Manager for contracts, in the name of John Jackson, Director Social Services, to all homes. This was followed by a letter from the LINk project with reassurance that what was proposed was a visit and in no way an inspection, and naming the two people who would make arrangements to visit them. A preparatory visit was thought to be useful when possible but did not usually happen. Many of the homes visited said they had not received the e-mail from the County Council or the letter from the LINk which explained the process. This perhaps points to a general problem in their systems of processing information.

The sample

The homes visited are broadly representative of all homes in Oxfordshire, though with a bias towards larger ones. More than half the twenty eight have between 31 and 60 beds, while a further nine have between 61 and 90. More than half are situated in the city or in the major towns of Oxfordshire and another third in larger villages. More than half are purpose built. A few are in older properties, occasionally listed. The providers may be not-for-profit charities, one or other of the larger commercial companies for care homes, religious orders or private owners. The managers, who generally received visitors with courtesy, even when they were uninformed of the purpose of the visit, were more often concerned with the day-to-day running of their homes than with the administrative details, so that visit notes are sometimes short on some facts, particularly about funding or reasons for vacancies. But despite the non-statistical base, some trends and matters of concern can be confidently recorded, especially as the survey is primarily concerned with the quality of care and of life experienced by residents.

Occupancy

Not all the notes record the numbers of beds occupied. But it is worth remarking that on the days of the visits over a four month period more than a hundred beds were standing

empty. This does not of course mean that at any one time 100 beds were simultaneously empty: nevertheless, this is a gravely disconcerting figure. Some of both the medium sized homes and the larger ones could have a third of their beds unoccupied. Occasionally the cause is given as modernisation or other building work, and a couple of homes are too new to be fully established. But more often it is stated or implied that the cost of the room may be an issue, particularly if County Council funding is involved. The problems arising for management from these vacancies cannot be underestimated, while the problems for those seeking admission are probably even greater. Attention is drawn in one report to the coincidence of empty beds and reported bed-blocking at the Horton.

Respite beds

Visitors paid particular attention to the availability and use of respite beds, which are so important for both those with long-term conditions and for their carers. The picture that emerges is unclear, not very reassuring and with signs that things may be getting worse.

The most common situation recorded is for respite care to be obtainable only when beds are available, sometimes only for weekends. But in about a third of the homes, it is noted that the County Council retains respite beds, usually one per home. These were, however, not always occupied and managers said there were problems over the rate of payment. Interestingly, in two homes, respite beds were regularly occupied by a rota of users, in one case for a week or two at a time, and in the other for anything from a weekend to twelve weeks.

There is some uncertainty in a few sets of notes over beds classified as ‘short stay’ or ‘intermediate care’, and in one case nine intermediate care beds had recently been withdrawn because of unsuitable occupancy.

The managers usually made it plain that they would be happy to provide respite care whenever they were not full and payment could be made at a rate satisfactory to their companies. But, from what we were told, it seems likely that the County Council may be retaining beds which, in the event could not be used because of local funding rates. And would-be occupants of such beds seem likely to have a fairly bleak time when seeking one.

Residents

It is not possible to categorise the populations of the 28 homes visited, other than to note that the very great majority are women. Several homes note having only one or two men. Of only one home is it noted that men are present in sufficient numbers to hold their own. The last traces of the ‘home for gentlefolk’ can still be found and a small number of homes have ‘residential’ wings. Two thirds of the homes visited have numbers of residents with varying degrees of dementia. As a caveat, it has to be said that the terms ‘dementia’ and ‘early onset dementia’ are not always used in their clinical sense. But there is no avoiding the prevalence of the condition. Several homes not registered for dementia nevertheless cope with it to some degree and make clear that, unless there were disturbance for other residents, they would not move anyone on if he or she developed the condition. The other patients in the homes were visibly the ‘elderly frail’, sometimes in need of considerable nursing care. A problem which seems to be of homes’ own making arises when beds are reserved for the young brain-damaged. In one home the only young man in this group had been given dementia training so that he could relate to his fellow residents.

Staffing numbers

Here again there is no clear picture. We have no details from some homes and others list the overall numbers of 'care staff' available to them, without distinguishing between nurses, care staff and care assistants or explaining how they are deployed. About half the homes employ nurses day and night, and those homes that quote their ratios for care staff vary from the standard variations between day, evening and night to the more generous. Most homes list chef, maintenance man and part-time activities co-ordinator. On the whole no problems of recruitment are mentioned, other than for nurses in Abingdon, and most managers insist that they would never employ anyone whose English might not be up to scratch. In many homes notices about staffing suggest that considerable numbers do not have English as their native tongue. We have no information about rates of pay.

