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Notice of a Meeting

Adult Services Scrutiny Committee
Tuesday, 13 November 2012 at 10.00 am
County Hall

Membership

Chairman - Councillor Jim Couchman
Deputy Chairman - Councillor Mrs Anda Fitzgerald-O'Connor

Councillors:	Jenny Hannaby	John Sanders	Alan Thompson
	Alyas Ahmed	Dr Peter Skolar	David Wilmshurst
	Charles Mathew	Richard Stevens	

Notes:

Date of next meeting: *17 December 2012*

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 Jim Couchman E.Mail: jim.couchman@oxfordshire.gov.uk
Committee Officer	-	*Simon Grove-White, Tel: (01865) 323628* *simon.grove-white@oxfordshire.gov.uk*

Peter G. Clark.

Peter G. Clark
County Solicitor

November 2012

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.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note

3. Minutes (Pages 1 - 6)

To approve the minutes of the meeting held on 25th Sept **(AS3)** and to note for information any matters arising from them

4. Speaking to or petitioning the Committee

5. Director's Update

10:00

John Jackson, Director for Social and Community Services, will give an update on local and national issues.

6. LINk Report on Care Homes Visits and Update (Pages 7 - 16)

11:00

Sheila Browne and Mary Judge will deliver a report discussing the outcomes of recent visits to residential care homes (**AS6a**).

Adrian Chant, LINk Host manager, will give an update on other recent activities of the LINk (**AS6b**). This will include a verbal update on the action plan resulting from this year's Hearsay event.

7. Video: Older People Commissioning Strategy

11:30

The committee are invited to view the video on the Older People's Commissioning Strategy.

8. Ensuring Quality in Commissioned Services (Pages 17 - 22)

11:45

Sara Livadeas, Deputy Director for Joint Commissioning, will introduce a report on the development of a risk based approach to contract monitoring commissioned services (**AS8**).

The committee are invited to comment on the proposals.

9. Close of Meeting

12:20

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

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ADULT SERVICES SCRUTINY COMMITTEE

MINUTES of the meeting held on Tuesday, 25 September 2012 commencing at 10.00 am and finishing at 13:00

Present:

Voting Members:	Councillor Jim Couchman – in the Chair
	Councillor Mrs Anda Fitzgerald-O'Connor (Deputy Chairman) Councillor Jenny Hannaby Councillor John Sanders Councillor Dr Peter Skolar Councillor Richard Stevens Councillor Alan Thompson Councillor David Wilmshurst Councillor Lawrie Stratford
Other Members in Attendance:	Councillor Arash Fatemian
By Invitation:	
Officers:	
Whole of meeting	John Jackson Sara Livadeas Lucy Butler Simon Grove-White
Part of meeting	Alan Sinclair Yvonne Taylor Paul Brennan Pete McGrane Rachel Coney Adrian Chant Sue Butterworth

Agenda Item

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

228/12 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Lawrie Stratford substituted for Councillor Alyas Ahmed.

Councillor Don Seale substituted for Councillor Charles Mathew.

229/12 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE
(Agenda No. 2)

None

230/12 MINUTES
(Agenda No. 3)

The minutes of the meeting of June 12th were signed and approved.

231/12 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

None

232/12 LINK ANNUAL REPORT AND UPDATE
(Agenda No. 5)

Sue Butterworth, LINk Chairman, and Adrian Chant, LINk Host Manager, introduced the LINk Annual Report and updated the committee the work taking place to ensure a seamless transition to Healthwatch.

Lisa Gregory, Engagement Manager, Joint Commissioning, gave further detail on the key milestones in this process. The committee were informed that the procurement process for the advocacy contract will begin in November. Councillors Hannaby and Stratford will be on the procurement panel.

The Chairman thanked the LINk for the fullness of the report and these sentiments were echoed by members of the committee.

Adrian Chant **AGREED** that a report on residential home visits would be brought to the November meeting of the committee.

