Leicester
City Council

Minutes of the Meeting of the
ADULT SOCIAL CARE SCRUTINY COMMISSION

Held: THURSDAY, 9 JANUARY 2014 at 5.30 pm

P R E S E N T :

Councillor Dr Moore – Chair
Councillor Chaplin – Vice Chair

Councillor Alfonso
Councillor Fonseca
Councillor Joshi
Councillor Willmott

In Attendance

Councillor Rita Patel – Assistant City Mayor (Adult Social Care)

* * * * * * * *

76. APOLOGIES FOR ABSENCE

There were no apologies for absence.

77. DECLARATIONS OF INTEREST

Councillor Chaplin declared an Other Disclosable Interest in agenda item 6, "Elderly Persons' Homes", in that she had attended a birthday party for three residents at Herrick Lodge on 3 January 2014 in a private capacity.

Councillor Joshi declared an Other Disclosable Interest in the general business of the meeting in that his wife worked for the City Council's Reablement service. He also declared an Other Disclosable Interest in the general business of the meeting in that he worked in the voluntary sector with people with mental health problems.

As a standing invitee to Commission meetings Philip Parkinson, Interim Chair of Healthwatch Leicester, declared an Other Disclosable Interest in the general business of the meeting in that his mother-in-law was in receipt of services from the City Council's Adult Social Care and Safeguarding division.

Although not a member of the Commission, Councillor Rita Patel declared an Other Disclosable Interest in the general business of the meeting in that her sister worked for the City Council's Adult Social Care and Safeguarding

division. She also declared an Other Disclosable Interest in the general business of the meeting in that in the last few weeks her mother had started to receive a package of services from the City Council's Adult Social Care and Safeguarding division.

In accordance with the Council's Code of Conduct, these interests were not considered so significant that they were likely to prejudice the respective people's judgement of the public interest. They were not, therefore, required to withdraw from the meeting.

78. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 5 December 2013 be approved as a correct record.

79. PETITIONS

The Monitoring Officer reported that no petitions had been received.

80. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Five questions were submitted by Mrs Chandarana, as follows:-

"Re: Social Services responsibilities under the Community Care (Delayed Discharges Etc.) Act 2003 (LAC (2003)21 Circular)

1. Can the Assistant Mayor for Adult Social Care (ASC), the Director of Adult Social Services (DASS) or the Relevant Officer confirm that?

   The Council has a responsibility to work with the UHL NHS Trust to identify the causes of delayed transfers of care within the City and assess the appropriate intervention and investment needed to tackle them.

Re: DTOC - Awaiting Residential Home Placement or Availability in Leicester UA (DOH data)

2. Can the Assistant Mayor for ASC, the DASS or the Relevant Officer confirm that?

   Leicester UA has had the biggest increase in the number of bed days lost due to delayed transfers of care attributed to patients Awaiting a Residential Home placement or availability per month from April 2011 to August 2013 compared to every one of its closest fifteen comparator councils - CIPFA's nearest neighbour comparators (Per 100,000 Population).

3. Can the Assistant Mayor for ASC, the DASS or the Relevant Officer confirm that?

Leicester UA had the highest number of bed days lost due to delayed transfers of care per month attributed to patients Awaiting a Residential Home placement or availability in both July 2013 and August 2013 compared to every one of its closest fifteen comparator councils (Per 100,000 Population).

4. Can the Assistant Mayor for ASC, the DASS or the Relevant Officer confirm that?
   In August 2013 a total of 249 bed days were lost due to delayed transfers of care attributed to patients Awaiting a Residential Home placement or availability, this reason accounted for 18% (the second largest proportion) of all bed days lost. Hence nearly 1 in 5 of all bed days lost due to delayed transfers of care in Leicester attributed to patients Awaiting a Residential Home placement or availability.