Funding

Understandably we cannot say who pays what for whom in the various homes. Some managers were not the right people to tell us. Also, while some homes classified anyone even part funded by the local authority as council funded, others classified anyone topping up a degree of council funding as self funded. We do know that self-funding costs are high, usually between £700 and £800 a week, and even as high as £1096 a week. Against this, figures for funding by Oxfordshire were variously quoted as £367 (reduced from a previous £552) a week or £452 for dementia care. An NHS figure of £760 for nursing care is also given. Without putting too much weight on these reports, one can see the problems for those homes who report 70 or 80% of their residents funded by Oxfordshire compared with those who have mainly self-funding residents. A few managers point out that Oxfordshire pays less than some other authorities. But in any case what anyone pays makes no difference to their care. Staff do not know and in any case would not discriminate.

What managers do make plain is that the rates of local authority reimbursement are a factor in the number of beds left empty. We are sure Oxfordshire is well aware of these problems and is much better informed than we are. We hope, however, that they can reassure us and future would-be residents about the constancy of future provision.

The physical environment

Most of the homes are purpose-built and the rest well-modified. All are well cleaned and fresh smelling. The buildings have lifts and good wide stairs. The great majority of rooms are singles and most are equipped with en suite facilities, wet rooms in the most modern. Less modern homes provide only hand basins and lavatories, and a very few have all sanitation along the corridor. Bathrooms for the disabled are usually available. A few very modern homes provide flatlets which include kitchens. The rooms are generally of a good size, sometimes large. Doors to rooms are normally fire doors, though kept open during the day. In one home where residents with dementia have a tendency to wander, rooms also have either stable doors or hanging blinds so that they are not invaded and occupants still feel in touch. Most rooms have call bells and some, telephones.

Almost all the homes have welcoming, functional, secure entrance halls, some described as of good hotel standard and occasionally with background music. Information is on display, with details of staff and notices in decent size type. Occasionally the information needed up-dating, and it was dispiriting in one home that the manager thought it of no importance that notices were ill-spelt and ungrammatical. The use of jokey notices may

also need thinking about.

Administrative offices are usually near the entrance. Care staff common rooms are less obvious as are the points where call bells register. The common rooms, dayrooms, dining rooms and conservatories, all usually of good size, are generally on the ground floor, though some homes find advantage in having a variety of day rooms spread throughout the home. Dining rooms in the more modern homes provide separate tables. In others the tables are large and sometimes also used for crafts or games. There is only one mention in the notes so far received of a craft room and none of an exercise room.

The majority of homes speak of gardens or patios while others have lost them to car parking, still sometimes in short supply. Some gardens are only to be looked at and quite a number are accessible to residents only when a member of staff can accompany them or the home puts on a barbecue. Comparatively few homes give access to residents to walk in the garden, use their wheelchairs, sit or even garden. A very fortunate few have larger grounds with farm animals and glasshouses. Particularly given the lack of in-house exercise space, access to gardens warrants greater importance than it is given.

Daily life

We had planned to talk to residents as well as managers and staff but, mainly because of the fragility of many residents, could not often do so. In most homes we spoke to one or two, who expressed general satisfaction. The few homes where there were groups of residents able to express views were clearly at an advantage, as were the residents. On the other hand, the occasional resident who was fitter than her fellows, made us aware of how isolated she could feel, how lonely and even a bit resentful of being followed around by staff. In two cases we were alerted to existing residents' disquiet about the greater needs of recent incomers. The picture given to us by managers did not always correspond with what we saw, but this may be explained in part by the fact that many visits were made in the mornings when the staff were busy helping residents to get bathed and dressed.