233/12 COMMISSIONING INTENTIONS FOR OLDER PEOPLE
(Agenda No. 6)

Sara Livadeas, Deputy Director for Joint Commissioning, introduced the paper with Lucy Butler, Deputy Director for Adult Services, and Councillor Arash Fatemian, Cabinet Member for Adult Services. The document will ensure that the provision of

services is joined up across the directorate. To achieve this each workstream has a lead officer who will be focussed on turning the intentions into actions. This will then feed into a Joint Commissioning Strategy with the NHS.

Members sought further clarity on the long term intentions for tier three day services and transport to day services.

Councillor Fatemian stated that whilst the county council are committed to exploring whether alternative options exist to run day opportunities, no decision has been taken as to how this will happen. The council is committed to continuing to provide these services and will explore all available option including

It was emphasised that the reason for the increase in fees is to bring the services into line with other counties and to ensure their long term sustainability. The county council will continue to pay the fees of FACS eligible service users, so people who cannot afford to pay will not be priced out of using the services.

Regarding the long term intentions for transport to day services, John Jackson highlighted to the committee that this is dependent on the cross-cutting programme of work on Community Transport. This programme will include a fundamental review of transport needs and provision across the county and will seek to ensure sustainable transport solutions.

It was **AGREED** that an update on the consultation on Day Opportunities would be brought to the committee following the closure of the consultation.

234/12 REVIEW OF SERVICES

(Agenda No. 7)

The item was introduced by Alan Sinclair, Lead Commissioner for Older People. Yvonne Taylor and Pete McGrane of Oxford Health, Paul Brennan of the Oxford Universities Hospital Trust, and Rachel Coney of the Oxfordshire Clinical Commissioning Group were also present for the item.

Alan Sinclair introduced the report stating that the three services are key to the Oxfordshire social care system. All services have seen recent improvements in activity and outcomes but performance is not yet at expected levels in some areas.

The importance of services taking a whole system approach was emphasised by all organisations.

The committee discussed the issue of recruitment and retention of staff and queried the impact that this was having on performance. Yvonne Taylor and Paul Brennan acknowledged that there had been difficulties but suggested that the response to recent recruitment drives had been successful and staffing levels are stabilising at a healthy level. The importance of joining up recruitment efforts across OH and OUHT was emphasised.

The committee complemented the quality of the report but expressed some disappointment that the delayed transfers continue to be a problem. The Director responded that it would take some time for policy changes to show results but that recent performance suggests some improvements.

It was **AGREED** that the Director would update the committee on delayed transfers of care at the November meeting of the committee.

235/12 DIRECTOR'S UPDATE

(Agenda No. 8)

The director outlined recent developments in Adult Social Care at the national and local level.

The director introduced the Draft Care and Support White Paper stating that the Association of Directors of Adult Social Care broadly welcome it's recommendations. Members were invited to contact the Director should they wish to discuss the implications further.

The committee expressed concerns that the issue of funding is not resolved in the white paper. The director stated that locally the assumption has been made that NHS funding will continue. However, there is some disappointment that the recommendations of the Dilnot commission have not been incorporated. Councillor Arash Fatemian stated that a motion will be put to the county council to make a further recommendation to government on the subject.

The director discussed the recent reports on the safeguarding issues at Winterbourne View. The key recommendations and the next steps for Oxfordshire were also outlined.

The director further updated the committee on the phasing for the pooled budgets project.

236/12 ADOPT A CARE HOME

(Agenda No. 9)

Sara Livadeas introduced the proposals for local councillors to Adopt a Care Home. It was emphasised that this should be seen as part of a wider push to ensure quality in care services, with the explicit aim to encourage local members to form a relationship with care organisations in their divisions. It is not intended to replace the role of officers in robustly monitoring contracted services. It was pointed out that a number of members already have positive relationships with the organisations in their divisions, and that anything which increases the flow of people in and out of institutions would provide further safeguarding assurances.

The opinion of committee members was divided on the issue, with some fully endorsing the proposals, and others feeling that the task does not fall within the remit of councillors and should be preformed by officers.

It was **AGREED** that a report on contract monitoring would be brought to the next meeting of the committee.

