Leicester
City Council

MEETING OF THE ADULT SOCIAL CARE SCRUTINY COMMISSION

DATE: THURSDAY, 9 JANUARY 2014
TIME: 5:30 pm
PLACE: THE OAK ROOM - GROUND FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Committee

Councillor Dr Moore (Chair)
Councillor Chaplin (Vice-Chair)

Councillors Alfonso, Fonseca, Joshi, Wann and Willmott

Standing Invitee (Non-voting)

Chair of Healthwatch Leicester

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Elaine Baker

for the Monitoring Officer

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PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed.

3. MINUTES OF PREVIOUS MEETING **Appendix A**

The minutes of the meeting of the Adult Social Care Commission held on 5 December 2013 are attached and the Commission is to confirm them as a correct record.

4. PETITIONS

The Monitoring Officer to report on any petitions received.

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer to report on any questions, representations or statements of case received.

Questions received after despatch of the agenda are attached.

6. ELDERLY PERSONS' HOMES **Appendix B**

The Director of Care Services and Commissioning will give an update on progress with:-

a) The relocation of residents currently in Council Elderly Persons' Homes to be closed in Phase I (**Appendix B1**); and

b) The creation of a new Intermediate Care Facility (**Appendix B2**).

7. MOBILE MEALS SERVICE

The Assistant Mayor (Adult Social Care) will provide an update on progress with the current review of the Council's Mobile Meals Service.

8. REVIEW OF ALTERNATIVE CARE FOR ELDERLY PEOPLE **Appendix C**

The Chair submits the draft report of the review of Alternative Care for Elderly

People. The Commission is recommended to adopt the report and the recommendations contained within it.

9. DEMENTIA CARE FOR ELDERLY PEOPLE

As agreed at its last meeting, the Commission is invited to consider how a review of Dementia Care for Elderly People should be conducted and where this review should be included in the Commission's work programme. (See minute 67, "Mental Health Care", 5 December 2013.)

10. DOMICILIARY CARE **Appendix D**

The Director for Care Services and Commissioning (Adult Social Care) submits a report providing further information to Members as part of the Domiciliary Care Scrutiny Review, and in response to the questions noted in the Scrutiny meeting of 5 December 2013, (minute 69 refers). The Commission is recommended to receive this information and comment as appropriate.

11. WORK PROGRAMME **Appendix E**

The current work programme for the Commission is attached. The Commission is asked to consider this and make comments and/or amendments as it considers necessary.

12. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
ADULT SOCIAL CARE SCRUTINY COMMISSION

Held: THURSDAY, 5 DECEMBER 2013 at 5.30 pm

P R E S E N T :

Councillor Dr Moore – Chair
Councillor Chaplin – Vice Chair

Councillor Alfonso
Councillor Fonseca
Councillor Willmott

In Attendance

Councillor Kitterick
Councillor Senior

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62. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Joshi and from Philip Parkinson, (Chair of Health Watch Leicester).

63. DECLARATIONS OF INTEREST

Councillor Fonseca declared an Other Disclosable Interest in the general business of the meeting, in that his son worked for a charity involved in adult social care.

Councillor Willmott declared an Other Disclosable Interest in the general business of the meeting, in that a relative used adult social services.

Councillor Dr Moore declared an Other Disclosable Interest in agenda item 6, “Mental Health Care”, as she had close family members who had used mental health services.

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

64. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting of the Adult Social Care Scrutiny commission held on 7 November 2013 be approved as a correct record.

65. PETITIONS

The Monitoring Officer reported that no petitions had been received.

66. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations or statements of case had been received.

67. MENTAL HEALTH CARE

The Commission noted that Councillor Cooke, Chair of the Health and Wellbeing Scrutiny Commission, had been invited to the meeting to present an overview of that Commission's review of the mental health services for working age adults in Leicester, but was unable to attend the meeting.

Councillor Dr Moore reminded Members of the interest she had declared in this item.

The Commission suggested that it would be useful to establish timescales for the commissioning priorities identified in the report in to timescales, so that an indication could be obtained of what would be done and how. This could be assisted by making the recommendations more precise, so that achievements could be evaluated with greater accuracy.

Members were reminded that, since the review report had been produced, the Health and Wellbeing Scrutiny Commission had undertaken a review of the Bradgate Unit, which currently provided mental health services. It therefore was suggested that the Adult Social Care Scrutiny Commission could review dementia services. This could focus on older vulnerable people, in order to not repeat the work done by the Health and Wellbeing Scrutiny Commission.

RESOLVED:

That it be agreed at the next meeting of this Commission how the review of services for people with dementia will be reviewed and where this review should be included in the Commission's work programme.

68. REPRESENTATIONS ON THE HOUSING SUPPORT SERVICES CONSULTATION

a) Representations

At the invitation of the Chair, the Commission received representations from the following people on proposed changes to housing related support services and how people would be affected if those changes happened.

i) Alistair Jackson – Chief Executive of Leicester Quaker Housing Association

Alistair Jackson introduced himself to the Commission, explaining that Leicester Quaker Housing Association offered approximately 70 units of sheltered housing, plus a care home and day centre specialising in dementia care. Residents at John Woolman House were able to live independently in sheltered housing. Without the support services provided, many of these people would have to live in more expensive accommodation and some would be living on the streets.

It was understood that the Council had to make cuts in its services and so was considering how it needed to change the services it provided. Under the current proposal, the Leicester Quaker Housing Association would no longer manage the services offered. Instead, the Council would operate a centrally managed service, which would be phoned when a need arose and an officer would attend.

Tenants unanimously wanted to keep the current service and management system, as tenants knew the sheltered housing officers, and the housing officers had full knowledge of the tenants. The officers worked 8 hours a day and Saturday mornings, so were available when needed by the tenants. Under the new model, officers would only be present for a few hours in the week, at pre-set days and times. This would reduce the flexibility that the current service had to respond to tenants' needs and could result in crisis situations not being dealt with as effectively as they could be at present.

Alistair Jackson gave examples of the sort of work currently done with tenants. These showed the ability of officers to work with people to enquire beyond immediate problems to identify reasons for those problems that were not immediately obvious. They also were able to work closely with tenants to manage behaviour that otherwise could jeopardise their tenancy.

Leicester Quaker Housing Association was happy to continue to provide its current services and the tenants wanted the Association to do this. This would give the Council the savings it needed, while giving the tenants a good quality of life. It also would keep them out of hostels and off the streets, so the Council would not have to increase the budgets for work in those areas.

In reply to questions from the Commission, Alistair Jackson confirmed that, if there were funding cuts, the Association would need to be more focussed

about how it defined tenants' vulnerabilities and how these were dealt with. It also would review its business model, in order to keep staff and find other ways of funding its work.

The Commission expressed concern that:-

- If the service was centralised, the required savings would not be achieved if the same service was not provided for all of its sheltered accommodation;

- A way of protecting the most vulnerable people affected by these proposed changes needed to be found; and

- If these services were not protected now, it could be difficult to return to providing them in the future, so the Council had to plan for that eventuality.

ii) Derek Seaton – Tenant at Vernon House

Derek Seaton introduced himself, explaining that Vernon House was a sheltered housing unit with 22 flats and that he spoke for all the tenants there.

He stressed that elderly people chose to live in sheltered housing so that they could live independently, but with support. The concept of sheltered housing had been readily accepted by the Council, but the Council was now threatening its provision at a time when there was an increasing elderly population.

Derek Seaton then made the following points:-

- The scheme manager currently worked Monday – Friday and when they were not present support was provided through a 24-hour emergency service. The changes proposed by the Council could lead to a reduction in the hours of the scheme manager. At the same time, tenants would be assessed and then buy the level of support they needed. This could lead to increased anxiety for the tenants;

- Vernon House currently had a programme of social events that was very important to tenants;

- One reason why people chose to live at Vernon House was that there was a manager there. The manager could help with a wide variety of things, including more personal tasks such as filling in forms;

- There was concern that security at the flats could be compromised by individual support workers coming and going at different times. It also could be difficult to verify who people visiting the flats were; and

- It was proposed to withdraw funding for the alarm system, but this was a vital lifeline in an emergency, especially for tenants who were unwell or living alone. It cost approximately 45 pence per day and was one of the

most cost-effective and important service provided by the Council. It was recognised that tenants could buy their own services, but if they chose not to do so, situations could arise where no-one was aware of an emergency.

In summary, Derek Seaton explained that sheltered housing accommodation was very worthwhile for the tenants and the general public, with local residents in the area of Vernon House also being very concerned about the proposed changes to services. The independence, security, social life and degree of dignity currently experienced by the tenants could change, which could result in those tenants becoming vulnerable, depressed and anxious. As a result, they could need to move to residential accommodation, where they would need other Council services, so the proposed changes would be counter-productive.

iii) Ruth Raiser – Resident of John Woolman House

Ruth Raiser explained that:-

- She had chosen to live in John Woolman House on the basis of the staff and services available and its security;

- The services provided by the staff were varied and responded to needs as they arose. For example, if a resident's medications were not delivered, the staff were able to resolve this situation very quickly. Under the proposed arrangements this was not likely to be the case; and

- The idea that the new proposals were about individual choice was challenged. Individuals made their choice when they moved in to their accommodation and that choice was based on many factors.

The Commission was asked to consider whether the proposals met the needs of elderly people and whether they were cost-effective, as everyone was aware of what the consequences could be if the services were not provided. Sheltered housing let people live their own lives, especially as they became more frail, so should be given increased support.

iv) Councillor Senior – Castle Ward

Councillor Senior introduced herself and explained that she was speaking on behalf of all of the Castle Ward Councillors.

Housing support and the alarm services had many human and financial benefits. People commonly wanted to retain their independence and stay in their own accommodation as long as possible. This was made possible by things such as the alarm system, which was simple and cost-effective. Costs could still be examined, but it was sensible for all tenants in sheltered housing units to have access to the alarm system.

The changes were being suggested as part of the personalisation of services, but it was questionable that it could be called personalisation if they were not

receiving the support they needed. If tenants did not have an alarm in their home, they could be very vulnerable if, for example, they fell or were taken ill. It therefore was sensible for all of the tenants in sheltered accommodation to have an alarm.

It also was sensible to have a team of support officers in the sheltered housing block. This made services accessible and the accommodation safe, as well as helping to create a sense of community.

The Ward Councillors therefore requested that an Equalities Impact Assessment be done for these proposals.

b) <u>General Discussion</u>

The Chair thanked all those making representations for their contributions and assured them that their representations would be considered when the Commission made a formal examination of the proposals.

It was recognised that the reliability and consistency of the services currently provided were important to tenants. They also were personal, as tenants and officers knew each other and it removed the pressure of making decisions from tenants where appropriate. Personal budgets often were devoid of this. There was a risk therefore that just looking at financial savings could mean that things that were not quantifiable would not be taken in to account.

Disappointment was expressed that there were no members of the Executive at the meeting to hear the representations that had been made.

RESOLVED:

That the representations recorded above be noted and considered as part of this Commission's formal review of the proposals for the reshaping of Housing Related Support Services.

69. DOMICILIARY CARE REVIEW

The Commission received the scoping document for the review of Domiciliary Care. It also noted that background information on the domiciliary care tendering process was included in the exempt part of the agenda. Concern was expressed at the large volume of information that had been included, and that there was no index and some of the pages did not appear to contain much, if any, information.

The Commission raised the following comments and questions during discussion of the scoping document:-

- Zero hours contracts should not be being used;

- The aspirations contained in the service specification document were good, but could be hard to implement, as low paid staff could be less motivated towards them;

- Rather than just assess people's very basic needs and provide a level of service that met them, people should be given the service they wanted. For example, they may want to visit a day centre, or go shopping, but if this was beyond their basic needs this level of service would not be provided;

- If a service user was difficult, or refused to accept care, or the care provider felt unable to continue to provide care for someone, the Council would work with the user, and their family if appropriate, to manage such situations. The Council's statutory duty to provide care and support would remain, but carers could not be required to work with an individual in these situations. If this developed to the extent that an agency could not continue to provide a person's care, alternatives could be examined, such as establishing a tailor-made service from the user's personal budget, or linking the user to a personal assistant;

- How was the break-down of time for visits worked out? Information also was needed on what was included as activities and how time was allocated to these, as there currently appeared to be a mismatch between aspirations and outcomes;

- Approximately 6% of users had 15 minute visits allocated to them. However, these could be part of a package that included other visits on the same day of different durations. The Commission requested that the actual number of people receiving 15 minute visits be provided;

- Work was underway to phase out 15 minute visits over the next 12 months, as users' reviews were completed;

- Information was requested on who the providers were;

- A quality assurance framework was built in to the Domiciliary Care framework. This could be made available to the Commission;

- The Commission asked whether any form of "mystery shopping" was done and, if so, how often and what sample size was used. It also requested that information be provided on whether service users were asked for feedback on their care;

- It would be useful for the Commission to hear the experiences of users of domiciliary care and / or their families, in order to get a broad overview of the service;

- Some users could be concerned about spending money. This could cause problems if their families were unaware of the user's resources, or the user had no family with which to liaise; and

- Home carers could support users' very specific needs and could identify issues that prevented adequate care being given, (for example, if there was

inadequate hot water in a home). When the things that were important to individual users were understood, it was usually possible to work to accommodate them. Service contracts stipulated that employee training and development work had to be carried out by suppliers to enable carers to work with these situations.