<u>Re: Statutory Guidance – 'Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services'</u>

5. Can the Assistant Mayor for ASC, the DASS or the Relevant Officer confirm that?
   The Assistant City Mayor for Adult Social Care is accountable and hence, responsible for *preventing unnecessary use of healthcare resources*.*"*

It was noted that, as neither Mrs Chandarana or her representative were able to be at the meeting to present the questions, Mrs Chandarana asked that they be withdrawn. However, the Chair stated that, due to the level of interest in the matters raised through the questions, she would like the response to be given at this meeting. This would then be sent to Mrs Chandarana in writing and she would be able to ask further questions at a future meeting if she wished.

The Director of Adult Social Care and Safeguarding then gave the following response:-

"I shall respond to questions 1 and 5 first.

I confirm that the Council, through the Director, has a clear responsibility to work with University Hospitals Leicester (UHL) NHS trust, to identify the causes of delayed transfers. However delayed transfer of care responsibilities are not confined to acute (UHL) hospital settings and therefore we also work with our other NHS trust, the Leicestershire Partnership Trust (LPT), notably in relation to transfers from inpatient mental health facilities. LPT is classed as a non-acute hospital setting for the purposes of delayed transfers.

The Council is also required to ensure clear political accountability for the effectiveness, availability and value of social care services, with the aim of preventing the unnecessary use of healthcare resources. In Leicester this is provided through the role of Assistant Mayor for Adult Social Care. However accountability is different to responsibility for action, which rests

primarily with Council officers.

I also confirm that there are robust mechanisms in place to ensure that issues relating to delayed transfers of care are actively addressed. Specifically there is the multi-agency discharge group, which is identifying blocks and solutions to discharge delays. There is also a strategic weekly meeting of chief officers to look at acute care issues, including delays, attended by the Director for Adult Social Care. Examples of the impact of partnership working include:

- Equipment, for use within the community, can now be accessed on the same day, 7 days per week
- Engagement with care home managers and their representative bodies to improve the timeliness of care provider assessments
- Package of care delays are reducing due to the bridging of services through the Integrated Crisis Response Service.
- The actions put in place over Christmas - telephone support in addition to normal referrals has expedited decisions and earlier discharge
- Social Care teams have supported the 'super weekends' to test 7 day working
- Social Care has actively engaged in the escalation and capacity planning process, which includes supporting flow through the emergency pathway.

As the joint Health and Wellbeing and Adult Social Care scrutiny meeting heard during its recent review, social care is actively engaged in the winter planning process to support resilience through the peak Christmas and New Year periods. Our engagement is described by partners as positive and constructive.

I will now respond to questions 2, 3 and 4.

The short answer is that all 3 statements can be confirmed as technically correct. However, these headline statements do not convey the complexity of the delayed transfer data, which, if further explored, gives a much clearer picture of the local situation regarding delays attributable to patients awaiting a residential home placement. I do need to provide a level of detail in my answer, in order to assist the questioner (Mrs Chandarana) and the Scrutiny Commission to understand the actual issues that lie behind the high level performance, to avoid misleading assumptions being drawn.

The questions have been produced using nationally published data from NHS England. The statistics presented in the questions do not distinguish between delays attributable to social care, delays attributable to the NHS or to both organisations – it reflects all delays. Therefore some of what is

presented is outside of the Council's responsibility, for example delays relating to people who are eligible for 100% continuing healthcare arranged by the NHS.

The statements also present delayed transfers of care from all settings, including from non-acute settings. Although the questioner has drawn a focus on delays from UHL acute settings, through the first question, it is important to note that delays from LPT are the more significant feature of the statistics. This is particularly relevant when looking at the reasons for any delays related to 'awaiting residential home placement or availability'.

Specifically regarding question 2, it is the case that Leicester had the highest increase in beds days lost for this reason compared to the 15 other CIPFA comparators, if calculated over the full period, although the monthly variation is considerable. I would confirm that this is largely due to a significant increase in bed days lost during 2013 /14.

During 11/12, Leicester had the 3rd highest number of delays for this reason; during 12/13 Leicester was ranked only 11th highest of 16.