237/12 WORKING GROUP ON QUALITY
(Agenda No. 10)

It was **AGREED** that no further meetings of the working group on quality would take place in the next six months. The composition of the group and it's terms of reference will be reconsidered in the spring of next year. In the meantime, any issues arising on the subject will be referred to the full committee for consideration.

238/12 CLOSE OF MEETING
(Agenda No. 11)

The meeting closed at 13:00.

..... in the Chair

Date of signing .....

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Visits to Care Homes

REPORT

OCTOBER 2012

OXFORDSHIRE LINk
Visits to Care Homes
REPORT OCTOBER 2012

This report describes the second phase of the project to assess the quality of life in the care homes of Oxfordshire.

The enter and view visitors Twenty duly accredited visitors worked in pairs and followed pre-determined guidelines. They brought to their visits different sorts of professionalism, expertise and specific interests but all were operating on behalf of the public and of recipients of social care in Oxfordshire. They were not inspecting.

The care homes visited Twenty four homes from across Oxfordshire were visited between the end of March and August 2012. In addition there were notes from one home visited in May 2011. The homes came in a large variety of denominations: residential homes; care homes; care homes with nursing care; nursing homes; homes caring in whole or in part for those with dementia; a few for those with learning difficulties; and one drug and alcohol rehabilitation project. They ranged in size from caring for three residents to over seventy, two of the bigger ones being part of larger complexes. Some were family owned and run; some were part of longstanding professional organisations; others were part of looser groupings. A few had been established only in the last couple of years or so; considerably more had changed overall management or individual managers in the same time frame. The life-span of most of the homes is not recorded. In location they vary from the grandly – sometimes remotely – rural to the most restrictedly urban, and from the determinedly and recently purpose built to the homely and quirky adaptation of private houses or in one case of a redundant public house. Some homes set a distinctive style, of their own choosing or their parent organisations. To make a modest point, residents' drinking might be sherry parties or even Pimm's but more often in the part-time in-house 'pub'.

What is or isn't in a name The notes of visit make plain that the description of a home is not a matter or fixed definition. 'With nursing care' does not necessarily mean the home has qualified nurses on the staff; on the other hand a simple 'care home' may well employ qualified nurses as carers. 'Special care for those with dementia' clearly varies according to the home's understanding of this diagnosis and there was concern that the term was at times loosely applied. At a more practical level, 'single rooms en suite' might mean with full bath or shower and w.c. or perhaps more often with basin and w.c. only or even washbasin only. Visitors favoured the more generous provision.

Diversity and choice It does not need saying that every would-be resident of a care home brings a totally individual character, life history and need. A degree of non-conformity in the homes is therefore to be welcomed, but the visits emphasised how essential it is for potential residents and their families or carers to visit and fully understand what is actually on offer. As our visits showed, understanding calls for more than printed information and managers' reassuring words.

How close can short visits get Most visits lasted about two hours. For a variety of reasons they often became more 'enter and ask questions or be talked at' than 'enter and view'. Some managements remained stubbornly vague about the standing of the LINk; some owners and managers had work programmes which led to their constant distraction; key staff likewise; in many of the homes the apparent frailty of residents made meaningful conversation with them impractical. All of which made visitors the more grateful for the open welcome and the sharing of thoughts offered confidently in some homes.