It was noted that the Chair had requested the opportunity to accompany a care worker for a day, to get a better understanding of their work. Confidentiality and privacy would be respected at all times and appropriate arrangements would be made to ensure this.

NOTED:

1) The scoping document for the review of Domiciliary Care;

2) The concerns of the Commission about the way that background information to this item had been presented; and

3) That examples of anonymised care plans could be viewed via the Democratic Support Officer.

RESOLVED:

1) That the Communications Manager be asked to work with the Commission to issue an appeal for users of domiciliary care and / or their families to discuss their experiences of domiciliary care, both good and bad, the appropriate setting for these discussions to be decided;

2) That the Director of Adult Social Care and Safeguarding and the Director of Commissioning and Care Services be asked to provide the Commission with the information requested during discussion on this item, as recorded above; and

3) That the review of Domiciliary Care continue at the Commission's next ordinary meeting.

(See also minute number 74 below)

70. OUTLINE TIMETABLE FOR THE FUTURE OF THE COUNCIL'S ELDERLY PERSONS' HOMES

The Director for Care Services and Commissioning (Adult Social Care) submitted a report setting out an indicative timetable for the actions needed to support existing residents living in the Council's Elderly Persons Homes that were due to be closed.

The Director for Care Services and Commissioning (Adult Social Care) advised the Commission that, once individual assessments had started, an overview would be provided for each resident, so that Members could see how the moves from homes that were closing were progressing.

In response to questions raised during discussion on the report, it was noted that:-

- Officers had identified residents placed in city homes by Leicestershire County Council. Details of these could be made available;

- Some residents had indicated that they would prefer to move as soon as possible, but residents' assessments had not started yet;

- Residents' moving plans would be reviewed as they progressed through the process;

- No detailed discussions had been held yet with family members regarding preparing residents' new accommodation with appropriate equipment and/or furniture prior to their move;

- Work was underway to make sure that governance was in place so that a proposal for intermediate care could be drawn up, but a formal proposal had not been drafted yet;

- Due to the absence of the Assistant Mayor (Adult Social Care) due to ill health, it had not been possible to progress the establishment of an Elderly Persons' Commission; and

- Options for the structure of Intermediate Care provision would be included in a report to the Executive. Enough detail would be included to see the requirements and implications of each alternative. A preferred option would be identified and details provided of how it was anticipated that it would be delivered.

RESOLVED:

That consideration of the options for Intermediate Care provision be included in the Commission's work programme.

71. PROPOSAL FOR THE FUTURE OF MOBILE MEALS PROVISION

The Director for Care Services and Commissioning (Adult Social Care) submitted a report setting out the results of a statutory consultation on a proposal to stop the Council's current mobile meals service and help people to prepare or obtain meals in alternative and more flexible ways.

In response to questions from the Commission, the Director for Care Services and Commissioning (Adult Social Care) advised that the consultation did not explicitly ask people if they did not want to lose the mobile meals service. Instead, it asked how stopping the service would affect them and what the impact of obtaining a meal in an alternative way would be.

The direct question was not asked, as the Council had to move to providing service users with personal budgets and people were choosing other options, so the current service was not financially viable. In order to assess the impact

of the changes, respondents therefore had been asked if they had any views about the fairness of the changes and the ability of a new service to still give help to those who needed it.

The consultation findings showed that people still wanted a hot meal, but there were issues about quality. For this reason, one of the options for the service was to provide a managed service through the Council from a Framework Agreement that included nutritional and quality standards. This would mean that the Council could buy meals where wanted, meaning that recipients would not have to manage the financial aspects of this.

Members stated that it appeared that the consultation had been worded to obtain a preference for this option. This in turn made it appear that the consultation was about meeting a budget savings target, not about providing a service.

Members also asked what would happen to staff if no providers tendered for the contracts and so staff could not be transferred under the Protection of Employment (Transfer of Undertakings) Regulations (TUPE). In reply, it was explained that the possibility of costs increasing and staff being transferred to a new provider were acknowledged as potential risks. Soft market testing had indicated that there were providers who could provide the service required within the budget, so it was felt that the risk could be managed. The full cost of the meals provided, and the subsidy paid by the Council, had been identified in the consultation so that service users were aware of those costs.

The Commission expressed concern that consultees had not been given the option of not changing anything. This meant that the consultation would not achieve a full range of answers and gave the appearance of trying to skew answers in favour of certain outcomes. The Commission also expressed concern that no pilot had been undertaken. Officers confirmed that this consultation had been discussed with the Council's corporate unit dealing with consultations to ensure that the consultation was balanced and fair.

The Commission also was concerned that, from the information presented, the majority response from the consultation was that service users wanted to keep a mobile meals service, but this did not accord with the requirement to reduce costs to the Council. Officers confirmed that service users who needed it would still receive a hot meal under the proposed new arrangements, but there would be more opportunities to co-ordinate the service. In this way, savings would be achieved, but individuals would still receive the service they needed.

The Commission acknowledged that meals would continue to be provided, but was concerned that the quality of the service from an external provider could be lower than that given by the current Council service. The majority of respondents stated that they liked the current service and the way that it was provided, so Members suggested that one option available was to try the suggestion from the trades unions that the service be remarketed and tested for a few years.

The Commission welcomed the inclusion of consideration of winter care pressures in the report submitted.

RESOLVED:

1) That the Executive be recommended to consider the way that consultations are carried out in view of the Commission's concerns about the consultation on the Mobile Meals service recorded above; and

2) That, in view of the preference shown through the consultation for a continuation of the current mobile meals service, the Executive be asked to reconsider the way forward for this service and to adopt option 2, (expand the in-house service).

72. WORK PROGRAMME

Members expressed concern that it had not been possible to progress some of the Commission's work programme in the absence of the Assistant Mayor (Adult Social Care) due to ill health and queried whether her portfolio responsibilities could be managed by another Executive member in her absence.

NOTED:

That a meeting of the Shared Lives review task group will be held on Friday 13 December 2013, which Liz Kendall MP will attend.

RESOLVED:

1) That the Chair of this Commission be asked to liaise with the City Mayor and/or Deputy City Mayor to determine if the portfolio responsibilities of the Assistant Mayor (Adult Social Care) can be managed by another Executive member in her absence;

2) That the Chair and Vice-Chair of this Commission review how the work programme of this Commission can be managed in view of the outcome of the consultations referred to in resolution 1) above; and

3) That consideration of Housing Related Support Services be deferred to February 2014.

73. PRIVATE SESSION

The Commission did not consider it necessary to consider the item below in private. Members of the public therefore were not asked to leave the meeting.

74. DOMICILIARY CARE REVIEW - ADDITIONAL INFORMATION

NOTED:

The background information provided regarding the proposed review of

Domiciliary Care, (see minute number 69 above).

75. CLOSE OF MEETING

The meeting closed at 8.32 pm

Agenda Item 5

Leicester
City Council

SECOND DESPATCH

ADULT SOCIAL CARE SCRUTINY COMMISSION
9 JANUARY 2014

ADDITIONAL INFORMATION

Further to the agenda for the above meeting which has already been circulated, please find attached the following:-

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Mrs J Chandarana submits the questions attached.

Please bring these papers with you to the meeting

Elaine Baker
Democratic Support
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E-mail: elaine.baker@leicester.gov.uk

Questions for the Adult Social Care Scrutiny Commission meeting on 9th January 2014

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.

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

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.*

Appendix B1

Report to the Adult Social Care Scrutiny Commission

Date: 9th January 2014

Elderly Persons Homes Update

Lead Director: Tracie Rees

Useful Information:

- Ward(s) affected: New Parks, Western Park, Latimer, Eyres Monsell
- Author: Tracie Rees
- Author contact details Ext 2301

1. Summary

1.1 This report provides an indicative timetable for the actions needed to support existing residents living in the Council's Elderly Persons Homes that are due to be closed. See Appendix 1.

1.2 Appendix 2 provides an ammonised summary of the progress of individual residents to move to alternative accommodation, where the homes are to be closed in phase I (Herrick Lodge, Elizabeth House and Nuffield House). The provision of this information has been agreed by the Council's Information Governance service.

1.3 The information details progress against the 7 stages in the "My Moving Plan" process.

Appendix 1. Indicative Timetable for the closure of Herrick Lodge, Elizabeth House and Nuffield House **Activity**	**Task Owner**	**Due Date**
Set up dedicated reassessment team to provide specific support to the residents and families affected by change	JH	Complete
Produce information for residents and families on how we will support them through change	AH	Complete
Produce template for registered managers to use to develop a moving plan for each resident and guidance for registered managers and social work staff on how to approach each stage of the moving plan	AH/RR	Complete
Hold staff workshop to enable all staff to fully understand the above	TR/AH/RR/ JH	Complete
Allocate cases to social workers so that officers can start to build relationships with residents and their families	JH	Complete
Identify if there are any residents who have been placed in our homes by the County Council. (We would need to liaise with the County Council about the process)	JH	Complete **1 county resident identified**
Identify residents who have told home managers that they prefer to move as soon as possible.	RR	Complete **None identified a wish to move early**

Develop a practical checklist that managers can use to ensure that all arrangements are in place to make sure that each move runs smoothly.	AH	**Developed in draft awaiting finalisation**
Complete stages 1 and 2 of moving plans Stage 1 is identifying the people each resident wants to be involved in their moving plan. This can include keyworkers in the home who know the resident well. Stage 2 is developing an outline moving plan which is passed to the social worker so that the resident's wishes are fully taken into account as part of the reassessment process.	Home Managers	**31 residents have completed stage 1 and 2.** **3 residents are awaiting involvement from their relatives.**
Develop resident tracking plan for updating progress to Adult Social Care Scrutiny Commission once the process is underway.	RR/JH/AH	**Complete**
Complete stage 3 of all moving plan (reassessments and support plans) (Assessments will be staggered and start at different times, assessments will vary in timescale depending on complexity)	JH	**Assessments have started**
Review of moving plans planning the move day, and completing a moving checklist	Home	January 2014

Following the reassessment residents will review and choose a new home. They can be supported by key workers from the home who know them well, if they wish We will then start to plan with each resident and their families, what needs to happen before and on the day of the move. We will set up a moving checklist so that we can keep a check that everything is on track.	Managers	– the end date will be determined on individual circumstances
Check that resident's new accommodation has been prepared with appropriate equipment /furniture etc. prior to move and everything is in place to make the move successful. (The date people move will be individually determined)	JH	The end date will be determined on individual circumstances
Day of Move: Ensure all actions on checklist have been implemented and safe transport of resident to new accommodation is organised. People can be supported by key workers from the home who know them well, if they wish.	Registered Manager/ Social worker	The end date will be determined on individual circumstances
We will put in place follow up checks in line with the residents' wishes to check how they are settling in. This will include members of staff from the social work team as well as informal networks such as family and friends.	Social worker	Weeks 1-4 after move
Four weeks after each resident has moved there will be a formal review of the resident's needs and this will be recorded. Residents and their families/ representatives are fully involved in this.	Social worker	4 weeks after the move
Six months after each resident has moved there will be a formal review of the resident's needs and this will be recorded. Residents and their families/ representatives are fully involved in this.	Social worker	6 months after the move

Appendix 2

DATE: 16 December 2013

Step 1	Deciding who needs to be involved in your moving plan
Step 2	Meeting to look at what is most important to you in a new home
Step 3	Your social worker carries out a new assessment of your needs
Step 4	Meeting to review your moving plan and agree what will happen next
Step 5	Planning your move
Step 6	The day you move
Step 7	After you move

RESIDENT NO	STATUS	STEP ON MOVING PLAN	NOTES AND TARGET MOVING DATE
1	Resident	**Step 3**	
2	Resident	**Step 3**	
3	Resident	**Step 3**	
4	Resident	**Step 3**	
5	Resident	**Step 3**	
6	Resident	**Step 3**	
7	Resident	**Step 3**	
8	Resident	**Step 3**	
9	Resident	**Step 3**	
10	Resident	**Step 3**	
11	Resident	Step 2	
12	Resident		Awaiting involvement from representative
13	Resident	Step 2	
14	Resident	Step 2	Awaiting involvement from representative
15	Resident	Step 2	
16	Resident	Step 2	Awaiting involvement from representative
17	Resident	Step 2	
18	Deceased	**n/a**	Deceased
19	Resident	**Step 3**	
20	Resident	**Step 3**	
21	Resident	**Step 3**	
22	Resident	**Step 3**	
23	Resident	**Step 3**	
24	Resident	**Step 3**	
25	Resident	**Step 3**	
26	Resident	**Step 3**	

27	Resident	**Step 3**	
28	Resident	**Step 3**	
29	Resident	**Step 3**	
30	Resident	**Step 3**	
31	Resident	**Step 3**	
32	Resident	**Step 3**	
33	Resident	**Step 3**	
34	Resident	**Step 3**	
35	Resident	**Step 3**	

Appendix B2

Adult Social Care Scrutiny Commission

Developing Intermediate Care Facilities

Update on Progress

Thursday 9th January 2014

Establishing the project team

Work continues to develop the project governance arrangements that will support the work required to deliver new intermediate care facilities. A governance framework has been developed and roles are currently being populated. Due to changes in the resources available within property services, i.e. construction project management capacity being an externally sourced role, there is ongoing dialogue with the section on how best to provide this input to the project. A project manager role is also required to oversee the overall scheme through to delivery; this post will shortly be advertised internally. It is anticipated that the project governance arrangement is presented to the Capital Projects Board in January for approval.