The significant majority of lost bed days relate to delays within non-acute care settings and primarily from adult mental health wards. For the period April to November 2013, of those residential care-related delays attributable to social care, only 12 of 1,103 lost bed days related to UHL acute discharges. This is just 1%.

Of that 1%, they were attributable to process delays. It is usual for the care home to visit the patient to make their own assessment of the home's ability to meet needs, given Care Quality Commission expectations that a home must be satisfied that it can do so before admission. Some providers have small staff teams and delays occur in waiting for the manager, or a senior carer, to be available to complete this assessment visit on the ward. The other reason for delay occurs whilst families select a preferred home from those available to them. Statistically, delays from acute hospitals are not attributable to there being a lack of available placements.

Given this local picture of delays from non-acute, adult mental health settings, we have worked closely with LPT to understand the barriers. It is the case that these lost days relate to a small number of complex individuals, who have lengthy delays due to the specialist nature of the placements they require. Adult Social Care is engaged in the discharge arrangements for these individuals, so we know that this includes people with chronic, challenging mental health needs, which can be combined with forensic (criminal) issues such as convictions for arson, physical or sexual assault.

It is therefore the case that, once a residential placement is assessed as needed and the 'delayed data clock' starts ticking, it can take some time to identify a suitable placement. This requires careful clinical judgements on the safety of any given setting, the potential provider's thorough

assessment of suitability, taking into account their other residents (for example it may not be possible to place in a setting with female or older residents) and the development of risk plans to facilitate a placement. It is the case that some placements are not readily available in Leicester, being so specialist. In terms of the increase during 13/14, we know that observations about adequacy of discharge arrangements, from the coroner and other inspections, have meant that there is a heightened level of caution by all professionals in ensuring that things are right before a placement is agreed or made.

With regards to question 3, I would note that Leicester did have the highest number of bed days lost for this reason during July 2013 and August 2013 but did not have during April June, October or November of that year.

With regards to question 4, this also draws on a specific month of data, August 2013. The monthly variation in the percentage of delays for this particular reason is between 8% and 20%. The average percentage for April to November 2013 is 14%. As previously noted, these relate almost entirely to non-acute delays.

Given the causes behind the delays being discussed tonight, I can confirm that a number of actions have been taken with the support of the Assistant Mayor. This includes the creation of a new Health and Social Care Co-ordinator post for adult mental health wards, to assist with discharge planning; it also includes a continued focus on developing services which prevent admission to mental health wards, such as crisis teams, and services which promote accommodation options on discharge, such as supported living for adults with mental health needs. We continue to work closely with all partners on all aspects of the discharge agenda.

In summary, I would confirm that delays relating to residential care availability occur very rarely for people awaiting discharge from UHL, and the issue lies with discharges for people with mental health needs in LPT beds. I would also confirm that, whilst correct, the statements in questions 3 and 4 are based on selectively drawn data, which does not give the full picture of local issues.

I apologise for the length of this response; whist the questions have asked for simple confirmation, it would be misleading to the Commission to not provide the detail that lies behind the data, so that a fuller understanding of the nature of the issues being presented can be taken."

RESOLVED:

That the Director of Adult Social Care and Safeguarding be asked to send this response to the questioner, (Mrs Chandarana), in writing.

81. ELDERLY PERSONS' HOMES

a) Relocation of Residents

The Director for Care Services and Commissioning (Adult Social Care) presented an update on progress with the relocation of residents currently in Council elderly persons' homes that were scheduled for closure. It was noted that, since the decision to relocate the residents had been taken, one resident had died. All other residents were now on Stage 3 of the process, which was the stage at which social workers made their assessments of residents.

In reply to questions from Members, the Director for Care Services and Commissioning (Adult Social Care) advised the Commission that at stage 2 residents were invited to identify what was important to them in their new homes. This could include things such as friendship groups or preferred areas. After an assessment had been made, discussions were started on what accommodation was available for individual residents based on their stated interests and preferences.

