CAMBRIDGESHIRE COUNTY COUNCIL ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

REVIEW OF HOME CARE SERVICES

FINAL REPORT AND RECOMMENDATIONS

MARCH 2012

CONTENTS

1. BACKGROUND

1.1 This report sets out the findings and recommendations of the review of home care services conducted by the Adults, Wellbeing and Health Overview and Scrutiny Committee Adult Social Care working group. The review took place between August 2011 and January 2012.

1.2 The working group consisted of County Councillors Kevin Reynolds, Sue Austen, Gail Kenney, Simon King, Simon Sedgwick-Jell and Caroline Shepherd and Huntingdonshire District Councillor Richard West. Officer support was provided by Jane Belman, Scrutiny and Improvement Officer.

1.3 The review group was assisted by officers of Cambridgeshire County Council Community and Adult Services, who briefed members on issues relating to home care services, how it was intended to address these in future contracts with providers, and the way that current services were monitored.

Age UK Cambridgeshire supported the review by providing evidence and facilitating meetings between service users and review group members.

2. CONTEXT AND REASONS FOR REVIEW

2.1 The nature and quality of home care, which consists of personal support such as help with washing, dressing, toileting, getting up and going to bed, has a crucial impact on people's quality of life, dignity, choice, safety and ability to retain independence.

Members were aware in their role as local councillors that individuals' experience of home care services varied, but did not have sufficient information to put this knowledge into a wider context.

2.2 Home care is a key component of the Council's adult social care services. It makes a major contribution, alongside other services, such as provision of equipment or day care, to the Council's goals of helping people live at home rather than in residential care, and of preventing un-necessary hospital admissions and reducing delayed discharge. It is also key to the success of reablement, the programme of short term support which is being provided to older people to enable them to become as independent as possible.

2.2.1 In 2010/11 the Council commissioned home care services for a total of 6079 people. The majority of these (4921) were older people, including people with dementia. Data so far for 2011/12 indicates that while the number of older people receiving a home care service is decreasing as a result of the introduction of reablement, the average hours of care commissioned per client is increasing.

2.2.2 At present, the Council commissions these services from 37 independent providers (currently all private sector), using a combination of block, cost and volume and spot contracts. Care agencies throughout the County are paid a standard rate per hour of care provided. Council officers monitor the contracts to ensure that providers are meeting the requirements, and that any areas of improvement identified by the monitoring process are addressed.

2.2.3 The Council is also required to provide information to people who arrange and fund their own care.

2.3 Home care is a key aspect of the more integrated and personalised approach to health and social care that is developing, linked to the implementation of self-directed support in adult social care. This requires a major shift away from the current approach of commissioning set tasks to be done at set times, to a more flexible approach based on achieving agreed outcomes for the user.

The home care sector will need to change considerably to respond to these developments, in terms of the range of services it provides and how they are delivered.

2.4 Home care is a major area of Council expenditure. Under the pooled budget arrangements, Adult Social Care currently spends around £16m a year on home care services. (The total budget for home care for older people in 2011/12 was £26.68m with a projected end of financial year overspend of £5.68m).

Given the ongoing requirements on the Council to make savings, and the increasing demographic demand on services arising from an ageing population, it is therefore essential that home care is commissioned and provided in a way that is cost effective. This relates both to the service itself, and to its contribution to the success and hence cost-effectiveness of other parts of the system, such as reablement, prevention of hospital admissions, and delaying or preventing the need for people to enter residential care.

2.5 The review is timely, as work is currently being undertaken by the Council's commissioners for Adult Social Care to address these issues through the development of a framework specification, as a basis for retendering the contracts for home care services later in 2012. It is intended that the findings and recommendations of the review will contribute to this.

3. OBJECTIVES

3.1 The objectives of the review were to

- Obtain an understanding of the user experience of home care services
- Identify the extent to which the current home care services
    - Provide a high quality service for individuals
    - Use resources effectively
    - Promote a personalised approach
    - Support the objectives of reablement and timely hospital discharge
    - Are part of a well co-ordinated system of health and social care
- Make recommendations for improvement in relation to the above.