Developing the proposals

There has been preliminary work to consider options, including the financial modelling work undertaken in part for the scrutiny commission's review. Options in relation to available sites have been explored. Procurement routes have been considered for a developer, leaning to a design and build contract for the facilities.

An options paper will be developed in January / February for further political consideration, in advance of a formal decision report being presented.

Resourcing

The capital programme for 2014/15 is currently being drafted, for presentation to the Executive in January. Resourcing for intermediate care facilities will be included for consideration as part of the programme, which will be taken to full council in March 2014.

Ruth Lake

20th December 2013

Appendix C

Leicester City Council

Leicester City Council Scrutiny Review

Alternative Care for Elderly People

A Review Report of the Adult Social Care Scrutiny Commission

December 2013

Contents

Adult Social Care Scrutiny Commission

Commission Members:

Councillor Dr Lynn Moore (Chair)
Councillor Lucy Chaplin (Vice-chair)
Councillor Dawn Alfonso
Councillor Luis Fonseca
Councillor Rashmi Joshi
Councillor Rob Wann
Councillor Ross Willmott

Chair's Foreword

It has been a pleasure to chair this review which has looked at a constructive and humane approach to solving the problem of offering company and support to an aging population, which grows in size annually.

I'm particularly grateful, as usual, to the work carried out by members of the commission and to the officers who support us. Many thanks also to the members of the Leicester City Council Shared Lives team; and for all those other Shared Lives personnel – in Lincolnshire, Oxfordshire, Hampshire and Leicestershire - for the information they have provided for as to how the schemes work in their areas.

I'm also very grateful to Liz Kendall, MP, for attending a commission task group, reporting on her contacts with the Shared Lives schemes nationally and for her measured and sensible encouragement to report on the benefits Shared Lives can offer while acknowledging that it is only one of a set of options which must be made available to older people in providing for their care.

Lastly and by no means least, thanks to the Assistant Mayor for Adult Social Care, Cllr Rita Patel, for deciding to invest in Shared Lives in anticipation of a positive Scrutiny review.

Councillor Dr Lynn Moore

Chair, Adult Social Care Scrutiny Commission

1 Executive Summary

1.1 Background to the Review and Key Findings

1.1.1. We were keen, in the current economic climate, to look at creative and innovative ways of supporting elderly people which could go some way to overcoming the effects of cuts in provision, particularly in the closure of elderly persons' homes. The long-term success of fostering looked-after children as an alternative to placement in children's homes offered an interesting model. It was encouraging to discover that schemes offering "foster placements" for elderly persons already operated in many parts of the UK, providing another option to people who could no long care for themselves with support in their own homes, but who might lack family members to augment independent support.

1.1.2. In early 2013 the commission received a report on the Shared Lives Scheme, already operating in the city, which supported independent living but was aimed more at those recovering from illness or with learning difficulties, so that it had a slightly different ethos to long term fostering.

1.1.3. The scrutiny commission were keen therefore to examine whether this scheme could be adapted and extended to support elderly people to live in family homes as another alternative to residential care. It wanted to ensure that the scheme is well suited to deliver this effectively.

1.1.4. During the review the Executive put extra financial resources into the scheme. With this in mind the commission changed the scope of the review to examine whether the extra resources put in are sufficient and if the service provided meets the need for supporting elderly people.

1.1.5. The commission heard much evidence about the scheme and looked at examples of schemes already in operation from across the country. The Chair also visited Lincolnshire to see their scheme first hand and meet organisers, carers and an elderly client.

1.1.6. The benefits of the scheme to users was apparent but it was also noticeable that the scheme would not be suitable for everyone and also was not the only solution to the dilemma of providing affordable care for elderly persons who have become too frail to support themselves.

1.1.7. Liz Kendall MP was invited to give evidence to the review and speak of her experiences of schemes nationally through her role in Labour's front bench team as Shadow Minister for Care and Older People. Liz spoke highly of the benefits of the scheme particularly in supporting dementia sufferers as a preventative measure and as a real alternative to institutional support.

1.1.8. Liz agreed to investigate national schemes further and report back to the commission about their viability and the resources they required.

1.1.9. With the scheme expanding due to extra resources the commission asked for assurances that the scheme would be effectively evaluated after the first year before further expansion.

1.2 Recommendations

The Assistant Mayor for Adult Social Care and the Executive are asked to consider the following recommendations:

1.2.1. The current investment is welcomed. The scheme needs to be targeted to offer greater support to older people.

1.2.2. Greater use should be made of local media (Leicester Mercury and BBC Radio Leicester) to promote the scheme.

1.2.3. Evidence gathered by Liz Kendall should be used as part of a first year evaluation to monitor whether a better alternative or method is possible.

1.2.4. The current model should be evaluated after its first year of operation, with a report of findings to commission before expanding the scheme further.

2 Report

2.1 Background

2.1.1. The scrutiny commission were keen to examine alternative methods of care for elderly people and in particular whether the Shared Lives Scheme could be adapted to support elderly people to live in family homes through methods such as fostering or mirroring traditional extended family set ups; rather than in residential care.

2.1.2. With this in mind the review considered evidence from officers. The Chair actively looked at other areas where the Shared Lives Scheme was functioning across the country and spoke to several organisers. She also made a visit to Lincolnshire.

2.1.3. Liz Kendall MP was invited to the commission to give evidence on her experience of Shared Lives schemes, encountered as part of her work as Shadow Minister for Care and Older People. Shared Lives Scheme (SLS)

2.2.1. In Shared Lives, an adult (16+) who needs support and/or accommodation becomes a regular visitor to, or moves in with, a registered Shared Lives carer. Together, they share family and community life. In many cases the individual becomes a settled part of a supportive family, although Shared Lives is also used as day support, as provision of breaks for unpaid family carers, as intermediate care on discharge from hospital, and as a stepping stone for someone to live independently. Shared Lives carers and those they care for are matched for compatibility. In most cases, they develop real relationships, with the carer acting as ‘extended family’, so that a

person can live at the heart of their community in a supportive family setting.

2.2.2. Shared Lives is used by older people, people with learning disabilities, people with mental health problems, care leavers, disabled children becoming young adults, parents with learning disabilities and their children, people who misuse substances and (ex-) offenders.

2.2.3. There are 8,000 Shared Lives carers in the UK, recruited, trained and approved by 152 local schemes, which are regulated by the government's social care inspectors. In 2010, England's care inspectors, Care Quality Commission (CQC), gave 38% of Shared Lives schemes the top rating of excellent (three star): double the percentages for other forms of regulated care.

2.2.4. When people labelled 'challenging' have moved from care homes or 'assessment and referral units' into Shared Lives households there have been annual savings of up to £50,000 per person realised. The average saving is £13,000 per person.

2.2.5. Locally there is a very small scale SLS in comparison to much larger schemes in other parts of the country. Also in Leicester the scheme is run by the city council whereas many (but not all) other schemes are run independently of the council.

2.2 Leicester's Shared Lives Scheme

2.3.1. The cost of supporting people through the SLS is separated into two areas; the majority of the cost consists of payments made directly to carers. The remainder covers running costs such as staffing and marketing. The below table summarises costs for 2011/12:

Payments to Carers	
Residential Placements	£523,800
Day Services	£89,600
Total Payments to Carers	**£613,400**
Shared Lives Team	
Staffing Costs	£131,200
Running Costs	£7,600
Total Team Costs	**£138,800**
Total Cost of Scheme – 2011/12	**£752,000**

£486,100 of this came from the Adult Social Care base budget, with the remaining £266,100 coming from customer contributions.

2.3.2. Carers in the scheme are paid standard amounts for the support that they provide based on banded levels dependant on the needs of the user. For 2012/13 these rates are as follows:

Band 1	Older People	£224 per week
Band 2	Mental Illness/Drug & Alcohol	£241 per week
Band 3	Dependant Older People	£274 per week
Band 4	Learning Disability	£291 per week
Band 5	Physical Disability	£344 per week
Band 6	Special Care	£320 per week
Band 7	Severe Multiple Disabilities	£411 per week

2.3.3. If carers are providing support during the day and not providing residential accommodation they are paid one of two rate dependent upon level of need:

Higher rate - £53.38 per day
Lower rate - £34.33 per day

2.3.4. The commission heard that an additional £115,000 was designated for 2013/14 staffing costs to increase the team from 3FTE staff members and 0.5FTE Manager to 6FTE staff and 1 FTE manager. A small amount was earmarked for marketing and additional costs for an increase in carers such as insurance costs.

2.3.5. With a greater capacity in the team, they are able to cater for a larger number of carers in that more evaluations and more promotional work for the scheme can be carried out

2.3.6. The scheme currently supports 30 long term placements and it is aimed to increase these to 60 over three years.

2.3.7. The commission questioned whether a carer's house could be adapted to support certain users as part of the scheme. It was confirmed that users are very carefully matched to carers and the amenities available to the carer, including the suitability of the house. If indeed a carer was suitable but the house wasn't. there might be an option of exploring specific grants to carry out adaptations.

2.3.8. The commission agreed that the move to put extra resources into the scheme was a very positive development and that this investment should be applauded. However, whilst mindful of this there was also agreement that there should be an evaluation after the first year before any further expansion of the scheme to ensure it is meeting the needs of users and is financially viable.

2.3 Visit to Lincolnshire

2.4.1. The commission chair visited Lincolnshire to review the operation of their SLS (Appendix A). The scheme in Lincolnshire operates independently of the local authority.

2.4.2. The scheme in Lincolnshire supports 400 users with a range of needs and caters for older people, the learning disabled and people suffering from dementia. The organizers admitted difficulty recruiting volunteers as carers but they actively publicise their scheme through a range of avenues.

2.4.3. The visit also involved meeting a carer, and a user and her family. It was clear that the carer derived a great deal of reward and satisfaction from participating in the scheme. She had supported multiple users. The user and her family spoke highly of the scheme: indeed, her daughter was convinced that her mother's dementia had diminished since joining the scheme.

2.4 Evidence from Liz Kendall MP

2.5.1. Liz Kendall MP was invited to give evidence to the commission from her experience of Shared Lives Schemes as Shadow Minister for Care and Older People.

2.5.2. The commission heard from Liz that often care is not personalised for an individual in an institutional setting. In such cases the individual is expected to merge into the culture and needs of the institution rather than the needs of the individual being catered for. However it must be acknowledged that there will always be a need for some residential care for those people whose condition has worsened to the point where they need specialist facilities.

2.5.3. Liz also stated that the quality of care for people with dementia is often impaired in institutions as dementia sufferers can be seen as difficult. Personal and individualised care based on a strong relationship can be very important for them.

2.5.4. Therefore it is important to look at alternative methods of care for older people. Whether it is through the SLS or through time banks (where people offer a certain amount of their time e.g. an hour) or other initiatives, there is a need to look at resources available in the community which can offer a better quality of care, such as regularly visits and support from neighbours, family or volunteers.

2.5.5. Liz stressed that SLS could not the only solution to the care of older people who can no longer live independently. They should be considered as a part of the preventative agenda to cater for a particular spectrum of need. The commission members agreed.

2.5.6. Commission Members asked Liz in her capacity as Shadow Minister for Care and Older People to investigate other schemes across the country and the feasibility and scalability of such schemes in terms of costs and resource. Liz agreed to look further into this so that it could be considered by the scrutiny commission and the Executive.

2.5.7. The commission members would like the information produced by Liz Kendall MP to be considered by the Executive as a means to consider alternative care for elderly people based on a wider analysis of best practice models.

2.5 Communication and Publicity

2.6.1. Leaflets (Appendix B) have been developed which give people information on how to become a carer as part of the scheme. Case studies have been produced to describe others' experiences as carers and how rewarding the process has been for them (Appendix C).

2.6.2. The Shared Lives Team are working closely with the Marketing team to raise the profile of SLS, both to recruit new carers and to raise awareness of the service to potential users and their families. The council jobs' website contains a link to the Shared Lives web pages as a further way to recruit new carers.

2.6.3. Commission members suggested greater use of local media to promote the scheme such as the Leicester Mercury and BBC Radio Leicester.

2.6 Conclusions

2.7.1. The commission has heard that the scheme offers many benefits to users and can provide a viable, humane and attractive alternative to people being housed in an institutional environment. Nonetheless it was agreed that it is one of a spectrum of preventative support measures and should not be considered as a solution for all older people who need support.

2.7.2. The commission welcome the extra resource put into the scheme but would urge that an evaluation is completed after the first year to analyse the effects of the scheme and its financial viability.

2.7.3. Along with an end of year evaluation, information offered by Liz Kendall MP as to national best practice of alternative care methods should also be considered.

2.7.4. The commission would like to be kept informed of progress of Leicester's SLS with an update and evaluation to be brought back to the commission after the first year.

3 Financial, Legal and Other Implications

3.1 Financial implications

To follow

3.2 Legal implications

To follow

3.3 Equality Impact Assessment

To follow

3.4 Other Implications

None

4 Summary of Appendices

Appendix A – Visit to Lincolnshire
Appendix B – Information Leaflets on How to become a carer
Appendix C – Case study flyers
Appendix D – Evidence from Oxford and Hampshire to follow

5 Officers to Contact

Kalvaran Sandhu
Scrutiny Support Officer
Ext. 39 8824

APPENDIX A

Notes on visit to Shared Lives scheme in Lincolnshire 11 March 2013

Meeting with Shared Lives Team

We will be meeting one client who has respite care and day care from Shared Lives carers – she pays out of her personal budget. She is in her 80s, has dementia and lives with her daughter and son-in-law. Her respite carer also gives day care to three adults with dementia.