Daily life in all the homes is gentle, kindly and broadly respectful of individual wishes. But within that common description are variations that do not seem to correspond to residents' state of health. In some homes residents are mainly lying in or on their beds, only emerging for meals and not always then; in others, they are mainly in the day rooms, talking with or at least flanked by care staff; in a minority they are involved in a variety of activities and have the possibility of being taken out locally by carers or further afield in the home's minibus – even limousine. Each home's degree of involvement with the local community and volunteers is a key factor. Admittedly staying in one's room can be a statement of independence and a wish to decide one's own television diet or even a vote of no confidence in the activities offered. These in general seem rather limited and possibly childish; there is perhaps a mismatch sometimes in the levels of education of residents and carers. But one has to remember that the average stay in a care home is two to three years and ask serious questions about the desirable degree of stimulation. Residents can of course receive visits from friends and families at any time but this cannot compensate for the lack of stimulus observed in some homes.

Almost all the homes have an activities co-ordinator rather than an occupational therapist and programmes of planned activity are often on display. In a very few homes the co-ordinator is said to visit individuals in their rooms to ensure that they have help with activities of their choosing rather than the public flower arranging or bingo. There seem to be few group activities with any particular appeal to men. In some homes the visit of the

hairdresser or manicurist is claimed as an activity. In a very few homes residents help with the daily chores like laying tables or preparing vegetables but more commonly the programme is board games, crosswords, painting, memory boxes, concerts by visiting schoolchildren, PAT dogs and the like in many different mixes. (A number of homes make benevolent noises about how welcome residents' pets are, but in the event no more than one or two cats seem to have been brought into residence.) The offer is mainly sedentary, even sometimes when it involves exercise, though there are exceptional dances and full exercise sessions. Even more exceptional but growing in favour are sensory rooms and sensory gardens.

Only two homes mention access to a computer for residents. This hardly seems to correspond to the real world.

No-one should underestimate the difficulty of programming to meet the many needs of residents, and managers were often keenly aware of how much more there was for them to do. But the best homes are so almost effortlessly successful that we can only advocate that more time, effort and possibly cash are devoted to finding solutions. The effort needs to involve the local community. Room perhaps for the Big Society?

Care

All homes know how to summon medical care when necessary. A large number have arrangements with local surgeries and some receive regular visits from local doctors. Because of the distance some residents are from their former homes, it is not always possible to honour the promise that they can keep their own GP. All homes also know how to provide podiatry, dental care and physiotherapy for their residents, usually against payment, but this often involves being taken out to local services. For a few homes this causes transport problems. The quality of both dental care and physiotherapy is not always as good as homes would like.

All homes ensure that their staff receive mandatory care training, in some cases including end of life care. But most managers spoke sympathetically of how they managed the latter for both residents and families. Even in homes not registered for dementia care, staff generally had a degree of dementia training. There can be a problem with the provision of training when it takes care staff away from their normal duties and even out of their homes to another base.

Most homes spoke of good relations with local religious leaders for both routine and crisis needs.

Food

Food is commonly described as bland or comfort food. A choice is invariably given and confused residents are helped to choose. Monthly menus are often on display though not always closely followed. Residents were generally content though in one case the food offered was obviously not what one resident was accustomed to. In some homes there could be more fresh vegetables, and fresh fruit was also sometimes lacking. No resident need ever go hungry as snacks are always available. Catering done 'in house' was the most popular.

Help with feeding was regularly available, though it was occasionally observed that it was a bit automatic and without encouragement.

Inspection

There was some feeling that the old CQC regime of three year visits had caused a lot of paper work and taken staff away from their real work of caring for people. On the other hand some felt they could profit from more involvement and help from social services.

Finding a home

Several comments were made about the difficulty of finding a home which fitted an individual's requirements. Location, ease of access and charges are frequent criteria. Some people simply do not know where and how to start to find information about this poorly understood service. Some web sites are excellent but these still do not meet the needs of many people. Although considerable care has been devoted to communication, it does not cover all homes nor is it always up to date. There should be ways of making the information simpler and more user friendly.

Conclusions and recommendations

The members of the Oxfordshire LINk who took part in these visits would like to thank very warmly the managers, staff, residents and some of their families and friends for their welcome. We hope we have appreciated all the care and thought they give to running the homes and that we have not underestimated the complexity of the task.

The picture we describe is not peculiar to Oxfordshire and readers will be familiar with recent press reports of the costs to providers, residents and funders. But we think there is room for local action both by the local authority and by the homes themselves.

We found a wide range of practice in the homes we visited even when their populations seemed similar. Given the high level of charges and allowing for differences of style, it is vital to consider whether value for money is given in all cases and whether the care received by residents is always as good as it can be. Many of the residents are very frail and many have at least a degree of dementia. It is important that there is no underestimate of their need for and capacity to respond to stimulus. Nor should they be exposed to well-intentioned but over-childish activities. The best homes show what can be achieved, particularly when the approach is both personalised and socially integrating.