The general picture given by management National media attention to unfortunate happenings in one or two care homes seems to have re-inforced care home managers' understanding of what visitors are interested in, but not all managers directly control the detail of what they describe. In matters of staffing, almost all quote the same standard ratios though only a minority could actually say how staff were deployed; all stressed their care to appoint only those with 'adequate' English; all said they provided induction and mandatory training, usually using NVQs, but only a few had schedules of individualised training programmes; many spoke of dementia training but only a handful specified courses of known standing. If training is given in stimulation, activities or even reminiscence, it is barely mentioned. Managers are quick to speak of 'personalisation' or 'individualisation' of care but visitors did not see much in practice. Food is said to be fresh and locally sourced where possible, offering choice, with differences in size of portion and snacks available on demand. A few homes stressed the attention paid to hydration and weight, gain or loss. (In one case, proper attention to these matters had allowed the return home of a new resident labelled as a dementia sufferer.) Special diets are said to be no problem, with only a minority using medical prescriptions for, say, gluten free foods. All managers describe satisfactory arrangements with GP practices and district nurses though there are two cases of a retainer being paid for extra local medical cover. Some homes further cite with approval their links with the Falls clinic, the local hospice or psychiatrists from the local hospital. All claim suitable arrangements for podiatry, physiotherapy, dentistry and the like, usually against payment and not necessarily in house. Where the question arose, they all profess very careful medication policies. But if one is really looking for unanimity of answers, it comes in the listing of activities and in the confidence placed in one or more 'activities co-ordinators'

Daily life as visitors saw it

First, **who are the residents?** Little detail is available. There are certainly more women than men. Of only one home is it recorded that men and women are fifty fifty. In one home records show that the average age on entry is mid-80s and the average length of stay four years. Other homes quote three years as the average, while pointing out individuals who have been with them much longer. Some homes distinguish between those who are elderly frail and socially isolated and others who have a degree of dementia (undefined). It is understood to be Oxfordshire's current policy only to fund new placements in residential social care in exceptional circumstances. Many residents are part or fully self-funded – not that homes make any distinction in care according to who pays what. Visitors did not, of course, have access to admission assessments or individual care plans. In some homes they had the benefit of conversation with individuals or groups of residents, but in many

homes the state of residents' health made this impossible. On the whole visitors' notes describe a large majority of markedly frail men and women, very accepting of their limitations. (The exception is the drug/alcohol rehabilitation project, which takes ten people at a time for ten week courses, and where 76% of those accepted are said to complete their course.)

The shape of the day Any visit is a minute proportion of a resident's week. The weather was often unfriendly. But still the collective notes of visit, with a few encouraging exceptions, portray an unmistakable picture of a life lived almost entirely indoors, mainly sitting or lying down, either in one's own room or more commonly in ordered groups in small or large communal rooms, and often doing nothing in particular. Life is secure – sometimes almost to a fault, with controlled doors and lifts and restricted access for wheelchair users; clean and mainly uncluttered; warm; familiar and comfortable; even comforting – though visitors questioned the need for quite so many soft toys and baby dolls. And all this despite most homes' lists of events, activities and visits, inwards or outwards; and despite the range of facilities available in some homes with their sensory rooms and gardens, their shops, cinemas, tea rooms and so on.

Activities The tension seems to be between the irregular happenings organised by usually very keen activities co-ordinators and the more modest and personal activity which can be part of an individual's day to day existence. Further tension may come from the assumptions made by the co-ordinators and care assistants about the attitudes and interests of residents. Not all residents want enforced jollity or pub-type sing-alongs; not all of them will have the background to join in film or television quizzes. Even in reminiscence sessions, there will not necessarily be important communal memories as residents recall the vast differences in their situations some sixty years ago. All the same, visitors welcomed the records of many distractions, even though some of the lists make strange reading with manicurists, hairdressers, visiting clerics, 90-year-old guitarists, primary school children and pat-a-dogs all listed on a par. In all the accounts of activities, there are few signs of specifically male interests – if one may make a sexist remark. And there is limited reference to art, crafts, and music, let alone helping in kitchen or garden or simply reading or knitting – for those who might enjoy these things. It is noted in particular that the range of music on offer does not cater for many tastes.

Mobility and physical exercise It is not for occasional visitors to say how much physical exercise and of what kind is suitable for the residents of any given care home, but it is striking that none was seen in 25 visits. One home has a purpose-equipped physiotherapy room, which is promising in that it offers targeted care. Otherwise the reports speak of some music and movement and the like listed as activities, but do not say who directs it. A few homes either have no outside space or have not yet set up what they have so as to allow residents to have access. But others have well set out gardens or grounds, though we saw little use of them. On the other hand, a fine morning and a genuinely open access policy found eight or nine people outside in one home, doing their own thing, with care assistants keeping an unobtrusive eye. This home has well organised generous staffing. (It must be recognised that the standard 1+4 or 1+5 ratios simplistically applied to rather vague numbers of residents do not easily allow for individuals to be accompanied into the

garden or further afield. It may be that these ratios are too tight given the condition of residents, but staffing costs must be a major concern for proprietors.)