There are four day care groups in Grantham called "Sprightlies" which meet weekly. A paid daytime worker oversees transport to meetings. The groups are no bigger than 15. All are elderly and some have dementia. Some live with families, some in their own home. Some are self-referrals, some are referred by social workers, some from the third sector. Meetings can be in a community lounge, or in some cases at a carer's home (who is paid) with no more than 3 people in the group.

There are no local authority homes in the authority: all homes are run by private providers. Some carers go into residential homes to work with clients. The number of older people in the county is above the national average, so social services are stretched.

A menu of options is provided to clients, printed on an attractive cardboard concertina.

Shared Lives has worked with Age UK Lincs and LACE (a provider of residential care) from A&E Lincoln to prevent admission to hospital. They provide transport home and whatever is necessary to block a bed. There is no local authority involvement. They are able to do this as there is no bureaucracy, so they can develop the quality of ideas.

They support 400 clients with ratio of elderly to learning disabled adults shifting to former. They accept clients with mental disability and dementia. One of the defining factors of the client group was mental age.

They employ two day care staff, but numbers have dwindled since personalization. They can't afford to market the scheme as much as big providers, but they provide quality and stimulation and estimate that this prolongs life for at least 2 to 3 years. They are subject to quality assurance CQC checks and have contracts with the LA so checks are in place.

Even with a long term placement, carers also need respite. They have difficulty recruiting volunteers.

They market via a website, literature distributed to organisations, libraries, marketing events with Age UK, church groups, Alzheimer's Society.

Most Shared Lives carers were female. Carers were a mixture of couples and single persons, often with care experience. Recruitment tended to be by word-of-mouth with a once-a-year drive.

Interview with Brenda (not her real name) a shared lives carer

Brenda worked in the private residential sector but disliked not being able to give individual personal care.

She and her husband decided to take in someone they knew. He was referred to them by Shared Lives and his social worker. It took about a year to be vetted. They looked after this man for 10 years to his end of life and he became part of their family. He had been looked after by his parents before this and had been very indulged. He came to them when he was 59. He had severe learning difficulties, was partially-sighted, was afraid of noise, particularly distant noises and was a very strong character. He could be very stubborn. They were able to introduce him gradually to different experiences. Their grandchildren helped, because he had to learn to take turns.

They became his advocate when an eye-operation went badly wrong and he lost all sight. This revealed the extent of his learning difficulties, such as no ability to be independent. They used their own experience to support him such as observing comforting routines for him, helping him to access day care, encouraging him to join in family routines such as meal preparation, watching TV. They moved to a bungalow to help him have easier access to his room. They supported him through an operation for bowel cancer, but when he had to go into care while Brenda had a hip replacement, he lost weight, was not being fed properly, lost confidence, so even though they were able to bring him home, he died shortly afterwards.

After this Shared Lives suggested that they could offer respite care and they now supported 14 clients, eight regularly – the youngest with learning difficulty was 37, most were over 60 with two in their nineties. Most were living at home on their own or with their family. Brenda and her husband enjoyed this very much and it was such fun for them meeting different people. It got them out of the retirement rut. Regular spots were booked with them. Great care was taken matching them to clients. They were still learning to be specific to make sure what clients' expectations were i.e. it wasn't a holiday although they provided enjoyable experiences. They were so pleased that they could offer this, particular to older people who might not be able to speak for themselves.

If they had a new referral, there would be a two or three night introductory stay. Both carers and client had a choice whether to accept. There was latitude over length and timing of stay so managing their diary was an issue. They were able to step in as necessary, and wuld work with other carers to get optimal arrangements for the client. They dealt directly with clients' families. As they were a couple, they didn't feel any need for supervision to vent any frustrations, although there was a providers' forum with representatives from each area to cascade information.

Interview with Ethel (not her real name) an older person; and her daughter and son-in-law NB The carer was not present

Ethel was 93. She had started her contact with Shared Lives by going to a Sprightly group, which she had attended for six months. She now has respite care with Brenda for 7 days at a time. She enjoys talking to Brenda's father in law, her grown-up children and her teenage grandchildren – and the family's five cats! Everyone is very kind.

Everything was very nice and comfortable: a bedroom and WC, with use of a bathroom. There is a wheelchair for her if needed, a commode and other appliances. Food was very good and they often go out for meals. She watches TV with the family or can go to bed at 9 and watch TV in her room. They give her her medication. She gets a good night's sleep: the bed is very comfortable. She would give 10 out of 10 for the care she receives. She liked Harrison House before (a care home) but prefers Brenda and her husband as it's "more fun". She looks forward to staying with them.

She also goes out every Friday at 2pm with a Shared Lives carer for coffee and cake; and she goes weekly to a carer's home to play games such as Scrabble and dominoes.

She pays £10 per Sprightly session with extra for lunch. £469.98 for a week's respite care with Brenda costs £469.98, with Ethel paying £127.38 out of her personal budget. She pays £43.80 (10am to 3pm) for at-home games session and pays for her own lunch. She pays £12.80 an hour for three hours "coffee and cake".

Ethel's daughter said that they now get peace of mind when she goes to respite care. At first, they were very worried about leaving her, and about back-up if there was a problem. Now they can enjoy their week on their own and don't feel any need to telephone to see if she is OK. Ethel takes her own spending money with her and Brenda provides receipts e.g. for meals out. It is very helpful that Ethel has her own budget. When this arrangement was first mooted, Ethel was reluctant to consider it, but on her first visit to Brenda's house, she booked her first stay within an hour of arriving. They felt that Ethel's dementia has improved because of the weekly stimulation of her outings.

They described the process of placement: the social worker met with the family, talked about respite care, arranged a visit to the carer's home to be shown around. They were given time to think about it and asked to get back in touch to book. A care plan with assessment was drawn up and when complete, the placement was set up.

Appendix D

Report to the Adult Social Care Scrutiny Commission

Date: 9th January 2014

Domiciliary Care

Lead Director: Tracie Rees

City Mayor

Useful information

- Ward(s) affected: All wards
- Report author: Tracie Rees
- Author contact details: Ext 2301

1. Summary

1.1 This report provides further information to members as part of the Domiciliary Care Scrutiny Review, and in response to the questions noted in the Scrutiny meeting of 5th December 2013.

1.2 Appendices 1-3 provide further detailed information in response to the questions raised.

1.3 Appendix 4 provides an overview of the differences between the previous service specification and the new service specification, which officers offered to provide to members.

2. Report

2.1 As part of the Scrutiny Commission Review into Domiciliary Care members asked a number of additional questions at its meeting of 5th December. The responses are outlined here, and within the attached appendices.

2.1.1 Zero hours contracts should not be being used

Legally we cannot stipulate that providers cannot use zero based contracts. However, discussions will be held with the providers on the Council's framework about the future use of zero contracts.

2.1.2 Rather than just assess people's very basic needs and provide a level of service that met them, people should be given the service they wanted. For example, they may want to visit a day centre, or go shopping, but if this was beyond their basic needs this level of service would not be provided

Assessment is completed within a statutory framework, which sets out levels of need across 4 eligibility levels. Leicester (like the vast majority of Councils) meets substantial and critical needs. The threshold is set according to the available resources for the Council to meet need. Therefore home care providers will only be commissioned to undertake tasks that meet needs which relate to a critical or substantial risk. Any other needs (low or moderate) will not be provided for. This is not a matter for the provider, but for the assessment. It is therefore the case that people are only give a service that meets their eligible (basic) needs as this is all the Council is able to afford.
It would be worth noting that the draft Care Bill proposes to set a national eligibility threshold at substantial and critical, replicating our current level across all Councils as a statutory minimum; this is in recognition of the fact that most Council's already have this threshold in place.

2.1.2 How was the break-down of time for visits worked out? Information also was needed on what was included as activities and how time was allocated to these, as there currently appeared to be a mismatch between aspirations and outcomes.

Where services are commissioned directly, the allocated worker, in conjunction with the Service User (or their representative) will discuss what needs have been identified via the assessment process and what services are required (and for how long) to ensure these needs are met. An outcome is, in effect, the result of a met, identified need. Whilst officers within Adult Social Care will attempt to meet aspirations if they are linked to needs/outcomes, the Council is only legally obliged to meet needs (and only then for those Service Users who meet the locally set Eligibility Criteria) and are expected to have due regard to the public purse.

There is slightly more flexibility for Service Users who opt to receive Direct Payments rather than commissioned services as, whilst they are still expected to use their payments to meet their needs/achieve their outcomes, they can spend the payments on services that the Council may be unable to commission directly and which may be more in tune with their aspirations.

2.1.3 Approximately 6% of users had 15 minute visits allocated to them. However, these could be part of a package that included other visits on the same day of different durations. The Commission requested that the actual number of people receiving 15 minute visits be provided.

Due to the limitations of the current IT system, CareFirst; and current business practices the number of 15 minutes domiciliary support service calls cannot be reported with absolute certainty. Previously reported was the figure of 6% of all domiciliary support service calls lasting 15 minutes based on a 2013 weekly snapshot of the electronic care management (ECM) data.

The only 15 minute calls that can be reported from CareFirst are those where it is the only call that day and this account for 350 calls per week or approximately 1% of the total number of calls and to 47 service users (see appendix 1). This is due to the business practice of only inputting the total number of domiciliary support hours and minutes per day and not each call; to do otherwise would result in a substantial increase in data inputting. There is a record of every call in each service user's support plan but this is in a word based document and in free text so it is not possible to report from that format.

When the new IT system comes into use in April 2014 it will be possible to record each new call, this will provide data relating to the number and length of calls delivered to a service user. The system will import the data in its current format so no historic extrapolation of 15 minute calls will be possible.

No 15 minute calls have been commissioned since the new domiciliary support framework agreement was set up on October 14th 2013.

2.1.4 Information was requested on who the providers were.

This is attached at Appendix 2

2.1.5 A quality assurance framework was built in to the Domiciliary Care framework. This could be made available to the Commission.

This is attached at Appendix 3

2.1.6 The Commission asked whether any form of "mystery shopping" was done and, if so, how often and what sample size was used. It also requested that information be provided on whether service users were asked for feedback on their care.

An Annual User survey is conducted.

2.1.7 It would be useful for the Commission to hear the experiences of users of domiciliary care and / or their families, in order to get a broad overview of the service.

As per the minute resolved, Democratic support to action the following:

1) That the Communications Manager be asked to work with the Commission to issue an appeal for users of domiciliary care and / or their families to discuss their experiences of domiciliary care, both good and bad, the appropriate setting for these discussions to be decided.

3. Summary of appendices:

Appendix 1: Table of 15 minute calls

Appendix 2: List of Providers

Appendix 3: QAF

Appendix 4: Comparator Table of Service Specifications

Appendix 1

Provider	Mon Mins	Tues Mins	Weds Mins	Thurs Mins	Fri Mins	Sat Mins	Sun Mins	Week Sum	Weekly Vists
Always There Homecare Ltd	15	15	15	15	15	15	15	105	7
Always There Homecare Ltd	15	15	15	15	15	15	15	105	7
Always There Homecare Ltd	15	15	15	15	15	15	15	105	7
Always There Homecare Ltd	15				15		15	45	
Amicare		15		15		15	15	60	7
Amicare	15	15	15	15	15	15	15	105	7
Amicare	15	15	15	15	15	15	15	105	7
Amicare	15			15	15	15	15	75	7
Amicare	15	15		15		15	15	75	8
Amicare	15	15	15	15		15	15	90	7
Amicare		15	15	15				45	5
Care UK Homecare	15	15	15	15	15	15	15	105	7
Care UK Homecare	15	15	15	15	15	15	15	105	7
Carewatch Care Services	15	15	15	15	15	15	15	105	7
Carewatch Care Services						15	15	30	2
Carewatch Care Services				15				15	7
Carewatch Care Services			15		15			30	2
Carewatch Care Services					15			15	1
Carewatch Care Services	15							15	1
Claimar Care Ltd (Housing 21)	15	15	15	15		15	15	90	8
Claimar Care Ltd (Housing 21)	15	15	15		15	15	15	90	8
Claimar Care Ltd (Housing 21)		15	15		15	15	15	75	7
Claimar Care Ltd (Housing 21)		15		15	15		15	60	7
Claimar Care Ltd (Housing 21)		15		15	15			45	11
Claimar Care Ltd (Housing 21)		15	15	15	15			60	6
Claimar Care Ltd (Housing 21)	15	15	15	15	15			75	5
Direct Health UK Ltd	15	15	15	15	15	15	15	105	54
Direct Health UK Ltd,	15	15	15	15	15	15	15	105	7
Direct Health UK Ltd,	15	15	15	15	15	15	15	105	7
Direct Health UK Ltd,	15	15	15	15	15	15	15	105	7
Direct Health UK Ltd,	15	15	15	15	15			75	5
Direct Health UK Ltd,	15	15	15	15	15			75	5
Domiciliary Care Services (D.C.S.)	15	15	15	15	15	15	15	105	7
Domiciliary Care Services (D.C.S.)	15		15		15			45	9
Help At Home		15						15	19
Help At Home	15	15		15	15	15	15	90	8
Help At Home	15	15	15	15	15	15	15	105	7
Help At Home	15	15	15	15	15	15	15	105	7
Help At Home	15	15	15	15	15	15	15	105	7
Help At Home	15	15	15	15	15	15	15	105	7
Help At Home	15	15	15	15	15	15	15	105	7