We are not in a position to know whether part of the problem may not lie in the content of some of the dementia training offered. We have also to question how far the language skills of some staff may contribute to what we observed. It is too easy to say 'a kind face and manner is a language in itself', true as this is. Meaningful conversation with those suffering from dementia is a considerable skill and not easy to conduct even when resident and carer share a mother tongue. We would in general like to see more interchange between staff and residents whenever possible, with the latter more often taking the lead and able to pitch the conversation at their own level.

Continuing mobility may also be a general problem. Exercise is often restricted and opportunities to walk out, with or without a care attendant, equally so. The need for homes to be able to draw on the active support of their community is very marked. Difficulties in arranging for attendance at outside medical appointments are an extreme and fortunately rare case of this problem.

The homes are all subject to inspection but it is not clear that the existing form this takes is the most helpful to their performance. All the homes want to do well and several said how much they would appreciate more contact with social services. Monitoring needs to be reinforced by support.

This is a matter for the local authority as is the need in these cash-strapped days to consider with providers, residents and the public how much money can be spent on care homes and what is its best use. The use of respite beds needs clarification as does the whole problem of empty beds, particularly when there is known bed-blocking in local hospitals. The latest national report on the cost of being in a care home gave the average figure as £30,000 per year and the average stay as 2.3 years, with the warning that costs in the south are higher and that prices are going up. The need is unavoidable and the older population is growing.

Oxfordshire LINk is hosted by
Oxfordshire Rural Community Council

Report dated 4th May 2011

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ADULT SERVICES SCRUTINY COMMITTEE

MONDAY 13 JUNE 2011

OXFORDSHIRE RESIDENTIAL & NURSING HOMES REPORT

Response from the Director for Social & Community Services

INTRODUCTION

Firstly can I say that I welcome the report from the Local Involvement Network (LINk). The addition of an independent view about the care home sector will help to complement information that is already available across Oxfordshire.

However I would like to take this opportunity to comment on some of the points raised and in particular on the following:

OCCUPANCY

The factors affecting occupancy are several. I have made comment on a number below:

Overall Market Share - In terms of overall market share I estimate that the council purchases just over a third of all care home places in Oxfordshire. A further 9% of places are purchased by the PCT or other local authorities with just over a half of all places being purchased by people placing themselves in care homes.

Length of Stay - For older people in Oxfordshire a greater proportion of the people the council supports live in care homes than the rest of the country. Oxfordshire took part in a local benchmarking study on length of stays in care homes with 6 other authorities. This work has indicated that people live in care homes in Oxfordshire for longer than the rest of the country; people in Oxfordshire had the highest length of stay in care homes. On average this is 5 months longer than the average authority in the study (an extra 20%).

Last year the Council funded about 450 new permanent placements, with over 20% of these being people who had originally funded their own care. Further analysis is suggesting that when their needs have been compared against this council's eligibility criteria a number of these people may not have needed care home services when they first went into a care home. Everyone is entitled to a social care assessment irrespective of their means. Therefore the council is concerned that some people may be entering a care home setting too early in their life. With this in mind we are actively looking to encourage people who fund their own care to look at alternatives to care home placements at the time of potential admission.

Occupancy Levels - The Oxfordshire Care Homes Association has regularly reported on occupancy levels within a selective sample of care homes and their statistics have indicated occupancy levels at between 94%-96%. Vacancies are therefore a natural part of the care homes market dynamics. However the indication is that if expansion continues to outstrip demand then there will be an increase in the number of vacant beds available unless these are taken up through demographic demand.

New capacity within the care home market – Despite the above there is still a healthy interest in building new care home services and extra-care housing in Oxfordshire and a number of developments are currently taking place. Furthermore information from this year's Laing & Buisson Annual Long Term Care Conference is suggesting that (nationally) available beds are increasing faster than occupied beds, but the number of occupied beds is increasing also. This trend may be being fuelled by the demographic changes that are being reported on a regular basis.

In response to this and on a number of occasions over recent years I have spoken to representatives from the care homes sector about my commissioning intentions. I have been clear that I do not envisage buying residential care home services in the future but will instead purchase alternatives such as extra-care housing and community based services. I envisage that this trend will continue for the foreseeable future although I do expect to continue to buy nursing beds in a care home setting to respond to assessed needs.