Encouraging exceptions

It was reported of one medium-sized specialist home for dementia that 'perhaps the most striking thing in our visit was the activity going on....We found people all over the building in a calm quiet atmosphere....It was hard to believe how very demented residents were. Care staff were very evident talking to, reading, playing a game or just sitting holding a comforting hand'.

And of a very small residential home: 'Although there are no formal 'activities' offered, (the residents) enjoy each other's company.....They were listening to an audio book when we were there, and there are books and games within reach and (the owner's son) assists them with a large print computer, bingo or with television programmes.....They talk lucidly about their past lives and their families.....We were struck by their contentment.'

Or again of a small residential care home: 'the most remarkable thing about this home was the attitude of the many residents we were able to talk to. They feel themselves to be part of a community which enjoys each other's company and, with the help of the staff, find plenty to do to amuse them.....They would not wish to be anywhere else....(and) were grateful to be able to live a supported life but still to be themselves.'

Fees The range of fees quoted varies from £500 to £1,400 a week, in some cases varying according to need. Most homes visited are in the £700 to £800 bracket. The major concern for both homes and visitors is what happens to a resident when funding fails. Wherever this was discussed, it seems clear that homes do their utmost not to have to shed a resident.

End of life care For homes with a limited remit, end of life can be a very difficult problem. Most again do their utmost to retain the resident and, with expert advice and reinforcement, to care for them appropriately. It is one or two of the more highly professionalised homes which make clear that if extremely challenging behaviour, pain management or palliative care requires, residents will be sent to hospital. The visitors would have liked to be clearer about whether or not living wills or DNR were discussed with residents so that their wishes could be complied with.

Occupancy and respite Many of the homes visited are full with waiting lists. Some have empty beds either because they are new or have building works. Most recognize the need for respite beds and many would offer respite beds when they had vacancies. A few have planned respite programmes and a number have a respite bed retained by Oxfordshire, occasionally temporarily unoccupied. One home quoted an arrangement by which local GPs had limited dedicated funds to buy respite care.

Is there enough support? Not all the homes have been recently CQC-inspected and some found the process a bit disappointing in focus. Some have had an Oxfordshire social services visit. Those run by a major organisation can and do call upon its collective experience and professionalism. But for many homes, and

particularly managers of homes, it is vital to recognize the complexity of their task and the unremitting commitment asked of them. The best managers take great care to support their staff but without equivalent arrangements for themselves. It is too easy to suggest they visit homes popularly judged particularly successful in this or that: that takes time out from the day to day job, and in any case implementing change in a different context may call for changes of attitude and the acquisition of new skills which daily duties do not easily permit But with the potential growth in the number of care homes and the probable complexity of residents' needs, it would be rash not to seek solutions.

Reflections on these visits The first and overwhelming thought must be of gratitude to all the staff, residents and their families and friends who made us welcome and were prepared to talk with us about their work and experiences. No visitor could fail to appreciate the complex demands they all daily confront. But we hope they will understand that, coming from the outside, we may have areas of general concern – which we know do not arise in every home. For those building new accommodation or remodelling the existing, we see a clear need to ensure the maximum freedom of movement, consistent with security, for all residents both within the building and in respect of access to gardens and the larger outside world. Thought may also need to be given to the appropriate extent of private bathroom facilities and the range and nature of spaces for spending time out of one's own room. But above all we wish we could have recorded greater stimulus of residents and greater mobility, with more interaction between care staff and residents and less unintentional condescension in some interchanges. If residents are to spend several years in their chosen care homes, everyone needs to give their minds to the enormous challenge of helping them still to be as far as possible themselves.

Annex – Profile of homes and district

A total of 30 care homes were visited across Oxfordshire.