Help At Home	15	15	15	15	15	15	15	105	7
Help At Home	15	15	15	15	15			75	5
Help At Home	15							15	2
Help At Home	15	15	15	15				60	4
Help At Home	15	15						30	2
Westminster Homecare			15					15	12
Totals	**525**	**555**	**495**	**525**	**510**	**420**	**450**	**3480**	**350**

Appendix 2

LOT 1: Generic Domiciliary Support Service

1. Housing 21
2. MEARS CARE LIMITED
3. Help at Home
4. Care UK Homecare Ltd
5. Amicare Domiciliary Care Services
6. Direct Health (UK) Limited
7. City & County Care Services Ltd t/as Carewatch Leicester
8. Comfort Call Limited
9. Always There Homecare Ltd
10. Domiciliary Care Services (UK) Limited
11. Castlerock Recruitment Group Limited
12. Sevacare UK Ltd
13. Universal Care Services (UK) Limited
14. GP Homecare Ltd t/a Radis Community Care
15. Westminster Homecare Limited

16. Hales Group Ltd (Reserve)
17. PRIVATE HOME CARE UK LTD (Reserve)
18. Age UK Leicester Shire and Rutland (Reserve)
19. LHA Support Services (Reserve)
20. Choices Care Ltd (Reserve)

LOT 2: Specialist Domiciliary Support Service

1. Voyage Care
2. MEARS CARE LIMITED
3. Creative Support Ltd

4. City & County Care Services Ltd t/as Carewatch Leicester (Reserve)
5. Amicare Domiciliary Care Services (Reserve)
6. Castlerock Recruitment Group Limited (Reserve)

LOT 3: Acquired Brain Injury Domiciliary Support

1. Voyage Care

2. City & County Care Services Ltd t/as Carewatch Leicester (Reserve)

LOT 4: Danbury Gardens – Extra Care Scheme

1. Care UK Homecare Ltd

2. MEARS CARE LIMITED (Reserve)

Name of Service/Care Home*

Name of Parent Organisation*

Service ID No*

Service CQC Reg No*

No of Registered Places*

Date of last CQC inspection*

Service type

Occupancy levels

City funded

CHC funded

County funded

Self funders

Out of county funded

Client Groups catered for (Select all that apply)

DE	LD	OP	D	SI	MD	PD	TI	A

Assessors:

Name

Name

Position

Position

Date self-assessment commenced*

Date self-assessment ended

* To be completed by Contracts and Assurance

Name of Inspection officer 1

Name of inspection officer 2

Date of inspection 1

Date of inspection 2

Date of inspection 3

Date of inspection 4

Date of inspection 5

Date of inspection 6

1	BUSINESS MANAGEMENT		
	The provider must demonstrate good business management which assists them to meet all service user outcomes.		

1.1	**Registration / Insurance Certificates**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Care Quality Commission Registration Certificate and CQC Registered Manager		
	Professional Indemnity Insurance (£5m)		
	Employers Liability (£10m)		
	NMC or GMC register (where applicable)		
	Malpractice Nursing (£5m)		
	Public/Products Liability (£10m)		
	GPs with special interests		
	Consultants RGP Level 1 or 2		
	Clinical Negligence (£5m)		
	Staff insurance for travel in their own vehicle.		
		Level C	
	Requirements for Level B		
	The Provider has a current risk assessment		
		Level B	
	Requirements for Level A		
	Insurance policies that cover use of / setting up temporary accommodation during an emergency (closure of the current site).		
	Insurance that covers costs of additional staff and other resources during this period		
		Level A	
		Overall assessment for Standard 1.1	**D**

Comments

1.2	**Business Premises**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	The facilities are suitable and sufficient for the needs of the service provision		
	Suitable meeting / training rooms (including meetings rooms for confidentiality)		
	Confidential information storage facilities		
	Office base within the geographical boundary of Leicestershire		
	Individuals able to contact the office base by telephone, e-mail, minicom and fax (at the cost of local rates or below) or in person by appointment if necessary.		
		Level C	
	Requirements for Level B		
	Risk assessments of the Service and any premises within which the service is delivered, are conducted at service inception and with appropriate frequency thereafter, following an incident, and at least annually.		
	Where staff work alone, risk assessments specifically address the risks faced by lone workers and clients.		
		Level B	
	Requirements for Level A		

Clients are involved in risk assessments (*other than individual client risk assessments*), which record their participation.		
There is a dynamic approach to risk management with the aim of reducing risk.		

Level A

Overall assessment for Standard 1.2 D

Comments

1.3

Requirements of the job		Service Self Assessment
Requirements for Level C	Evidence submitted and found where	
The person managing the service is approved, trained and skilled		
It is clear what all staff roles / responsibilities are		
Arrangements are in place for the Owner, managers and Senior Staff defining their roles and responsibilities		
Clear reporting and accountability mechanisms are in place and understood by all staff		
An accountable senior member of staff is contactable at all operational times		

Level C

Requirements for Level B		
Staff job descriptions and handbooks focus on the purposes and outcomes required of staff rather than the tasks to be performed. Staff members are assessed immediately following and several months after the receipt of training for confidence and competence in skills learned.		
Staff members report the quality and validity of training provided, and how it has improved their practice within the service provision.		

Level B

Requirements for Level A		
Staff members confirm that the organisational culture is one that is open to innovation and can point to service improvements that have come about as a result.		
The Provider has trained ambassadors in specialist areas such as dementia or brain injury.		

Level A

Overall assessment for Standard 1.3 D

Comments

1.4

Business Practices / Policies and Procedures		Service Self Assessment
Requirements for Level C	Evidence submitted and found where	
Staff understand and have access to up-to-date copies of all policies, procedures and codes of practice		
Service users have access to relevant information on the policies and procedures and other documents in appropriate formats		

Providers have systems / policies / procedures in place to deliver the “Service” as outlined within Leicester City Council’s Contract / Core Agreement and Service Specification.		
There is a system that ensures all staff are aware of, understand and implement all core company policies		
		Level C
Requirements for Level B		
There is a periodic (at least annual) review of the effectiveness of all policies including safeguarding and protection from abuse and their implementation.		
		Level B
Requirements for Level A		
The service can demonstrate that changes have been made as a result of policy and procedure review which shows the impact of and stakeholder involvement.		
		Level A
		Overall assessment for Standard 1.4 D

Comments

1.5	**Care at Home: Logistics (not currently applicable to DAAS)**	Service Self Assessment
	Requirements for Level C Evidence submitted and found where	
	The service operates within a clearly written set of aims and objectives. There are documented specific intended outcomes, which are sufficiently clear to enable managers or other stakeholders to assess the success of the service.	
	There is a system in place to calculate how long it will take for staff to travel between visits. This ensures that full time requirements are given to rotas which take into account staff travel times for car users, walkers, cyclists and drivers.	
	Level C	
	Requirements for Level B	
	Periodic reports to the governing body or senior managers analyse measures and indicators of service quality, identify any apparent strengths and weaknesses and outline plans of action to build on strengths and address weaknesses.	
	Level B	
	Requirements for Level A	
	Results of quality monitoring are periodically (at least annually) reported to SU and other stakeholders. The service is accredited by means of an appropriate quality system, for example, up-to-date certificates from accrediting bodies.	
	Level A	
	Overall assessment for Standard 1.5 D	

Comments

1.6	**Sub-Contracting**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Where sub-contracting is required, the provider will have in place: Checks that demonstrate qualified staff are able to carry out tasks e.g. plumber, an electrician or district nurse, GP, community pharmacy, holistic therapists, actvity providers. Suitable arrangements for checking the quality of the sub-contracted service Suitable arrangements for checking the quality of work provided as part of the contract Financial arrangements		
			Level C
	Requirements for Level B		
	Periodic progress reports from the subcontractor, as well as feedback about both the project at hand and the overall relationship		
			Level B
	Requirements for Level A		
	SU have been consulted about the quality of the work undertaken by the sub-contractor.		
			Level A
			Overall assessment for Standard 1.6 D

Comments

Overall Self Assessment Score Standard 1: Not Met D

2	**PERSONALISED CARE, TREATMENT AND SUPPORT**

The provider promotes and facilitates improved health and emotional well-being of its service users, ensuring they receive effective, safe and appropriate care, treatment and support to meet individual need. This approach enables service users to have a fulfilled life, making the most of their capacity and potential.

2.1	**Carrying out tasks in accordance with my needs**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Staff individually and collectively have the skills, knowledge and experience to deliver the services and care which the service states in its information material that it can provide		
	The skills and experience of care staff are matched to the care needs of each service user		
	Staff are able to communicate effectively with the service user using the individuals preferred method of communication		
	There are nutrition and fluid monitoring charts in place if required and this care is planned		
	Service user food choices, likes/dislikes, allergies and requirements are taken into account when preparing food		
	Access to/information about/choice of food and drink is provided to meet diverse needs, making sure food and drink is nutritionally balanced and supports good health		

Where there are concerns about SU's in relation to nutrition and fluid intake causing deterioration of general health, including Ulcer Ambition, timely remedial action is taken which includes a referral to the appropriate Health Agency such as SALT, District nurses, Home visitors, GP, Dentist, Optician		
Specialist expertise is sought which includes access to mentors, peer support, mutual aid (where applicable)		
		Level C
Requirements for Level B		
Support planning takes account of the wider needs of the client (beyond those being met directly in the service) which impact upon their need for support.		
Specialist expertise is sought, where required, when drawing up support / risk management plans.		
		Level B
Requirements for Level A		
Support and risk management plans complement any statutory care plan or support plans provided by other agencies. Support and risk management plans indicate that clients are encouraged to take reasonable risks in developing their independence.		
SU outcomes are used to inform service development and strategic planning. Support and risk management plans complement any statutory care plan or support plans provided by other agencies. SU's are consulted with regarding any environmental changes and have an input to the design process.		
		Level A
		Overall assessment for Standard 2.1 D

Comments

2.2	**My personal needs will be assessed to ensure I get safe and appropriate care that supports my human rights and that my wishes have been fully considered**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	The risk of the SU receiving unsafe or inappropriate care, treatment and support is reduced by: assessing the needs of the SU, planning and delivering care, treatment and support so that SU's are safe, their welfare is protected and their needs are met taking account of published research and guidance making reasonable adjustments to reflect people's needs, values and diversity having arrangements for dealing with foreseeable emergencies		
	An individual care plan outlining the delivery arrangements for care is developed and agreed with each SU. The plan is generated from the initial assessment and support plan completed by the Local Authority Care Management staff and the SU.		
	The plan is informed by the expressed wishes and preferences of the individual SU, including the use of an advocate, where appropriate and induces recovery ambitions (where appropriate)		
			Level C
	Requirements for Level B		
	Staff harness individual clients' insight into the assessment of needs and risks.		
	Specialist expertise is sought, where required, when conducting needs / risk assessments.		

		Level B
Requirements for Level A		
The needs and risk assessment policy and procedures encourage appropriate risk taking and discourage risk avoidance as the key feature of support delivery. Needs and risk assessments balance promotion of independence with effective risk management.		
There is clear evidence to demonstrate SU involvement in the design of services to encompass life choices. The service can demonstrate that changes have been made to improve service delivery as a result of SU involvement in policy and procedure review.		
		Level A
		Overall assessment for Standard 2.2 D

Comments

2.3	**My care and support will be reviewed and maintained to make sure it meets my needs**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Staff are proactive in identifying and reviewing changing need and risk. SU files show that all SU risks have been reviewed and updated.		
	Services update their own care assessments and continuously review, evaluate and revise care, health and recovery plans for all SU to inform Care Managers of changing needs.		
	Such plans will reflect that support needs can reduce as well as increase. Care plans reflect each individual's changing needs and circumstances.		
	Reviews of needs as a minimum are undertaken when a situation means a re-assessment of risk is required and if not at least annually.		
	The needs and risk assessment policy and procedure is written down and reviewed every three years. The procedures state how clients will be involved. Staff understand and follow the procedures. Needs and risk assessments take into account the views of other services as appropriate.		
			Level C
	Requirements for Level B		
	The service works constructively with risk and does not use risk assessment to exclude applicants inappropriately.		
	Staff harness individual clients' insight into the assessment of needs and risks. Specialist expertise is sought, where required, when conducting needs / risk assessments.		
			Level B
	Requirements for Level A		
	The needs and risk assessment policy and procedures encourage appropriate risk taking and discourage risk avoidance as the key feature of support delivery. Needs and risk assessments balance promotion of independence with effective risk management.		
	The service can demonstrate that changes have been made to improve service delivery as a result of policy and procedure review and can show the impact of client and stakeholder involvement.		
			Level A
			Overall assessment for Standard 2.3 D