In preparing moving plans, some residents wanted to represent themselves, but if they had relatives, efforts were made to get the relatives involved as well. The course of action to be taken when residents had no-one to represent them would depend on whether the individuals had capacity to make a decision about moving, as stated in the Mental Capacity Act.

People without capacity or anyone to represent them had to be referred to the Independent Mental Capacity Advocacy Service, as required under the legislation. People without capacity could however be represented by relatives or friends acting in their best interests. In addition, there were occasions when people who had capacity wanted some extra support. In these cases, the Council could refer people to mainstream and culturally appropriate advocacy services.

The Head of Care Services (Care Provision Residential) explained that steps had been taken to sensitively prepare and plan. For example, the process had paused to enable residents to enjoy Christmas. Overall, people were engaging well, which was reflected in the fact that the residents were now at Stage 3 of the process.

It was noted that some residents previously had indicated a wish to move early. The Head of Care Services (Care Provision Residential) reported that, now the process was underway, residents no longer appeared to be concerned about doing this. At present, there was no indication that any residents were reluctant or hesitant about moving, but it was recognised that situations could change and the Council would respond to such changes as they arose.

The Adult Social Care Business Transition Manager confirmed that officers met with service providers fortnightly. No general negativity about the moving process had been observed during these meetings. Dedicated teams were based in the homes, so residents and staff knew them, which helped provide

reassurance.

In response to further questions, the Adult Social Care Business Transition Manager confirmed that suggestions for suitable accommodation for people to move to were based on needs assessments. The Council's over-riding duty of care meant that these needs had to be met, but efforts also were made to meet the preferences stated by residents.

If a resident was unable to visit new homes to make their choice, officers could visit, feed back the results and discuss with the resident concerned how they would like to progress, (for example, social workers or relatives could also visit the home). The Council met the cost of visits to view new homes and no limit was put on the number of visits that could be made, as it was important that residents felt confident about moving. The presenting of possible choices to inform the moving plan was done at Stage 4 of the process.

When residents moved, they would keep the same social worker for up to 6 months after the move, to make sure they were settling in to their new accommodation well. Residents were given the assurance that, if the new accommodation turned out to be unsuitable, consideration could be given to moving the resident again.

Members asked if consideration could be given to merging Stages 4 to 6 of the process. The Adult Social Care Business Transition Manager explained that this would not be feasible, as this was a detailed process that needed to be worked through incrementally. Having separate steps helped people gradually get used to the idea of moving and residents had been assured that officers would work at a measured pace.

RESOLVED:

1) That the update on progress with the relocation of residents currently in Council elderly persons' homes that were scheduled for closure be received and noted; and

2) That the Director for Care Services and Commissioning (Adult Social Care) be asked to include a breakdown of the components of Stage 4 when the next update on the relocation of residents currently in the Council elderly persons' homes referred to under 1 above is presented to the Commission.

b) <u>Creation of Intermediate Care Facility</u>

RESOLVED:

1) That an options paper on the creation of an Intermediate Care Facility be brought to this Commission when prepared; and

2) That an appropriate officer from Property Services be asked to attend the meeting of the Commission at which the options paper referred to above is considered to provide advice.

c) Establishment of Elderly Persons' Commission

In response to a question, Councillor Rita Patel, Assistant Mayor (Adult Social Care), confirmed that it was hoped that a framework for a new Elderly Persons' Commission could be considered by the Executive shortly. The framework would be reported to the Commission as soon as possible.

82. MOBILE MEALS SERVICE

The Director for Care Services and Commissioning (Adult Social Care) reminded the Commission that clarification had been requested on various issues relating to the mobile meals service at the Commission's last meeting, (minute 71, "Proposal for the Future of Mobile Meals Provision", 5 December 2013 referred).

The Director reminded the Commission that a specific question had not been asked in the consultation on reconfiguring the service about whether service users wanted it to continue as at present, as a proposal for changing the service was being sought. Such a question therefore would not have been appropriate.