4. METHODOLOGY

Note: In this report a carer is defined as a person who provides practical and/or emotional support to a relative, friend or neighbour who is ill, frail, disabled, or experiencing mental distress, but who is not employed to do so. People who are paid to provide care are referred to as care staff or care workers.

In conducting the review, members obtained evidence as follows:

4.1 The views and experience of people who used home care services

- 1-1 interviews with two individuals who received home care services, one of whom had arranged their care independently of the County Council; and one carer of an older relative with dementia, who had made a number of complaints to the Council about the quality and reliability of the service the relative received
- Discussion with four service users at a day centre run by Age UK Cambridgeshire

  People were asked about their experience of home care services, what they considered worked well and less well, and what recommendations they would make for the future.

- Discussion with officers of Age UK Cambridgeshire, who provided information based on the experience of the people who used their services.

Cambridgeshire LINK and Cambridge Older People's Enterprise (COPE) also provided information.

The review also drew on the casework experience of members in their role as local councillors.

4.2 The views and experience of home care workers

- 1-1 interviews with two home care workers, who were known to members prior to the review.
- 1-1 Interviews and discussion with a total of six home care workers, an assessor and an office-based liaison officer, as part of member visits to two care agencies. The staff who participated were selected by the agency, but interviewed separately from their managers.

Members also considered a letter to a member from an individual care worker.

4.3 The perspective of care agencies

- Visits to two home care agencies, one in the North and one in the South of the County; one part of a large national agency, the other a local business. Members spoke with managers, care staff and office-based staff, to obtain their respective views on how well the home care system was working, its relationship to other parts of the health and social care system, and what

needed to change. One visit included observation of a follow-up monitoring visit to check progress against action points arising from the contract monitoring process.

4.4 The perspective of other statutory agencies

- Discussion with Cambridgeshire Community Services NHS Trust planned care managers for Cambridge and South Cambridgeshire
- Discussion with Dr Brimblecombe, then GP Senate lead for community services, and written feedback from 4 other Cambridge area GPs

In both cases, members focused particularly on issues relating to the quality and availability of home care, and on areas for improvement in inter-agency working

4.5 Written Information

Members considered the following:

- 'Close to Home; - an inquiry into older people and human rights in home care': Equalities and Human Rights Commission (EHRC) August 2011.
- 'Joining up Health and Social Care': Audit Commission December 2011

FINDINGS

5. SUMMARY OF FINDINGS

5.1 The review found considerable variation in the quality and consistency of care that people experienced. Issues highlighted by service users and those supporting them related to continuity of care staff, their level of understanding of people with dementia, care staff arriving at the wrong time and being rushed, medication, dignity, variations in the quality and competence of individual care workers, their responsiveness to signs of deterioration, and how agencies responded to complaints.

5.2 A number of inter-related issues were linked to the above. They included considerable variation in the quality of staff training, support and supervision and in the level of organisational commitment by agencies to a high-quality service; difficulties in recruiting and retaining sufficient staff of the right quality to meet demand; staff pay, working conditions and limited opportunity for career development.

5.3 The shortage of staffing in the Cambridge area was delaying arrangements for ongoing care provision for people in the community, including those being discharged from hospital, and those coming out of the reablement programme following hospital discharge.

5.4 Effective and ongoing monitoring, including unannounced visits to service users, to ensure that agencies were delivering a safe and high quality service, was seen as essential. This includes ensuring there is sufficient capacity within the Council to do this.

5.5 Given the reluctance of some service users to complain, members were concerned that the Council may not always be aware of instances where individuals receive a poor service or there are safeguarding issues. Users need to know how to complain or raise concerns, and have access to independent support in doing so.

5.6 The Council's Adult Social Care procurement staff had undertaken a focused programme of contracts monitoring of home care services during 2010 and 2011, involving visits to each agency and feedback from staff and service users, with follow-up monitoring of progress against areas of non-compliance. Where the monitoring had identified issues, officers had worked proactively with individual agencies to address shortcomings and improve their practice.

5.7 A specific concern was the level of information and safeguarding for people who arranged their care privately.

5.8 Managers and staff of care agencies, CCS NHS Trust, GPs and Age UK all highlighted the need for improvements in communication and collaboration between different parts of the system, particularly in relation to hospital discharge and medication.

