ADULT SOCIAL CARE SCRUTINY COMMITTEE
Minutes of the Adult Social Care Scrutiny Committee held on Tuesday, 17th April 2012 at 2.30 p.m. in the Civic Offices, Telford, Shropshire.

PRESENT: Councillors C. Turley (Chairman), F. Bould, J. Greenaway, J. Loveridge, C. Mason, J. Seymour; Co-optee Maurice Viney.

Also Present**:** Cllr. L. Clare, Cabinet Member Adult & Social Care; Cllr. V. Fletcher; J. Gulliver, Scrutiny Co-optee; Deb Holland, Compliance Central Region, Care Quality Commission; Karen Kalinowski, Assistant Director Care & Support; Chris Harrison, Care & Support Commissioning Manager; Stephanie Jones, Scrutiny Group Specialist.

ASCSC-24 MINUTES

RESOLVED - that the minutes of the meeting of the Adult Social Care Scrutiny Committee held on 2nd February 2012 be confirmed and signed by the Chairman.

Regarding the action points from the previous meeting, the Chairman informed members that:

- The Senior Citizens' Forum had been contacted about setting up an awareness-raising session. There were no available slots at a Forum meeting until April 2013, but an article would be published in the mid-June edition of the newsletter to coincide with World Elderly Abuse Awareness Day on 15th June.
- Information about the SSSFT thematic review had been downloaded from the website and e-mailed to Members. Theresa Moyes, Director of Quality & Clinical Performance at SSSFT, had offered to present the report at a future meeting of the Committee, and to discuss how SSSFT include safeguarding during unannounced visits to services to check on compliance with CQC essential standards of quality and safety. Members agreed this could be done to coincide with a report on the next Annual Report.
- Information regarding training for CSOs had been requested and was awaited.
- The Members' request that the number of staff trained in each organisation should be shown as a percentage of the overall relevant workforce in the next Annual Report had been fed-back.
- Additionally, a survey on training of staff in GP surgeries was being planned with a view to including the results in the next Annual Report.
- The VASB Annual Report 2011/12 had been added to the Committee's work programme. If the new scrutiny committee structure was put in place for next year, the new Health & Adult Care Scrutiny Committee would agree the work programme and this would go forward as a suggestion.

ASCSC-25 APOLOGIES FOR ABSENCE

None

ACSSC-26 DECLARATIONS OF INTEREST

None

ASCSC-27 CARE QUALITY COMMISSION: INSPECTION REGIME FOR CARE HOMES

Deb Holland, Compliance Manager Central Region, Care Quality Commission (CQC) gave a verbal report on the work of the CQC addressing a number of questions submitted prior to the meeting.

The CQC was formed 3 years ago from the merger of three former inspection regimes. The Health & Social Care Act had for the first time brought inspection under one regulatory framework across the whole health economy from acute to domiciliary care. The CQC was responsible for the registration and inspection of all health and adult social care providers including NHS Trusts, ambulances, care homes, domiciliary care and dentists. GP practices would be required to register with the CQC from next year. The Government sets the regulations and standards and the CQC inspects against the regulations and standards.

There were nine managers in the West Midlands each managing 10 inspectors. A restructure was being carried out to create bigger regional structures.

Essential standards included: treating people with dignity and respect, making sure food and drink meets people's needs, making sure that that the environment is clean and safe and managing and staffing services. Additional standards are applied for particular settings. Standards are not monitored in isolation, but also in terms of the impact on, and outcomes for, patients. Inspections focus on six key areas:

- The involvement of people in the design of care
- How care has been designed around the needs of the person from assessments to delivery of care plans
- Safeguarding and safety to ensure protection from abuse and equipment
- Staffing – recruitment, checks, induction, training and appraisal processes
- Management arrangements
- Suitability of managers - managers are registered separately from providers.

The work programme is developed based on three types of inspection:

- Routine or planned inspections. This includes an annual inspection of care

homes and agencies, and risk based inspections triggered by a pattern of information or complaints which suggest a problem.

- Responsive inspections where a serious complaint or safeguarding issue has been raised, or in response to a government directive.
- Themed inspections to look at specific standards, sectors or types of care e.g. a thematic review of dignity and nutrition standards in hospitals had recently been extended as a result of mixed results from the initial 100 ward inspections.

Intelligence is used to determine which standards will be inspected so that checks are focussed on problem areas e.g. if there have been complaints about infections, the CQC could inspect hygiene and infection control standards. Five outcomes are usually looked at for a planned visit to gain a balanced view.