Comments

2.4	**Dignity and Respect**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	The Registered Manager ensures that there is continuity in relation to the care or support worker/s who provide the service to each SU Staff deployment is in accordance with individual care plans (numbers and skills and taking into account gender issues)		
	Consultation with SU around any staff changes		
	The number of staff supporting each SU is kept to minimum and ensures that consistency is maintained with a minimum number of staff to respect individuals dignity		
	Staff are made aware of and understand their professional boundaries and their practice reflects this. A code of conduct (or similar document) makes clear appropriate boundaries for staff and volunteers		
	Staff are clear of their responsibilities. There is evidence of clients' views being incorporated. Where clients disagree with assessments or reviews their views and reasoning are recorded. Clients have access to their file and are provided with a copy of assessments and reviews if they wish.		
	Clients confirm that their views have been listened to and taken into account. Clients confirm that they are supported in meeting their cultural, religious and/or lifestyle needs, in line with the Equalities Act.		
			Level C
	Requirements for Level B		
	Needs and risk assessments, support plans and reviews seek to involve other professionals, carers, family and/or friends as the client wishes.		
	Records demonstrate that a SU is always consulted / informed when a staff member changes. The support plan is person centred and can demonstrate active involvement of the SU in its composition.		
			Level B
	Requirements for Level A		
	Needs and risk assessment and support planning procedures balance respect for clients' views, preferences and aspirations with effective risk management. Staff are able to describe how they deal with disagreements and how they balance respect for clients' wishes with effective risk management.		
	Staff are able to describe how they deal with disagreements and how they balance respect for clients' wishes with effective risk management. Clients confirm how they have been supported to access a range of services to meet their diverse needs – both those provided by the organisation and those available through other providers such as non-regulated activities from faith or community groups.		
			Level A
			Overall assessment for Standard 2.4 D

Comments

2.5	**Equality and Diversity**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	There are equality and diversity policies / procedures which have been reviewed in the last three years which are known and adhered to by all staff		
	Compliance with the Equality Act 2010 and reasonable adjustments (e.g. for sensory, physical, mental health needs or autism spectrum disorder)		
	Person centred assessment (self-assessment if possible) and family/advocate involvement as necessary, to identify health, social, personal and emotional needs, outcomes and preferences. Staff have received Equality and Diversity training.		
	Clients confirm that they are supported in meeting their cultural, religious and/or lifestyle needs, in line with the Equalities Act		
		Level C	
	Requirements for Level B		
	Needs and risk assessments, support plans and reviews seek to involve other professionals, carers, family and/or friends as the client wishes		
	The support plan is person centred.		
		Level B	
	Requirements for Level A		
	Needs and risk assessment and support planning procedures balance respect for clients' views, preferences and aspirations with effective risk management.		
	Staff are able to describe how they deal with disagreements and how they balance respect for clients' wishes with effective risk management. Clients confirm how they have been supported to access a range of services to meet their diverse needs – both those provided by the organisation and those available through other providers.		
		Level A	
		Overall assessment for Standard 2.5	**D**

Comments

Overall Self Assessment Score Standard 2: Not Met
D

3	**SAFEGUARDING AND SAFETY**
	Service users are protected from abuse, or the risk of abuse and their dignity and human rights respected and upheld. Access to care without hindrance from discrimination or prejudice. SU and staff should be as safe as they can be. Any risks are appropriately managed. Positive risk is encouraged, appropriately managed and the service is not risk adverse. Any 'vulnerable' situations are appropriately identified and responded

3.1	**I will be protected from abuse or the risk of abuse, discrimination and harassment and care workers will respect my human rights Should any serious incidents occur, relevant authorities are notified**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	SU, staff and visitors are in safe, accessible surroundings that promote wellbeing. Services take account of any relevant design, technical and operational standards and manage all risks in relation to the premises e.g. infection control.		
	SU, staff and visitors know they are protected against the risks of unsafe or unsuitable premises through: The design and layout of the premises being suitable for carrying out the regulated activity, appropriate measures being in place to ensure the security of the premises and any grounds being adequately maintained, compliance with any legal requirements relating to the premises.		
	There is a whistle blowing policy which has been reviewed in the last three years which is known and adhered to by staff		
	Have a business continuity / risk management plan that covers emergency situations such as fire, flood and/or significant change in the physical standard of the home		
	Emergency call-out and out of hours support arrangements are documented and publicised to service users and staff in ways appropriate to their needs		
	The service maintains appropriate records to demonstrate cleanliness and adherence to infection control procedures within the service provision. The service ensures the competence of staff members with cleanliness and infection control requirements		
	The service maintains an up to date business continuity plan.		
			Level C
	Requirements for Level B		
	The service ensures that a business continuity plan is updated at least annually. The service can demonstrate effective action when cleanliness and adherence to infection control procedures within the service provision has resulted in an infectious outbreak.		
	The service has an infection control champion.		
			Level B
	Requirements for Level A		
	The service undertakes regular and robust cleanliness and infection control audits, producing and implementing actions plans where appropriate including advice from LCC H&S.		
			Level A
			Overall assessment for Standard 3.1 D

Comments

3.2	**Equipment that meets my individual needs.**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	

The service follows published guidance and training about how to use medical devices safely and will make sure equipment is: - suitable for its purpose - available - properly maintained - used correctly and safely - promotes independence - comfortable		
		Level C
Requirements for Level B		
There is a documented approach to risk taking and the use of equipment that enables staff members to understand the meaning of “appropriate risk taking” and discourages risk avoidance as the key feature of support planning		
Support planning takes account of the wider needs of the client (beyond those being met directly in the service) which impact upon their need for support.		
		Level B
Requirements for Level A		
There is a strategic approach to promoting independence and maximising SU participation in the wider community. Expertise and resources are available to enable SU to develop their talents and abilities and positive risk taking.		
Mechanisms are in place between the service and external agencies to facilitate and enable joint working. Client outcomes are used to inform service development and strategic planning. SU’s have been consulted with regarding the choice of equipment they are offered.		
		Level A

Overall assessment for Standard 3.2 D

Comments

3.3

I will receive care, treatment and support that meets my needs		Service Self Assessment
Requirements for Level C	Evidence submitted and found where	
The service takes action to identify and prevent abuse from happening. Respond appropriately when it is suspected that abuse has occurred or is at risk of occurring.		
Ensure that Government and local guidance about safeguarding from abuse is accessible to all staff and put into practice.		
Demonstrate how the service ensures SU are protected from physical, financial, verbal, sexual or racial abuse and neglect or abuse through the misapplication of drugs by deliberate intent, negligence or ignorance. Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual and used in a way that respects dignity and protects human rights. Where possible its use respects the preferences of the SU.		
Protect others from the negative effect of any behaviour of SU. Where applicable, only use Deprivation of Liberty Safeguards when it is in the best interests of the SU and in accordance with the Mental Capacity Act 2005.		

The SU, families and friends are routinely provided with information about the MCA and DOLS and the right for them to bring to the service's attention that there should be an application for a DOLs authorisation and what else they could do if the service did not agree. Prompt action, consistent with agreed procedures, is taken in relation to individual concerns from staff, SU or others and appropriate support is provided to them including whistle blowers		
A log records detail of incidents, near misses and outcomes and shows appropriate action and reporting in line with the Contract and CQC. There are appropriate arrangements to enable SU and staff to access help in crisis or emergency. Emergency call-out and out of hours support arrangements are documented and publicised to SU and staff in ways appropriate to their needs.		
There is a no-response/ no access policy and procedure for example where SU's receive care at home and providers are unable to make contact at planned visit times. This includes sharing information with relevant agencies when SU are on a respite break or away with family / carers. There is a plan for dealing with any disruption to the service (contingency planning).		

Level C

Requirements for Level B		
There is a periodic (at least annual) review of the effectiveness of safeguarding and protection from abuse policies and procedures and their implementation. The policy and procedure review seeks to identify and address disincentives to reporting concerns.		
Disclosure and Barring Service checks are updated every three years. The service appropriately supports staff members through, for example, supervision, in dealing with abuse cases. Staff understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns. The service has mechanisms in place that reinforce professional boundaries.		

Level B

Requirements for Level A		
There is a planned approach to working with other agencies. The service can demonstrate that key safeguarding partners are involved in policy and procedure review. The service can demonstrate that changes have been made to improve service delivery as a result of review or following an incident / safeguarding investigation.		
Policy and procedure review can show the impact of client and stakeholder involvement. The service is proactive in promoting and sharing good practice beyond the service on safeguarding vulnerable adults. The service can demonstrate that changes have been made to improve service delivery as a result of policy and procedure review. Regular review of safeguarding incidents to assess the root cause(s) is undertaken the outcome of which is reflected in changes to service delivery.		

Level A

Overall assessment for Standard 3.3 D

Comments

3.4	**Care workers will carry out tasks in accordance with infection control guidelines**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Infection Control The service complies with the requirements of regulation 12, with regard to the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance		
			Level C
	Requirements for Level B		
	The service maintains appropriate records to demonstrate cleanliness and adherence to infection control procedures within the service provision. The service ensures the competence of staff members with cleanliness and infection control requirements.		
			Level B
	Requirements for Level A		
	The service undertakes regular cleanliness and infection control audits, producing and implementing actions plans including advice from LCC H&S.		
			Level A
			Overall assessment for Standard 3.4 D

Comments

3.5	**If the care provider is assisting me with medication, I will get the medicines I need, when I need them, and in a safe way**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	The service handles medicines in accordance with NICE guidance i.e safely, securely and appropriately prescribed medicines are given by people safely. There is a log book, policy and procedure for those who self-medicate. The service follows published guidance about how to use medicines: There is a medication policy which has been reviewed annually and is known and adhered to by all staff who administer.		
	Staff only provide assistance with taking medication or administering medication or undertake other health related tasks when it is within their assessed competence.		
	Staff have received necessary specialist SU specific training and it is with the informed consent of the SU or their relatives or representative.		
	Procedures for reporting medication concerns which include: How care and support workers follow the services procedures for reporting concerns, responding to incidents and seeking guidance. How the service identifies and responds to any changes or concerns in an individual's needs. Recording administration of medication within the care plan and other records.		
	Care and support workers agree with the SU to record any observations of the taking of medication and any assistance given (including dosage and time of medication)		
	The service has a homely remedies policy and procedure and Homely remedy MAR records that indicate what an SU can have, when, in what quantity and any contra-indicators if having other prescribed medicines. The service has a policy and procedure for accepting medicines from those on respite care / short breaks. The service has a policy and procedure for hospital discharge of SU.		
			Level C
	Requirements for Level B		

The service has a service agreement with a local pharmacy which includes a terms of reference, a clear statement in relation to ordering, waste management and returns. The Service has an alternative supplier for medicines in the event that its primary supplier cannot deliver an order on time.		
		Level B
Requirements for Level A		
The service can demonstrate that it encourages an SU to manage their own medication(s) including offering lockable storage in their own room.		
		Level A
		Overall assessment for Standard 3.5 D

Comments

3.6

If I have been assessed as requiring help with managing my financial affairs:		Service Self Assessment
Requirements for Level C	Evidence submitted and found where	
The registered person ensures there are policies and procedures in place for staff on the safe handling of service users money and property		
There are invoice procedures for private and direct payment clients		
Where service users are unable to take responsibility for the management of their finances, this is recorded on the risk assessment and action taken to minimise the risk		
Cash transactions are regularly recorded on cash record sheets if staff are handling a service users money (e.g. shopping)		
There are procedures to prevent staff from personal benefit when working with vulnerable people		
There is a documented risk assessment addressing potential for personal benefit		
		Level C
Requirements for Level B		
The service can demonstrate that changes have been made to improve service delivery as a result of policy and procedure review, learning and development, incidents and / or near misses.		
		Level B
Requirements for Level A		
The service can demonstrate that changes have been made to improve service delivery as a result of policy and procedure review that can show the impact of SU involvement.		
The service advises and encourages an SU to manage their own money		
		Level A
		Overall assessment for Standard 3.6 D

Comments

Overall Self Assessment Score Standard 3: Not Met
D

4	STAFFING
	The service has the right staff with the right skills, qualifications, experience and knowledge to support its service users. It looks at training needs for staff and how they should be supported to carry out their role, including the time they will need away from work in order to take part in learning and development opportunities. The service will be flexible and adaptable to service users changing needs and requirements.