RESPITE BEDS

I agree with the LINk when they say that respite beds provide an important element of this Directorate's support arrangements for people with long-term conditions and their carers. It is for this very reason that I purchase these beds on a block arrangement in order to secure the necessary access and support for people in Oxfordshire.

In 2010-11 Social & Community Services purchased 11,373 bed days worth of respite care. Usage of these beds during the year can be reported as

Total Booked beds		97%
Of which		
• Occupied beds	86%	
• Cancelled beds	11%	
Beds Not Booked/Vacant		3%

There are various reasons given for cancellation but the top three which account for over half of the 11% cancellations mentioned above are recorded as -

Change to carer plans/opt out	23%
Client moved to permanent care	22%
Client deceased	10%

Often the cancellation is notified very close to the actual date of placement. In such circumstances my placement staff make these vacancies known to hospital based staff in order to support hospital discharge activity. We are also intending to carry out further work to examine the reasons for 'Change to Carerplans/Opt out' in order to improve the total uptake of beds in any year.

SATISFACTION SURVEY

One of the indicators the council has looked at to demonstrate good quality care services has been the star rating system which was operated by the Care Quality Commission up to June 2010. The last reports by the Care Quality Commission on the old star rating system showed 86% of care home places in Oxfordshire were good or excellent compared to 82% nationally.

A Social Care User Questionnaire was undertaken in February this year. The results for those questionnaire's returned in respect of care home services indicated that overall

- 93% were satisfied with services;
- 76% of them being extremely or very satisfied;
- only 3% are dissatisfied

The survey went on to record that 79% of service users rated their quality of life as 'Good' while 18% scored their satisfaction as 'OK'.

98% reported that they felt 'adequately clean and presentable' whilst 96% stated that they received 'adequate food and drink at ok times'.

98% recorded that their home is 'adequately clean and comfortable'.

On the issues of socialising 85% said they had adequate social contact, 11% said that they had some social contact but not enough, while 4% said they had little social contact and felt socially isolated.

The full survey results will be considered by the Adult Social Care Leadership Team and an action plan drawn up. A number of service users have indicated their willingness to discuss their response with us and we will be taking this forward in December to identify the progress that has been made.

FUNDING

The LINk has reported on the level of funding associated with the placement of residents.

The topic is a complex one and the range of fees quoted in the report will reflect the different levels of dependency, the funding source behind each spot placement together with the availability of a bed and the fee levels that the home is willing to accept.

I have noted the suggestion that Oxfordshire pays less than some other authorities. However the last full expenditure dataset for 2009-10[1] indicated that the weekly costs of a care home in Oxfordshire was above both the national average and the average for the south east.

Fee levels are negotiated individually with the provider at the time of any spot placement of service. Our published banding levels for 2010-11 ranged from £350 to £612 per week.

The LINk have also commented on the constancy of future provision and in this respect I would like to assure Members that my staff undertake regular checks on the financial health of the sector. This is a part of our response to managing Risk and Business Continuity in the current financial climate. In my view the financial health of the sector in Oxfordshire generally remains stable.

Furthermore it is usual for potential operators to check our target payment rates for such services at the time of planning. Clearly the target banding levels we are operating at are not dissuading providers from investing further in the care homes sector.

FINDING A CARE HOME

I have noted the comments made by the LINk in respect of information about Care Homes. There is a wealth of information available to prospective residents. The council has a contract with Caresearch for the provision of a Vacancy Information Website with information available through the Council's website. In addition to this there is information available on the Care Quality Commission's website whilst other sources include the likes of AgeUK and Citizens Advice Bureau.

However I should like to reiterate that this council's strategy is to dissuade people from entering care home services too early and to explore maintaining people in their own homes. Having said that I will review our information provision to ensure that good quality information is available to those who need to make decisions at such a key stage in their life.

[1] (Source: Department of Health Adult Social Care Intelligence Service http://nascis.ic.nhs.uk/)

CONCLUSION

I welcome this report from the Local Involvement Network (LINk). It provides additional information and useful feedback about the services that are delivered in Oxfordshire and in particular about the quality of service that residents experience in a care home setting.

I will ensure that the LINk's finding are considered by the Directorate's Adult Social Care Leadership Team at a future meeting.

JOHN JACKSON
Director for Social & Community Services

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