The number of users of this service was falling, so it would not be financially viable for it to continue in its current form. The consultation therefore asked people what type of service they would like in the future. Responses received had indicated that people still wanted to receive a hot meal and therefore Option 4 has been proposed, which included a framework contract for the provision of a meal delivery service, managed by the Council.

Councillor Rita Patel, Assistant Mayor (Adult Social Care), addressed the Commission at the invitation of the Chair. She explained that the consultation recognised that people wanted the security they felt with the current system to continue. She also explained that Option 4 would ensure that people could still have a meal delivery service via a framework contract managed by the Council. This also would address various concerns that had been raised about the service, such as the nutritional value of meals, the quality of the food and difficulties found in complaining about the service.

There also were elements of the current service that led to unnecessary stages in the delivery process. For example, the East West Community Project prepared some meals in its kitchen, which were then delivered to the Council and the Council delivered them to the customers. Another example was that meals bought from a company were reheated in a Council kitchen by Council staff and then delivered by the Council.

Under a framework contract, the Council would still have responsibility for elements such as the nutritional quality of the meals, but would no longer reheat the meals provided by other suppliers. Alternatively, people could buy their own meals and heat them up themselves.

In summary, Councillor Patel stressed that the Council was committed to ensuring that people could still have access to a mobile meals service via a framework contract. Service users would be assessed and meals provided where needed. In particular, it was recognised that, for some users, this was their only social contact, so more suitable befriending services would be put into place to ensure people were not left lonely and isolated.

Members drew Councillor Patel's attention to the resolution made at the last meeting of the Commission that the Executive be asked to reconsider the way forward for this service and asked what progress there had been on this. Councillor Patel assured the Commission that she had looked at this following her return from her absence due to ill health. However, the current service was more expensive to operate than the alternatives considered under the review, as user numbers were reducing. As this was a time of financial constraint, it was suggested that expenditure on this service for people who did not need statutory social services could be reduced.

The Commission expressed concern that only those in need of statutory social services should receive meals under the revised service, as the mobile meals service could enhance the quality of life for many people across the city.

In reply, Councillor Patel explained that 500 new users, each having 4 meals per week, at a cost of £5.70 per meal, would be needed in order to continue a viable service in its current form. The Council was having to make very significant financial savings and so had to consider how services could be sustained for those most in need. The Council would prefer not to have to limit a future service to those in receipt of statutory social services, but the proposals made were a way forward that would support people and give them reassurance about the quality of the meals provided.

The Commission queried whether the service needed to continue to be funded from the Adult Social Care budget and whether other options could be considered. For example, the Council could consider whether the service could be provided at a reasonable rate through a separate (competitive) business. Some ready-meals were not very appetising or nutritious, so the Council could monitor these aspects if it prepared the meals itself.

The Commission also questioned why such an increase in the number of users was needed, as an example of how meal standards could be improved could be seen in the Council's school dinner service.

83. REVIEW OF ALTERNATIVE CARE FOR ELDERLY PEOPLE

The Chair submitted the draft report of the review of Alternative Care for Elderly People, thanking officers for their work in preparing the report and Commission members for their input to the review. Members were reminded that Liz Kendall MP also had attended one of the review meetings and provided useful input.

The Chair reported that she had been contacted by a Councillor from Liverpool,

who was very interested in the Shared Lives initiative. He had asked to meet the Commission and the Assistant Mayor (Adult Social Care) as part of his work to develop a similar initiative.

The following comments were then made in discussion on the report:-

- The local Asian radio network, (such as Sabras radio), also could be used to promote the Shared Lives scheme, (recommendation 1.2.2 referred), as this could be used to explain the scheme in some people's first language;

- A proper communication plan should be prepared; and

- It would be helpful if people could be asked to provide case studies as soon as possible, (for example, explaining how they had benefited from the scheme).

Councillor Rita Patel, Assistant Mayor (Adult Social Care), thanked the Commission for the very helpful interest it had taken in this scheme. It was already operating and officers were looking at how it could be expanded.