4.1	**I will be cared for by care workers who have the knowledge, skills and experience needed to meet my health and welfare needs**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Effective recruitment and selection procedures in place, relevant checks carried out when employing staff There is a rigorous recruitment and selection procedure which meets the requirements of legislation, equal opportunities and anti-discriminatory practice and which ensures the protection of SU and their relatives		
	Staff recruitment and induction has a clear focus on promoting the intrinsic value of each individual SU and ensures that the values of each member of staff are consistent with this message		
	All managers and staff are provided with a written job description, person and work specification identifying their responsibilities and accountabilities and copies of the organisations staff handbook		
	There is a structured induction process, which is completed by new care and support staff. Induction Program should include the Skills for Care Common Induction Standards		
			Level C
	Requirements for Level B		
	Staff job descriptions and handbooks focus on the purposes and outcomes required of staff rather than the tasks to be performed. There is documentary evidence of the service provider being able to respond to unexpected changes in staffing levels, for example, sickness, absences and emergencies.		
	Staff members are assessed immediately following and several months afterwards the receipt of training for confidence and competence in skills learned. Staff members report the quality and validity of training provided, and how it has improved their practice within the service provision.		
			Level B
	Requirements for Level A		
	There is a documented service-wide training plan, which cascades the needs of the service into individual training plans. There is formal recording of feedback from clients (e.g. via complaints, formal consultation processes, key-working, day-to-day discussions with staff etc.) and documentary evidence of this being collated and taken account of when preparing training plans		
	Staff members confirm that the organisational culture is one that is open to innovation and can point to service improvements that have come about as a result including the use of champions and ambassadors is specific areas such as dementia.		
			Level A
			Overall assessment for Standard 4.1 D

Comments

4.2	**I will be cared for by care workers who have gone through a thorough recruitment and induction process and who have the right training and skills to do their jobs properly .**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Staff are registered with the relevant professional regulator or professional body where necessary and are allowed to work by that body		
	Staff who are thought to be no longer fit to work in health and adult social care, and meet the requirement for referral, are referred to the appropriate bodies		
	Sufficient staff with the right knowledge, experience, qualification and skills to support Sus. There is a training needs analysis for each staff member which is incorporated into the staff training and development plan		
	The service measures on going staff competence in respect of each area of training provided; 'on the job' training is with the consent of the SU		
	There are staff supervision and appraisal mechanisms to monitor staff competence in core areas of service delivery		
	Statutory and mandatory training (e.g. medication, moving and handling, handling SU's finance) are covered in staff supervisions and appraisals There is documentary evidence that supervision specifically addresses the nature and limits of relationships between staff and SUs and maintains dignity		
	Staff are properly supported to provide care and treatment to SUs; properly trained, supervised and appraised		
	Staff are enabled to acquire further skills and qualifications that are relevant to the work they undertake		
			Level C
	Requirements for Level B		
	Staff are enabled to acquire further skills and qualifications that are relevant to the work they undertake (e.g. CPD). Where staff work alone, risk assessments specifically address the risks faced by lone workers and clients. There is documentary evidence of the service provider being able to respond to unexpected changes in staffing levels, for example, sickness, absences and emergencies.		
	Staff members are assessed immediately following and several months afterwards the receipt of training for confidence and competence in skills learned.		
			Level B
	Requirements for Level A		
	Clients are involved in risk assessments (*other than individual client risk assessments*), which record their participation. There is a dynamic approach to risk management and the service proactively looks to reduce risk, but is not risk averse.		
			Level A
			Overall assessment for Standard 4.2 D

Comments

4.3	**I will be consulted about the flexibility of my service, and whether informal arrangements have been taken into account in planning service delivery**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	

Staff are reliable and dependable. Staff can respond flexibly to the needs and preferences of SU which arise on a day to day basis and services are provided in a way that meets the outcomes identified in the care plan		
Staff rota's are appropriate to meet care needs; times to suit / agreed with SU		
Staff have a clear understanding of how they can communicate changing Circumstances within their own organisation		
Staff arrive at the SU home within the time band specified and work for the full amount of time allocated		
Care is not rushed, time is allocated in a way so that there is enough time to carry out what is required in a way that the SU wants		
There is continuity in relation to the staff who provide(s) support and care to each SU		
Staff deployment is in accordance with individual care plans		
	Level C	
Requirements for Level B		
Staff are enabled to acquire further skills and qualifications that are relevant to the work they undertake. Where staff work alone, risk assessments specifically address the risks faced by lone workers and clients. There is documentary evidence of the service provider being able to respond to unexpected changes in staffing levels, for example, sickness, absences and emergencies.		
Staff members are assessed immediately following and several months afterwards the receipt of training for confidence and competence in skills learned.		
	Level B	
Requirements for Level A		
Clients are involved in risk assessments (*other than individual client risk assessments*), which record their participation. There is a dynamic approach to risk management and the service proactively looks to reduce risk, but is not risk averse.		
No decision about me, without me		
	Level A	
	Overall assessment for Standard 4.3	**D**

Comments

4.4	**If I have more than one service, or if I am moved between services, I will get safe co-ordinated care, treatment and support**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	The service cooperates with others involved in the care, treatment and support of the SU i.e. when the responsibility is shared or transferred to one or more services, individuals, teams or agencies		
	Information is shared in a confidential manner with all relevant services, individuals, teams or agencies to enable the care, treatment and support needs of the SU to be met		
	The service proactively seeks to engage other agencies in supporting SU; works with other services, individuals, teams or agencies to respond to emergency situations. SU are supported to access other health and social care services they need		

Mechanisms are in place between the service and external agencies to facilitate and enable joint working		
		Level C
Requirements for Level B		
The service can demonstrate that there is a planned and effective approach to working with other agencies. There is a periodic (at least annual) review of the effectiveness of safeguarding and protection from abuse policies and procedures and their implementation.		
The policy and procedure review seeks to identify and address disincentives to reporting concerns. Disclosure and Barring Service checks are updated every three years.		
		Level B
Requirements for Level A		
There is a planned approach to working with other agencies and the service can demonstrate SU involvement.		
The service can demonstrate that changes have been made to improve service delivery as a result of review or following an incident / near miss and can show the impact of client and stakeholder involvement.		
		Level A
		Overall assessment for Standard 4.4 D

Comments

Overall Self Assessment Score Standard 4: Not Met D

5	**QUALITY AND MANAGEMENT**		
	The home care provider will routinely check the quality of their service.		
5.1	**The provider will regularly monitor the quality of the service they provide to make sure I receive the support I need**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	There is a Quality Management Plan (QMP) which has been reviewed annually and is known and adhered to by all staff; makes clear that where specialist knowledge is required to run the service safely that professional advice is sought. A QMP will identify, monitor and manage risks to people who use, work or visit/access the service and includes how the service will routinely involve SU, carers, families, peer mentors views in the running of the service		
	There is a process and a procedure for consulting on a regular basis with SU and their carers about the care service and assuring quality and monitoring performance		
	SU feedback is actively sought on their preferred methods of consultation		
	SU are offered a range of opportunities to give their views, make comments, and offer ideas about the services provided		
	The outcome from the Quality Management process is made available to SU, their family or representatives and reviewed		
	There is evidence that feedback is listened to and implemented and includes; Outcomes and Actions met		
			Level C
	Requirements for Level B		

SU are offered a range of opportunities to give their views, make comments, and offer ideas - both individually and in groups - about the services provided.		
Mechanisms for consultation are wide-ranging and aimed at securing the inclusion of all SU, to the extent and at the level they wish to be involved. Appropriate support is available to enable SU with different needs to be consulted e.g. travel expenses, signing, audio loop systems.		
		Level B
Requirements for Level A		
Consultation focuses on SU concerns and they have opportunities to play an active role in shaping current and future service delivery. Mechanisms for consultation are open and flexible so that clients can raise their own issues and concerns and not just respond to what the service defines as important. Forums and opportunities are available so that SU can come together, to share experiences and discuss what will meet their needs.		
Decision-making mechanisms facilitate SU involvement in designing and developing services and setting quality standards. There is a periodic (at least annual) review of the effectiveness of consultation mechanisms and the outcomes achieved.		
		Level A
		Overall assessment for Standard 5.1 D

Comments

5.2	**My personal records and information will be accurate and will be kept safe and confidential**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Keep accurate personalised care, treatment and support records secure and confidential for each SU Securely destroy records taking into account any relevant retention schedules. There are confidential waste facilities		
	There is a confidentiality policy which has been reviewed in the last three years which is known and adhered to by all staff		
	Care and support staff respects information given by SU or their representatives and in confidence and handle information about SU in accordance with Data Protection Act 1998. Service policies and procedures are written in the best interests of the SU		
	Store records in a secure, accessible way that allows them to be located quickly. Suitable provision is made for the safe and confidential storage of SU records and information including the provision of lockable filing cabinets and shielding computer screens or hand written records from general view when displaying personal data		
	The service maintains all the records required for the protection of SU and the efficient running of the business for the requisite length of time		
	Daily records and care plans will be recorded in a manner which is factual and avoids personal opinion or judgements		
			Level C
	Requirements for Level B		
	Support planning takes account of the wider needs of the SU (beyond those being met directly in the service) which impact upon their need for support. The service proactively seeks to engage other agencies in supporting SU.		

Specialist expertise is sought, where required, when drawing up support / risk management plans.		
		Level B
Requirements for Level A		
Support and risk management plans complement any statutory care plan or support plans provided by other agencies. Support and risk management plans indicate that clients are encouraged to take reasonable risks in developing their independence.		
Mechanisms are in place between the service and external agencies to facilitate and enable joint working. Reviews are co-ordinated to complement the reviews of any statutory care plan or support plans provided by other agencies. The service takes a case conference approach that includes engaging other services in reviews. SU outcomes and reviews of needs and risks are used to inform service development and strategic planning.		
		Level A
		Overall assessment for Standard 5.2 D

Comments

5.3	**I or someone acting on my behalf can complain and will be listened to**		Service Self Assessment
	Requirements for Level C	Evidence submitted and found where	
	Systems in place to deal with comments and complaints. Consider fully, respond appropriately and resolve, where possible, any comments and complaints		
	There is a written complaints policy and procedure that has been reviewed in the last three years and this is used as a tool for service development i.e. improves the service by learning from adverse events, incidents, errors and near misses that happen, the outcome from comments and complaints, and the advice of other expert bodies where this information shows the service is not fully compliant		
	All SU, carers and staff are made aware of the complaints procedures and how to use them		
	A record is kept of all complaints and compliments including details of the investigation and action taken within reasonable response times in accordance with the organisations complaints policy		
	The organisation carry out an on-going analysis of concerns/complaints to identify emerging patterns. The organisation uses the findings to inform its quality management and service/staff development and improvements plans		
	Positive action is taken to encourage, enable and empower SU to use the complaints and compliments procedure including access to appropriate interpretation methods of communication		
			Level C
	Requirements for Level B		
	The organisation and its staff see complaints as a positive tool. There is a periodic review (at least annual) of complaints received.		
	There is a periodic review (at least annual) that asks whether there is sufficient awareness of the procedure and what would inhibit complaints.		
			Level B
	Requirements for Level A		

The service can demonstrate that reviews of policy, procedure and complaints received have been used to improve service delivery and can show the impact of client and stakeholder involvement. There is a documented service-wide training plan, which cascades the needs of the service into individual training plans.		
Staff members confirm that the organisational culture is one that is open to innovation and can point to service improvements that have come about as a result.		

Level A

Overall assessment for Standard 5.3 D

Comments

Overall Assessment Score Standard 5: Not Met
D

6 **VOICE, CHOICE AND CONTROL**

Service users have access to choice and control of good quality care, which is responsive to individual needs and preference, includes consultation about personal preferences and wishes. Choices

6.1 **I will receive good advice and information to make choices**		Service Self Assessment
Requirements for Level C	Evidence submitted and found where	
A SU Guide / handbook / directory and other information materials are available/produced, setting out service aims and objectives, the range of facilities and services offered and the terms and conditions of receiving the service / occupancy.		
Copies of the following written policies (where applicable) are made readily available that deal with: The management of continence*. Care for those with advanced stages of dementia, including the management of challenging behaviour and procedures for dealing with medical emergencies. The ordering, storage and administration of drugs Dealing with abuse and allegations of abuse. Managing personal allowance Policies for admissions, transfers and discharges. Control of infection Providing care in a dignified manner which would include maximising independence.		
A care plan is drawn up with the involvement of the SU wherever possible and/or their representatives on their behalf, and any other professionals as appropriate The care plan takes into account the SU wishes and preferences about the way care is provided and their chosen lifestyle – in keeping with any legal requirements		
The care plan is used to determine what and how services are to be delivered		
Staff understand the approach and can describe how they work with the SU to promote independence. There is a documented approach to risk taking that enables staff to understand the meaning of 'appropriate risk taking' and discourages risk avoidance as the key feature of support planning		
Care assessments use appropriate methods of communication so that the SU and their representatives are fully involved		
The risk assessment policy and procedure is reviewed at least every three years		
Staff carrying out risk assessments and reviews are competent to do so There are systems in place to ensure that staff can be deployed / redeployed if there are any choices or concerns from SU		
The care plan sets out in detail the action that will be taken by care and support workers to meet the assessed needs and communication requirements		

The care plan identifies areas of flexibility to enable the SU to maximise their potential and maintain their independence		
The plan is signed by the SU and/or their representative and is available in a language and format that the SU can understand		
A copy of the plan is held by the SU unless there are clear and recorded reasons not to do so		
Reviews of needs are undertaken at least annually or more frequently if required and care, health and recovery plans are updated to reflects this		
		Level C
Requirements for Level B		
Support plans show that staff members and SU have discussed any wishes for volunteering, employment, training, education, social and leisure activities outside of the service.		
Information concerning the availability of such services, activities and opportunities is made readily available in ways appropriate to SU needs.		
		Level B
Requirements for Level A		
The Service can demonstrate that changes have been made as a result of policy and procedure review. Policy and procedure review show the impact of service user and stakeholder involvement.		
SU are able to influence how they receive information about safeguarding and protection from abuse and the reporting mechanisms for raising concerns. The service can demonstrate that where an SU has a licence to occupy or is placed in a care / nursing home a capacity test has been undertaken.		
		Level A
		Overall assessment for Standard 6.1 D

Comments

6.2

I will be supported and consulted about my preferences and wishes for planning end of life care (not currently applicable to DAAS)		Service Self Assessment
Requirements for Level C	Evidence submitted and found where	
There is a clear and documented approach to supporting the SU end of life wishes		
The service is able to demonstrate that there are robust process and procedures in place to ensure that SU (and families where appropriate) are consulted about their wishes for end of life care		
An end of life care plan is drawn up with the involvement of the service user whenever possible or their representatives on their behalf, and any other professionals as appropriate		
The end of life care plan takes into account service users' wishes and preferences in relation to the way in which the care is provided		
		Level C
Requirements for Level B		
The service has a person-centred approach to death and dying, and this is integral in service provision. The SU an End of Life care pathway, or equivalent, in the delivery of good quality end of life care		

The service understands, and recognises and promotes the psychological needs of SU. The Service support SU in receiving psychological support for themselves if dying, or if received news of the bereavement of someone close to the SU.		