Table 1 Care homes visited and district

Care home	District
Fairholme House	Cherwell
Lake House	Cherwell
Manor House Nursing Home	Cherwell
St Anne's Residential Home	Cherwell
Wardington House Nursing Home	Cherwell
Yarnton Residential and Nursing Home	Cherwell
Eden House	Oxford City
Fairfield Residential Home	Oxford City
Howard House	Oxford City
Jack Howarth House	Oxford City
St Andrew's Residential Care Home	Oxford City
The Albany Nursing Home	Oxford City
Vale House	Oxford City
Oxford Beaumont	Oxford City
Acacia Lodge	South Oxford
Lashbrook House	South Oxford
Watlington and District Care Home	South Oxford
Winterbrook Nursing Home	South Oxford
Abingdon Court	Vale
Mon Choisy	Vale
Oxenford House	Vale
Richmond Letcombe Regis	Vale
Shrublands Centre Care Home	Vale
Sterlings	Vale
Enstone House	West Oxford
Henry Cornish Care Centre	West Oxford
Jasmine House	West Oxford
Madley Park House	West Oxford
Ramping Cat House Nursing Home	West Oxford
The Cotswold Home	West Oxford

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Oxfordshire Local Involvement Network
Update for Adult Services Scrutiny Committee
meeting 13th November 2012

Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following projects being taken forwards. **The following update refers to LINk projects which have a <u>Social Care remit only</u>, unless there is joint service, or commissioning, with Health.**

'Enter and View' visits to Care Homes

The second series of visits to 30 care homes, ongoing from April 2012, has been completed. The report is presented at this meeting.

LINk Core Group

The most recent Core Group meeting was held in Yarnton, with presentations on the '15 Steps Challenge - Quality from a patient's perspective', Local HealthWatch, together with updates from current LINk projects:
Patient Participation Groups networking event – developing partnerships
Oxfordshire ME Group for Action (Omega)
Self-Directed Support/Personal Budgets
Maternity Services Review – post-natal care
Dentistry information survey

Ongoing projects and engagement:

Social Care Hearsay – action plan update

The action plan for 2012-13 covers all recommendations and actions completed, or still in progress, together with the views of service users and carers as to what has improved, remained the same or become more problematic over the last 12 months as a result of changes to services. The action plan update will be provided for members with a verbal report from the 8th Nov meeting with John Jackson.

The next full Social Care Hearsay event is being planned for 1st February 2013, in order that the report can be published in advance of the transition to Local HealthWatch and the 2013-14 action plan agreed, to be taken forward into the new organisation.

Other LINk projects due for completion in early 2013 are mostly health related and will be reported on at HOSC meetings on 15th November & 17th January.

Adrian Chant (LINk Locality Manager)
01865 883488
Update 01/11/2012

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Report to the Adult Social Care Scrutiny Committee on Contract Monitoring in Oxfordshire: 13th November 2012

Introduction

In March 2012 the Deputy Director for Joint Commissioning presented a paper to the Adult Services Scrutiny Committee setting out a plan to improve the quality of provision in externally purchased social care. Part of that plan was the proactive monitoring of services provided under a contract with the Council. This paper provides an update of progress in improving our approach to contract monitoring for adults (and children).

Context

Contract monitoring is only one method of securing quality in services provided to vulnerable people. This should be seen as part of a larger approach which includes a refresh of our Health & Safety Policies; working with the LINk and other stakeholders such as GPs; promoting the role of elected members as community champions (eg Adopt A Care Home); improving our responsiveness to complaints and comments; setting up a Quality Network with local service providers and responding to the issues raised by the Equalities and Human Rights Commission in their recent 'Closer to Home' Report.

The Challenge

1. Over 15,000 adults in Oxfordshire receive support services that are funded by the Council (OCC) in some way. These services are provided by over 300 external suppliers, using a wide variety of contracts which range from a few hundred pounds to over £20m per annum.