RESOLVED:

1) That the Overview Select Committee be asked to endorse the report of the review of alternative care for Elderly People before it is submitted to the Executive for adoption; and

2) That all involved in the preparation of this report be thanked for their work.

84. DEMENTIA CARE FOR ELDERLY PEOPLE

The Commission was invited to consider how a review of Dementia Care for Elderly People could be conducted and where this review should be included in the Commission's work programme. Members were reminded that information relevant to this had been considered at the Commission's last meeting, (minute 67, "Mental Health Care", 5 December 2013 referred).

The following comments were made during discussion on this item:-

- Due to the large amount of information already available on this subject, the Commission needed to be very clear about which issues it wished to address;

- Some issues, such as accessing existing services, could be complex to review, as the problems experienced by people with dementia could inhibit their ability to access them. In addition, it was an emotional and stressful time for their families and friends, which could limit their ability to assist;

- Members welcomed the clear identification in the "Leicester, Leicestershire and Rutland Joint Dementia Commissioning Strategy 2011-2014" of which agency would lead in each area;

- Research already had been undertaken with people who had not developed dementia, to identify if there were any key factors in why they had not developed it. The National Institute for Health and Care Excellence had developed standards in relation to these and they were taken in to account in the strategies developed to date;

- The Commission needed information on whether the recommendations arising from the previous review of the mental health of working age adults by the Health and Wellbeing Scrutiny Commission had been implemented and, if they had not, the reasons why;

- Consideration could be given to whether members of the Health and Wellbeing Scrutiny Commission should be invited to participate in the review;

- Support for carers of people with dementia, especially those with early-onset dementia, could be included in the review. This could include the role and effectiveness of respite care;

- The scoping document should include reference to the impact on dementia care for the elderly of budget decisions already taken and those to be taken in the future; and

- Information was needed on whether the recommendation contained in the "Joint Specific Needs Assessment: Dementia in Leicester" that commissioners should find ways of obtaining more effective coding of the attendance of patients with dementia at the emergency department had been implemented.

RESOLVED:

1) That the Assistant Mayor (Adult Social Care) be asked to arrange for a presentation to be made to the next meeting of the Commission on current dementia care, to include information on the following:-

   a) National Institute for Health and Care Excellence standards relating to mental health;

   b) The extent of the implementation of the recommendations arising from the previous review of the mental health of working age adults by the Health and Wellbeing Scrutiny Commission; and

   c) The extent of the implementation of the recommendation contained in the "Joint Specific Needs Assessment: Dementia in Leicester" that commissioners should find ways of obtaining more effective coding of the attendance of patients with dementia at the emergency department;

2) That members of the Health and Wellbeing Scrutiny Commission be invited to participate in this review;

3) That the Scrutiny Support Office be asked to invite the Carers Federation to participate in this review; and

4) That, following consideration of the presentation requested under resolution 1 above, the Commission agree the way forward for the review of dementia care for elderly people.

The meeting adjourned at 7.05 pm and reconvened at 7.13 pm

85. DOMICILIARY CARE

The Director for Care Services and Commissioning (Adult Social Care) submitted a report providing further information as part of the Domiciliary Care Scrutiny Review. This also addressed questions raised at the Commission's meeting held on 5 December 2013, (minute 69 referred).

Members were reminded that the Council's Communications team would be asked to make an appeal for users of domiciliary care to provide information on their experiences of that care, both positive and negative. In addition, arrangements were being made to enable the Chair to accompany a care worker for a day, to get a better understanding of their work. Appropriate arrangements would be made to ensure that confidentiality and privacy were maintained at all times.

In response to a question from the Commission, the Director of Adult Social Care and Safeguarding explained that, under direct payments, people received a personal budget as a cash payment. The recipient then became responsible for meeting the costs of the services they received.

In reply to further questions from the Commission, the Commissioning Manager (Care Services and Commissioning Division) explained that, during the last week, approximately 22,000 hours of care were provided. The standard of this care was carefully monitored. For example, providers' self-assessments were used and some providers came under the Care Quality Commission. Officers carefully analysed the data and graded providers on their standard of care. For example, an assessment is made of whether the minimum level of care was being provided, or whether there was a higher level of provision.