Most inspections are unannounced, except where the type of service or location make this impractical e.g. for dentists or remote locations. Staff sometimes arrive early in the morning or late in the evening depending on the service. Inspectors observe what is happening and talk to staff, patients, visitors and relatives, with follow up on the telephone where required. Sensitivity is used according to the circumstances and setting.

Reports document the findings of the inspection and any remedial action required. All reports are published on the QCQ website. Easy to read provider profiles show where the provider is compliant or non compliant against inspected standards and where action has been required. Repeat inspections are made to check progress against required actions. In serious or extreme cases, the CQC may limit or stop the operations of a provider under civil or criminal enforcement powers.

With regard to Telford and Wrekin, the priorities for the work programme were being decided. A detailed thematic review of domiciliary care agencies would be carried out starting in April to look at care standards, safeguarding, QA systems, staff training etc. and would include visits to offices and home visits where consent had been given. Members were invited to contact the CQC about any issues they were aware of to feed into this work. The CQC and Council have regular formal and informal communication to share information and ensure work programmes are not duplicated.

The following information was then provided by Deb Holland, Karen Kalinowski and Chris Harrison in response to members' comments and questions:

- Cllr. Seymour wanted to know whether CQC inspections of domiciliary care look at the length of care visits as there had been national reports of visits only taking 15 minutes. Where care is funded by social services, the commissioner specifies the provision and an agency's performance can only be measured against the constraints set by the authority. The key checks are: is the provider clear about the commissioner's expectations, does the person have a clear care plan and does the agency have a clear contingency and communication plan to maintain a

reliable service. From speaking to service users, their key concerns were with the reliability and consistency of the service. There are challenges with the length of care visits when people require services at the same time, and this is particularly acute in rural areas.

The Assistant Director emphasised that Telford & Wrekin care contracts do not ordinarily specify 15 minute visits, unless they are required in accordance with the care & support plan e.g. a pop in visit , and the majority of service calls would be a minimum of 30-60 minutes. This was important because for some people the care worker may be their only social contact. Social care was being looked at to find the best way of providing it across different budgets, and taking these social needs into account. Options for electronic homecare monitoring were being considered, but this would not replace personal care and contact. The domiciliary care commissioning framework was being reviewed to see how providers could be better held to account on cost and quality, with a move away from time limited tasks to needs led and outcome focused.

- Cllr. Seymour raised the issue of hospital patients being discharged in the middle of the night and wanted to know whether the CQC would be looking into this. It was thought that the issues highlighted in the national media may trigger some work nationally. The CQC outcome 6 “working with other partners” could be used to monitor hospital performance from the care or nursing homes’ point of view. Members raised a local issue of hospital patients being moved between wards in the middle of the night. Deb Holland thanked the members for bringing this to her attention. The CQC does not handle individual complaints, but where a pattern of complaints is established, the issue is reported to the provider so they have a chance to address the issue before an inspection.

- Cllr. Seymour drew attention to a recent survey which showed that fewer non-English speaking health professionals and carers were being asked to undergo language training, and that this was causing a communication problem for some patients and service users. Cllr. Greenaway felt that this problem was worse for people with dementia. Cllr. Seymour would forward details of the survey to Deb Holland.

- Cllr. Greenaway asked whether care homes sign-post people to the CQC or to the local authority as well as their internal complaints process. Care homes do not tend to sign-post to the CQC as it is not a complaints body. Complaints received by the local authority from people receiving Council funded care are linked back to the provider to address, and the Council will investigate complaints that are not addressed. Information about risk is passed to the CQC. Self-funders may make complaints to the health ombudsman.

- Staffing levels at the CQC had been increased to deal with the additional responsibilities placed on it and the forthcoming inclusion of GP practices within its

remit.

The Assistant Director welcomed Deb Holland back to Telford and Wrekin and welcomed the news that all care homes and agencies would be inspected at least once a year. The reports would enable people to find out whether providers were compliant or non-compliant with standards.

Members thanked Deb for attending the meeting and providing useful information. Contact details for the CQC would be circulated to members.

ASCSC-22 REHABILITATION AND REABLEMENT STRATEGY UPDATE

The Care & Support Commissioning Manager presented the Implementation Plan for the Telford & Wrekin Rehabilitation and Re-ablement Strategy and the Enablement Plan – Section 256.

The Strategy had been approved in June 2011 by the Council, the Health & Wellbeing Board and the PCT. The Strategy was built on evidence that providing up-front rehabilitation resulted in better outcomes for people. The Strategy would be delivered though a single point of contact, shared resources and a common approach across health and social care partners. The Implementation Plan was the overarching action plan for delivery of the Strategy which was monitored by a Steering Group comprising of health, social care and other key stakeholders. The Council's restructure had been completed with all staff in post and the re-ablement service had gone "live" on 16th April. The aim was to build up the service from 30% of people receiving support to a universal service.