2. Whilst the Care Quality Commission (CQC) has the primary duty to monitor and maintain quality standards against nationally set essential standards in both health and social care settings the statutory responsibility for care received by Oxfordshire residents rests with the Local Authority.

3. Members will be aware that in addition to the registered services within the scope of CQC, some key services are not 'registered' with CQC (Day Support, Lunch Clubs, Advice and Information, Personal Assistants) and anyone using such services does not have even the minimum protection or quality assurance that is offered by CQC for registered services.

Contract Monitoring

4. Due to the range and complexity of social services commissioned by the Council a risk based approach is being developed to Contract Monitoring. This sits alongside work being undertaken with service providers in Oxfordshire to co-produce an approach to quality monitoring for the future.

5. Work is underway to determine the frequency of monitoring with regard to the size and complexity of the contracted service, with robust action plans put in place to improve services.

6. This activity will be based on a) the identification of the size of contracts we have in place and b) profiling the risks associated with each contract. There are more details of this approach below. We also need to consider what we do where no contract exists between the County Council and the provider. This will be the subject of a further update in the near future. All contracts will be RAG rated according to the level of risk. All contracts have been allocated to a quality and contracts monitoring officer.

7. Performance measures have been developed that will ensure all contracts are reviewed annually and all significant follow up actions closed within 3 months. Performance is reported to SCS Leadership Team.

Internal Risk Management System (Traffic Lights)

8. Our Traffic Lights system applies to care homes and home support agencies. The system is designed to communicate important issues known about the quality of these providers with health and social care colleagues. Traffic lights are based on all information known about a provider, including the number and severity of safeguarding alerts and complaints; the provider's response to these; CQC reviews of Essential Standards of Quality and Safety; and outcomes from monitoring visits. We specifically consider the risk assessment process undertaken by our Safeguarding Team. The process we use has been endorsed by Oxfordshire Safeguarding Adults Board. Information about the Traffic Light status of a provider is shared with health colleagues and the Care Quality Commission. Our monitoring team works with all providers registered in Oxfordshire, including those with no or few placements funded by the County Council. This is because the safeguarding responsibility for each County Council area rests with the host local authority, and the Council considers ensuring the quality of services as a priority. Occasionally we work with providers situated outside Oxfordshire, where Oxfordshire funded residents may be placed.

Care Homes Monitoring

9. In preparation for a care home monitoring visit the Contracts Unit compile information regarding the care home. We consult health colleagues as part of this process. This includes:

    - Date and outcome of latest CQC report
    - Complaints
    - Safeguarding referrals
    - Feedback from social work teams
    - Feedback from Continuing Care
    - GP, district nurse and health professional feedback
    - Outcome of latest fire inspection (Fire & Rescue Service)

- Collation of this information before the monitoring visit ensures that the monitoring officer can focus on any known areas of concern.

A template Quality Monitoring Framework is used for each visit. This detailed framework covers the following areas:

- Staffing levels and recruitment
- Staff supervision
- Staff training
- Resident care
- Safeguarding
- Management & finances
- Staff feedback
- Medicine management

Feedback from residents or service users is an essential and critical part of the process. This may involve spending time in a care home, sitting eating a meal for example, or arranging for people who use services themselves (experts by experience) interviewing people and their carers.

These factors are used when we assess and decide upon the red/amber/green traffic light status. See also Annex 1 for a chart summarising our approach.

10. Work is prioritised on a risk basis with homes considered to be providing a poorer service visited more frequently and often at short notice. The level of risk is determined by all the information sources referred to above from which the Contracts Unit proactively seek information. Information from S&CS Safeguarding colleagues plays a key role in our work planning and how we target providers.

11. Links to other professionals
    - Regular link to CQC (formal and informal)
    - Medicine management
    - Referral to dieticians
    - Joint work promoting flu vaccination take up in care homes
    - Care Homes Support Service
    - Pressure care meetings
    - Updates from Health Protection Agency
    - Feedback from GPs
    - Feedback from care managers

The Approach

12. General areas of improvement and trends are identified and considered by staff as part of quality monitoring. For example, staff are currently working with colleagues in Learning & Development to design and implement training for providers regarding care planning, risk assessment and staff competency. It is

our intention to support providers to improve in these areas where quality monitoring has identified the improvement is necessary.