Respondents also identified the need for care agencies to operate more flexibly in order to provide personalised services, rather than the standardised service currently available. Because they saw the user every day, there was potential for care staff to make a greater contribution to integrated care and personalised services than at present, including end of life care.

5.9 The Integrated Plan 2012/13 includes a proposal to introduce an electronic call monitoring system for home care services, which would allow home care staff to log in and out for each visit, enable the Council to be charged for the actual time spent with the user, and provide management information. Members identified a number of ways in which this would improve the quality and cost-effectiveness of home care services.

5.10 Based on evidence from older people, carers and those who work with them, the EHRC report, 'Close to Home', recommends actions that local authorities should take to promote and protect the human rights of older people in the way that they commissioned services, and the way that contracts were procured and monitored.

These findings are set out in detail below

6. QUALITY OF CARE

6.1 <u>Overview</u>

6.1.1 Evidence from the service users, the carer, Age UK Cambridgeshire and the care staff that we interviewed showed there was considerable variation in the quality of care that people received. This was also reflected in the feedback from Cambridgeshire Community Services NHS Trust and GPs

6.1.2 Factors that contributed to user satisfaction or dissatisfaction largely revolved around getting the basics right - having regular care staff; who came at the right time, were not rushed, knew what they were doing, and had a caring attitude. While some of the users we spoke to reported that this was their experience, this was far from universal.

6.1.3 An area of concern was that it was apparent from the two individual users and the carer that we interviewed that they had to be assertive and prepared to complain on an ongoing basis in order to obtain a good quality service, and for this quality to be maintained. This implies that users who were isolated or who lacked confidence might be receiving a poor service without bringing it to the Council's attention. In Age UK's experience, care agencies could be slow to respond to problems when people complained

Key issues were as follows:

6.2 <u>Lack of continuity of care staff.</u>

6.2.1 Continuity of staff enables the care worker and client to establish a relationship and to understand each other, and for the care worker to know how the person wants things done. Continuity also helps the care worker to spot any signs of deterioration, and to ensure continuity of care. This is particularly important where the client has dementia or other mental health problems, and may need to be encouraged e.g. to eat, wash or get dressed. One care worker commented that over time you can learn how people communicate, for example with their eyes or with the sounds they make, but you cannot do this in a single visit. Continuity also helps with practical matters such as ensuring clean clothes are put aside for the following day. Care workers themselves found it satisfying to work with the same clients; service users disliked not knowing who was coming, and having to keep explaining things.

6.2.2 The carer we interviewed reported that their relative with dementia had had 28 care staff in a month, subsequently reducing to 19, despite an agreement between the Council and the home care agency that staff would be drawn from a pool of 6. Age UK informed us that in their experience, people could often have 10-15 different carers in a week.

6.3 <u>The need for care staff to have time to do the job properly, and not be rushed</u>.

6.3.1 Care staff reported that it was not always possible to do the tasks in the time allotted if they worked at the clients pace, particularly when caring for people with dementia or if there was a problem such as the client soiling their clothes. There was not always time to talk with users, especially when making short (15 minute) calls. Morning calls particularly could take longer. Care workers typically had very full schedules, with little or no time to travel between clients, so it was difficult for them to spend additional time with users. One example was given of a care worker not being able to stay with a client who was close to death, because of time pressure.

6.3.2 Less conscientious care workers would cut corners, or take people with dementia at their word if they said they did not want something done. One carer commented that social services needed to make a more realistic assessment of the time needed to do the job, which took into account the individuals home circumstances and their ability to cope.

6.3.3 The Council currently contracts for care services on the basis of 15 minute blocks, e.g. 15 mins, 30 mins, 45 minutes or 1 hour, which does not necessarily fit with the actual time needed to do the job.

6.4 <u>The importance of care staff understanding the needs of people with dementia</u>

6.4.1 The Council now requires the induction programme for new care staff to include modules on dementia. It is however up to the care agency whether they provide this to care workers who were employed prior to this requirement, or whether and to what extent they provide more in-depth training on dementia, such as the courses run by the County Council or by Cambridgeshire and Peterborough NHS Foundation Trust's (CPFT) specialist dementia training team.

The future funding of CPFT's dementia training programme, which is available to care home, day services or home care staff was however uncertain .