Level B

Requirements for Level A

The service is a registered provider of nationally recognised programmes of good practice in end of life care, for example, Gold Standards Framework. The framework has been integrated into their service provision		
Reviews of policies, procedures and practice guidance can show the impact of SU involvement. The service has a holistic approach to death and dying, supports SU in their physical, mental, emotional and spiritual needs.		

Level A

Overall assessment for Standard 6.2 D

Comments

Overall Assessment Score Standard 6: Not Met
D

Overall Assessment Score All Standards Not Met
D

Standard	Self Ass'ment
1	D
2	D
3	D
4	D
5	D
6	D

Appendix 4

2009 DOMICILIARY CARE CONTRACT & 2013 FRAMEOWORK AGREEMENT COMPARISON

Area	2009-2012 specification	2013-2017 specification
Local strategic links	n/a	Various commissioning strategies including Dementia, Learning disabilities and Mental Health
Regulation	Commission for Social Care Inspection (CSCI)	Care Quality Commission (CQC)
Number of providers	10 providers	16 providers
Reserve providers	None	Establishment of reserve framework to respond to increased service needs has resulted in 5 new providers.
Generic Contracts	6 block contracts of 800 hours per week; 1 block contract for sheltered schemes of 800 hours per week; 4 spot contracts with no guaranteed hours	Framework agreement with 15 providers (5 reserves), no guarantee of hours
Specialist contracts	For people with Acquired Brain Injury, complex disability, Multiple Sclerosis, Motor Neuron Disease, Stroke, Spinal Injuries, Epilepsy and any resulting challenging behaviours. 3 spot contracts with no guaranteed hours.	For people with Acquired Brain Injury. Framework Agreement with 1 provider (1 reserve), no guarantee of hours
Specialist contract	For People with Mental Health, Dementia and/or Complex Care needs. 1 block contract of 200 hours per week.	For People with Complex & Enduring Mental Health needs, A Dual Sensory Impairment and or Behavioural, Emotional & Social Difficulties Framework Agreement with 3 providers (3 reserves), no guarantee of hours
Disabled Children & Families contract	2 spot contracts with no guaranteed hours	Children & Families commissioning separately.
Specialist contract	Danbury Gardens – to be fulfilled by one provider 1 block contract for 720 hours. To include 24 hour on-call service and cover for lunchtimes. 1 spot contract with no guaranteed hours to provide for 38 individual support packages.	Danbury Gardens (1 reserve) 1 block contract for 720 hours. To include 24 hour on-call service and cover for lunchtimes. 1 spot contract with no guaranteed hours to provide for 38 individual support packages. Recommendation that at least 1 part time site manager (in fact TUPE resulted in 1 FTE + 3 Team Leaders) Under commissioning review October 2013 and due to report by end of 2014. Could lead to service remodelling.
Adult Social Care Outcomes Framework	-	List of outcomes to which the providers will be required to contribute: 1A; 1B; 1C; 1D; 1G; 1H;

(ASCOF)		2A; 2B; 2C; 3A; 3B; 3C; 3D; 4A; 4B
Area	**2009-2012 specification**	**2013-2017 specification**
Minimum staff requirements	Care Workers: NVQ 2 Managers: NVQ 4	Generic & Danbury Gardens: QCF level 2 Specialist contracts: QCF level 3 Manager/Director: qualification in social work, occupational therapy, nursing or management qualifications or equivalent experience.
Monitoring	Electronic Care Monitoring (ECM)	Electronic Care Monitoring (ECM) Quality Assessment Framework (QAF) Performance Standard Reports
Detailed reference to Employment issues	-	Recruitment; Matching Support Staff to Service Users; Respecting Service Users' Homes; Lone Working
Invoicing & Financial arrangements	-	Detailed appendices outlining how invoices should be laid out and submitted
Adult Social Care Outcomes Framework (ASCOF)	-	List of outcomes to which the providers will be required to contribute: 1A; 1B; 1C; 1D; 1G; 1H; 2A; 2B; 2C; 3A; 3B; 3C; 3D; 4A; 4B
Skills for Care	-	Requirement to be registered with Skills for Care National Minimum Data Set (NMDS-SC) and report annually
Commissioning of 15 minute calls	Permitted	End to commissioning of 15 minute calls in line with national guidance and in consultation with providers and stakeholders.
Commissioning Time Bands	These are the bands by which LCC pay providers, for example, a 30 minutes commissioned call may result in a carer only actually staying for 21 minutes and the council would pay for a 30 minute call, similarly if a carer stayed 39 minutes then a payment of 45 minutes would be made. Allowance of +/- 9 minutes	A performance analysis revealed that providers were consistently underproviding so this allowance was reduced to +/- 5 minutes
Schedule 8 – Safeguarding	Safeguarding policy referenced but not as separate schedule	Separate schedule relating to Safeguarding policy and stakeholders' obligations
Appendix 4 – Suspension of Services	n/a	Details the process under which a provider may be suspended from the framework agreement in terms of contract breaches, poor performance, etc
Area	**2009-2012 specification**	**2013-2017 specification**
Appendix 5 – Call off arrangements	n/a	Call-off process required under a framework agreement as each support package is individually

		tendered. Packages are awarded according to a provider being able to "match" a service user's needs according to the time of the call, gender of the carer and the language spoken by the carer; ranking would decide when there was an instance of a provider "tie"
Appendix 6 – Continuous Improvement Targets	n/a	Requirement for provider to submit annual improvement report.
Appendix 10 – Sustainability Plan	n/a	Requirement to report how the provider adds social value and contributes to the sustainability agenda.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Work from 2012/13

Meeting	Meeting Items	Standing Items	Scrutiny Review	Key Actions Agreed
10th Jan	- ASC 2013/14 Budget	- Elderly Persons Homes		ASC 2013/14 Budget Officers asked to note comments of the commission and that they are kept informed of changes introduced as minuted, particularly proposals to integrate community services in residential packages.
Special Mtg 16th Jan			- Domiciliary Care	Domiciliary Care The Scoping document was agreed with minor amendments.
13th Feb	- Protecting Elderly People from Rogue Traders	- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Protecting Elderly People from Rogue Traders It was agreed for information on what the current processes and actions are around financial abuse to come to the next meeting with the commission considering how it might be able to input into an awareness raising campaign.
7th Mar	- Healthwatch Leicester and ICAS - Protecting Elderly People from Rogue Traders	- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Healthwatch and ICAS Members of the commission asked that a further report on the ICAS be given at a future meeting.
4th Apr	- Day Care for People with Mental Health Problems	- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Elderly Persons Homes Cllr Patel mentioned that a letter to inform of the findings of her review into EPH will be circulated within the next week and a report will come to the next meeting of the commission. Day care for people with mental health problems It was agreed that findings of the consultation process would come back to a future meeting.
2nd May		- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Elderly Persons Homes Agreed for consultation findings to come back to the commission before a decision is made.

Appendix E

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

2013/14 Work Programme

Meeting	Meeting Items	Review/Report	Actions Agreed
Thurs 13th June 2013 at 5.30pm	- Adult Social Care Portfolio Overview	- Presentation	
	- Elderly Persons Homes	- Review Item Report	Agreed to hold a special meeting and cover in the scheduled July meeting to gather evidence. Also agreed to circulate the report completed by scrutiny previously.
	- Corporate Procurement Plan 2013/14	- Report	
	- City Mayor's Delivery Plan	- Report	Comments were submitted to officers. Asked for a further update in 3/6 months' time.
	- Access for All Work Programme	- Report	
	- Work Programme	- Report	A number of future items were discussed and were to be added to the work programme.
Special Mtg – Mon 1st July 2013 at 5.30pm	- Elderly Persons Homes	- Review Item Report	Extra information requested with regards to the proposals. Members of the public will be allowed to give representation at the next meeting.
Thurs 11th July at 5.30pm	- Elderly Persons Homes	- Review Item Report	Further information still required but a report to be drafted up pending this information.
Thurs 5th Sept 2013 at 5.30pm	- Elderly Persons Homes	- Review Item Report	Agreed that a final report with the commission's comments be completed and sent to the Executive.
	- Older Persons Mental Health Day Care Services	- Report	The commission voted in favour of the option to close the day service of older people with mental health problems and move the existing users to alternative provision.
	- Enablement Pilot and the Community Inclusion Team	- Presentation	The commission to receive a further update at the next meeting.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Meeting	Meeting Items	Review/Report	Actions Agreed
Thurs 10th Oct 2013 at 5.30pm	- Community Inclusion Team	- Report	
	- Douglas Bader Day Centre	- Report	Trade unions will be invited to give representation at the next meeting. The results of the consultation to come back to the January meeting of the commission.
	- Current Consultations	- Verbal Update	The series of consultations announced to be added to the work programme
	- Personal Budgets and Direct Payments	- Presentation	A report that evaluates the effectiveness of the indicative personal budgets be brought back to the commission in 6 months' time.
	- Elderly Persons Homes	- Verbal Update	The final review report was ratified. The direction of travel and timescales to brought back to the next meeting. The commission asked to be kept informed about progress of proposals to set up a commission for vulnerable people.
	- Winter Care Plan	- Scoping Document	The scoping document was agreed.
Thurs 7th Nov 2013 at 5.30pm	- ASC Local Account	- Report	Feedback was given to the draft ASC Local Account.
	- Douglas Bader Day Centre	- Verbal	Representation was received from Unison union and their views were endorsed by the commission.
	- Elderly Persons Homes	- Verbal	The commission requested anonymised updates on the position of each resident at each stage of the process of moving them from their current EPH to their new one.
	- Domiciliary Care Review	- Report	Further information was requested for the next meeting.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Meeting	Meeting Items	Review/Report	Actions Agreed
Thurs 5th Dec 2013 at 6.00pm	- Mental Health Care (Dementia)	- Report	It was agreed to consider all the information provided and follow up at the next meeting.
	- Mobile Meals Service	- Report	The commission agreed that the Executive be recommended to consider the way that consultations are carried out in view of the Commission's concerns about this consultation. Also recommended the Executive adopt option 2, (expand the in-house service).
	- Housing Related Support Services	- Verbal	Representations were received from residents and staff at John Woolman House and Vernon House and also from Castle Ward Councillors.
	- Domiciliary Care Review	- Report	The commission agreed to look at communicating the review to carers and family members in order for them to give representation. Further information was requested for the next meeting.
	- Elderly Persons Homes	- Report	

Meeting	Meeting Items	Points to be considered	Review Items	
Agenda Meeting – Wednesday 20th November 2013 at 4.30pm				
	-	• Background to review completed by Health scrutiny commission • Update on the current Dementia Strategy • The commission to consider avenues of work in relation to ASC, in particular Dementia	-	• Continuation of the review. • Scoping Document to be circulated
	-	• Update on the findings of the consultation	-	• Timetable for future to be considered
	-	• Representations to be received by John Woolman House and Vernon House		

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Meeting	Meeting Items	Points to be considered	Review Items	
Agenda Meeting – Wednesday 11th December 2013 at 4.30pm				
Thurs 9th Jan 2014 at 5.30pm	- Mobile Meals Service	• Update on decision	- Domiciliary Care Review	• Review information provided
	- Dementia Mental Health Care	• Consider information received and approach for commission	- Elderly Persons Homes	• Update since last meeting
			- Alternative Care for Elderly People	• Final review report
Agenda Meeting – Tuesday 28th January 2014 at 4.30pm				
Wed 12th Feb 2014 at 5.30pm	- Douglas Bader Day Centre	• Update on the findings of the consultation • Final Proposals	- Domiciliary Care Review	
	- Housing Related Support Services	• Update on the findings of the consultation including alarm services • Final Proposals	- Elderly Persons Homes	
Agenda Meeting – Wednesday 19th February 2014 at 4.30pm				
Thurs 6th Mar 2014 at 5.30pm	- Update on Personal Budgets	• Update report to evaluate the effectiveness of the indicative personal budgets		
	- Enforcement of Blue Badge Scheme	• What is the current system? • How is it administered?		
	- Transformation programme and I.T systems	• What is the system and why do we have it and what's changing? • What money is being spent on it? • What is the provision of the new system? • Any identified problems and how they will be resolved?		
Agenda Meeting – Wednesday 19th March 2014 at 4.30pm				
Thurs 3rd Apr 2014 at 5.30pm	- VCS Preventative Services	• Update on the findings of the consultation		
	-	•		
	-	•		
Thurs 1st May 2014 at 5.30pm	-	•		
	-	•		
	-	•		

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Future Items	Items to be considered
Integration Transformation Fund (February/March)	• Information on the transfer of funds from Dept. of Health to the Council • What does it involve? • How much will it be? • View the draft plan that is to be submitted to Dept. of Health
Internal Day Care for People with a Learning Disability Review (Later in 2014)	• An update of services • What is being changed and what will the review involve?