The Action Plan covered actions in 5 key areas:

1. Work in relation to combining appropriate resources (service reconfiguration).
2. Cost-modelling for shifts in community resources, including mapping resources and gaps, working with acute partners to shift resources to the community to help prevent hospital admissions.
3. Rehabilitation and re-ablement care pathways, building on work carried out in a number of work shops.
4. Developing third sector to deliver low level preventative support. More work needed to be done with a range of stakeholders.
5. Development of rapid response and multi-disciplinary teams, including the enhancement of stroke services with the Rehabilitation and Enablement Team.

The Enablement Plan - Section 256 showed how funding transferred from the PCT to the Council under a Section 256 agreement had been allocated. This was reported to the Strategic Health Authority. Funding had been allocated to:

- Additional Occupational Therapy, Physiotherapy and nurse posts to support the Rehabilitation and Enablement Team. Previously know as the Intermediate Care

team. The post holders would work with the Council's Enablement Team but would be employed by the Community Trust to ensure robust clinical governance and supervision.

- Intermediate Care beds. 10 beds were contracted last year and a further tender exercise is being undertaken to seek market interest.
- Investment in telecare equipment to support discharge. A contract had been awarded for an integrated community alarm and telecare service. Further consideration was being given to assisted technologies to complement personal care such as memo pads and sensors.
- Funding to support voluntary sector reablement support.
- Additional practitioner posts in social care to support increased patient numbers.
- Spot purchase of additional care capacity in the community in residential, care and domiciliary settings.

The following information was then provided in response to Members' comments and questions:

- Members raised the issue of how the Home from Hospital team support patients discharged during the night: nationally 1.8% of patients were discharged between 11.00pm and 6.00am. Members were informed that the Home from Hospital team did not work 24//7 but had changed shift patterns to cover more hours. A pro-active approach had been taken with team members being allocated to designated wards, and the team buddied-up with hospital staff to join ward rounds. It was hoped that this fundamental change in the way of working would eventually eliminate the need for Notification 2 notes, issued by wards when patients were ready to be discharged. The team worked in A&E so that people not admitted could be picked up, and admissions could be monitored. The Section 256 money had supported the involvement of the Red Cross to help people who need some low level support on discharge toreturn homeCllr. Mason commented that night time discharge may be necessary to free up beds for emergency admissions and that it was better to discharge a patient safely out of hours than to block beds needed for emergencies. It was agreed that this would continue to be an issue while hospitals were running at full bed capacity and not the optimum 85%. Bed block concerns should be addressed to SaTH and it was suggested members may want to look at the Unscheduled Care Strategy.

- There was a database to help identify the level of risk associated with a condition which had resulted in a person being admitted to hospital, for example with a stroke. There had been discussions with Dr. Mike Innes, Chair of the Clinical Commissioning Group (CCG), about the risk stratification. There was an issue with separate databases and the CCG wanted to look at a combined database; best practice in other authorities was being looked at.

- More work was being done with the Stroke Network, Shropshire Partners in Care and the PCT on supportive discharge for stroke patients as this had been

recognisedan area for further development. Preventative work was being done with the domiciliary and care home sector; a pilot had been run in 2 homes whereby indicators of stroke such as irregular pulse rates were being monitored so preventative and immediate assistance could be put in place.

ASCSC-23 FORWARD PLAN

The Chairman reminded Members about two Scrutiny Committee meetings which may be of interest to members of the Adult Social Care Scrutiny Committee:

- The Health Scrutiny Committee meeting at 5.00pm on 1st May would look at the Health & Wellbeing Board, HealthWatch / LINk arrangements, Public Health Transition. Dr. Mike Innes had been invited to speak about the CCG and confirmation of his attendance was awaited.

- The Budget & Finance Scrutiny Committee would be looking at the finances for Supporting People. A date for the meeting was to be confirmed but would be published on the scrutiny meeting notices.

The Chairman reminded Members about the proposals to merge the Health and Adult Social Care Scrutiny Committees in the next municipal year and that a decision would be taken by the Scrutiny Management Board the following day.

The Chairman said this was the last scheduled meeting of the Committee for the municipal year, but invited members to raise any other immediate issues they might want to look at, and a further meeting could be arranged. There were no further suggestions.

The meeting ended at 4.15 p.m.

Chairman: .....

Date: .....