13. Provider organisations will be identified for action against agreed criteria of risk and vulnerability in order to establish the level of quality monitoring they will require. We plan to have 5 levels of Quality monitoring, using templates currently being developed. We are also reviewing the way in which Health & Safety compliance is monitored. Colleagues from the Health & Safety team are advising on this, including the development of improved self-assessment by providers to encourage and promote ownership of this area amongst providers. This work will underpin the new Health & Safety Part III Policy.

14. Levels 1 & 2 are the lowest levels of quality monitoring and will be applied to the preventative contracts e.g. advice centres, advocacy, Tier 2 day services. These services do not normally provide personal care to people and are usually direct access (a referral by SCS is not required). At this level a desk based annual review of all available evidence, plus some sample visits will be relied on for the contract review process. We intend for this to be proactively supported through the introduction of provider self-assessment to help with early warning of potential problem areas.

15. Levels 3-5 are the more intensive levels of quality monitoring and will apply to contracts where people are eligible for social care or children's services e.g. Children's Centres, Supported Living, and Residential Care. Contracts will be monitored by a combination of:

    - At least a formal annual review, for very high risk areas more frequent e.g. quarterly reviews.
    - Regular, pre-arranged contract meetings.
    - More detailed provider returns (e.g. numbers using services, complaints, incidents, accidents, safeguarding).
    - Self-assessment in more detail when the self-assessment system is implemented.

16. We are of the view that we should work with providers to develop and co-produce a common toolkit for quality monitoring whose core elements can be applied to every service area, and to complement not duplicate any tools a provider may have in use that meet our needs.

17. If we do this each different client group area will need to have specific standards related to national guidance e.g. Valuing People, Supporting People, Dignity in Care.

18. The review and monitoring approach will also need to be complemented by our escalation procedure. This is needed to deal with situations where certain action events have occurred e.g. significant incident or failed CQC inspection.

Quality Standards

19. Quality is everyone's responsibility and we are developing a joint approach with our service providers, now turning in to a Quality Network. The joint work to co-develop quality standards is based on the seven principles set out in the Social Care White Paper 2012. The Quality Network has met twice and comprises of providers from all service user groups and across a range of services. The principles are that quality standards :-

    - Have a sound reference point – e.g. Making it Real
    - Have been co-produced in some way
    - Assesses the quality of the workforce
    - Start with the individual and work out
    - Uphold transparency
    - Assess the impact of commissioning
    - Are value for money and proportionate

Summary

20. Our approach seeks to ensure that monitoring is appropriate and proportionate to the levels of risk and vulnerability of the service users supported.

    Commissioners will monitor ***services*** on at least an annual basis, to ensure that the overall approach they have designed is working in terms of generic outcomes, our monitoring activities will be geared to the levels of risk and performance will be reported to the Directorate Leadership Team.

21. The work runs alongside the development of quality standards in partnership with service providers. Our underpinning value is that relationships are based on trust and that regulation and checking is the last line of defence.

Sara Livadeas
Deputy Director, Joint Commissioning

Stephen McHale
Lead Commissioner, Quality, Contracts & Procurement

13th November 2012

Annex 1. Current Contract Monitoring – Care Homes for Older People

- CQC Report
- Financial Payments Information
- Traffic Lights
- Last 3 Care reviews
- S&CS Locality Team
- Safeguarding Monthly Risk Report
- S&CS Complaints Team
- S&CS Learning Disability Team
- LINk
- Fire & Rescue
- GP
- Continuing Care
- CHUMS
- Tissue Viability
- Oxford Health (including Safeguarding)

- Staffing levels & Recruitment
- Staff Supervision
- Staff training
- Resident care
- Safeguarding
- Management & Finances
- Medicine's Management
- Discussions with
  - Residents
  - Staff

- Production of Monitoring Report
- Action Planning
- Provider Response

- Revisit by Contracts Staff