The contracts had been operating for two months. Their operation had been relatively stable, even during a period of high pressure regarding hospital stays over the Christmas period. However, starting on 27 January 2014, a consultation would be undertaken with users of Home Care. This would be done via the telephone.

It was recognised that people recently had been consulted on various services, (for example, mobile meals and elderly persons' homes), so it was possible that this could result in some "consultation fatigue", but there were no

proposals to change the method of consultation at this stage. The consultation would be undertaken through the Contracts and Assurance team. A stratified sample would be used, but the actual number of people to be consulted was not known at this time.

The Commission welcomed the consultation, but queried whether allowance had been made for the reasoning abilities of some service users. In addition, as the Council was not the service provider, it needed to be made very clear that information provided would be confidential and that individual users would not be identified in the data compiled. The Commissioning Manager assured Members that these factors had been taken in to account in preparing for the consultation. For example, support packages would be checked before anyone was telephoned to make sure they were capable of taking part in the consultation and that, where possible, they could be consulted in their first language.

Members noted that some service users had more than one provider through choice. These people would move to a single provider as soon as possible. Information on the number of people affected by this could be provided, although the reasons for each individual choosing more than one provider would not be available.

The following points were then made during discussion on this item:-

- At some authorities, trades unions had negotiated an agreement that zero contract hours contracts would not be allowed. This included external providers;

- The move away from 15 minute calls was very welcome;

- Currently, the only in-house care service was the Re-ablement service and that team did not use 15 minute calls;

- Consideration needed to be given to whether there should be a sole provider at Danbury Gardens, as there were concerns that to have this would limit choice; and

- In the ASRA scheme the care provider had started a company and so promoted the use of that company to residents in the scheme. This was in direct contrast to the situation at Danbury Gardens and there was concern that it could create problems when people who already had identified their own providers moved in to that facility.

Particular concern was expressed about the number of people employed by care providers. It was recognised that care workers tended to be a transient work force, but the Commission was assured that the contracts being operated were not block contracts. Each new care package was offered through a mini tendering exercise, so each package would state the minimum number of staff required for that particular element. The Care Quality Commission did not set minimum numbers of staff required.

At the pre-qualification stage of letting the contracts a full financial assessment was undertaken. This provided reassurance that provider would only take on the number of care packages they could provide. Although it was very unlikely to disrupt care if a large number of staff left a particular provider, there was provision in the contract about the action that would be taken if a large number left or were ill simultaneously. There also was provision in the contract for the Council to suspend a provider from the framework or terminate a package of care, but in practice this would be very unlikely to happen, as contract monitoring would enable action to be taken before it reached this stage.

RESOLVED:

1) That the Director for Care Services and Commissioning (Adult Social Care) be asked to provide information at the next meeting of the Commission on the number of people to be surveyed during the consultation of users of Home Care services, the questions they would be asked, the expected length of time of each interview and whether the same person would do all of the interviews;

2) That the Director of Adult Social Care and Safeguarding be asked to provide information at the next meeting of the Commission on the following matters:-

   a) the number of people who currently use more than one service provider; and

   b) whether the use of zero hours contracts was permitted; and

3) That consideration be given to reviewing the different methods of providing care at Danbury Gardens and the ASRA housing scheme.

86. WORK PROGRAMME

The Commission noted that:-

- Budget reports would not be considered by Scrutiny Commissions this year, as the budget had been approved for three years and exceptions were reported as they occurred;

- A special meeting was likely to be held to receive the presentation on dementia care for elderly people requested under minute 84, “Dementia Care for Elderly People”, above; and

- Information on the establishment of an Intermediate Care facility currently was being compiled, but was unlikely to be available for the Commission’s next meeting. However, an update on the development could be provided if wished.

87. CLOSE OF MEETING

The meeting closed at 7.55 pm