6.5 <u>Timing of calls</u>.

6.5.1 While care workers generally did arrive within the scheduled time window, it was not unusual for them to arrive early or late, with a range of implications for dignity, general quality of life or safety of service users. This could include, for example delays in getting up or toileting, people arriving at a day centre without breakfast or not properly dressed; having meals too close together; not being given medication at the right time; or simply the frustration of not knowing when or whether the carer would turn up, having to wait for breakfast or a cup of tea, or to get on with the day.

6.5.2 Age UK, Cambridgeshire Community Services NHS Trust and one of the service users highlighted missed calls, especially at weekends and holiday periods. Agencies had contingency plans which prioritised clients on the basis of need, for times of pressure such as holiday periods, cold weather or illness – but this inevitably resulted in some lower priority clients not being seen.

6.6 <u>Quality of care staff</u>

6.6.1 The care workers that we spoke to were conscientious, capable and committed to providing a good quality service for the people that they cared for, often going beyond what they were required to do. User experience indicated that this was true of the majority of care workers. The recruitment practices of the two agencies we spoke to aimed to weed unsuitable candidates out at an early stage. However, it was evident from the experience of users, care workers and Age UK that there was some very poor practice, and that some care staff were not suitable for the job.
Examples members were given include, among others:

- a person with dementia not being dressed, showered, or her lunch prepared although medication needed to be given after food; on one occasion being left in the same clothes several days running
- care worker arriving to provide an evening meal for someone with dementia an hour earlier than scheduled, then leaving without waiting to ensure the meal had been eaten
- communications book in the users home not being filled in properly
- care workers leaving the bathroom or kitchen in a bad state
- care staff not noticing signs of deterioration, such as an uneaten meal from the day before
- lack of basic skills, such as how to prepare a meal
- care staff doing the essential tasks and leaving, without communicating with the service user.

6.7 Medication

6.7.1 Care staff can prompt people to take medication, and can administer it if properly trained. A number of concerns arose in relation to medication. These related both to interagency working, and to day to day practice by the care workers. They included:

- Lack of information to the agency about medication when people are discharged from hospital; they may be discharged with wrong medication, or no medication at all.
- The need for better working between agencies and GPs. One agency commented on the lack of detailed information from GP surgeries to the agency about how and when medication should be administered, or where there are changes to medication. The GP respondent felt that there was a need to standardise the procedures, which varied between agencies, and ensure everyone understood them. This included clarity about the respective roles of the GP and the user's pharmacist
- Care staff not being aware that some medication needed to be taken with food, and not waiting to see that the medication was taken. This relates to training and to communication.
- Medication not being given at the right time, particularly if it needed to be taken with food and the care worker was running early or late
- Care staff not ensuring that dosette boxes, which are individualised boxes containing medications organised into compartments by day and time, were empty before starting a new one, or letting medication run out, resulting in a risk that medication might not be taken correctly.
- Medication action record (MARs) charts, which agencies are required to draw up and use to record the medication taken, need to be filled in correctly and kept up to date. This was not always the case in practice

6.8 Flexibility

6.8.1 The services that were provided were very much based around specific tasks being done at set times. While this routine suits many users, there was little or no flexibility to enable the user to have any choice in terms of how or when the

services were given, even, as one user suggested, to the extent of being able to have an occasional lie-in. The pressure on the service could make it difficult to meet individual preferences.

There is a need for greater flexibility and choice to be built into individual care plans

7. WORKFORCE ISSUES AND PROVIDER CAPACITY

The issues of service quality outlined above were closely linked to workforce and management issues.

7.1 Training, support and supervision

7.1.1 The review has found considerable variation in the level of training, support and supervision that was provided for care staff, with examples of good and poor practice

7.1.2 Agencies were now required to provide induction training, covering for example basic personal care, dealing with challenging behaviour, personal safety, moving and handling, prevention of abuse, and dementia.

7.1.3 Several carers commented that there was a need for a longer period of shadowing (which could be as low as 1 or 2 days) for new workers. Two of the carers we spoke to (who did not work for either of the two agencies we interviewed) felt that they were not adequately prepared for providing personal care such as washing people of the opposite sex in a way that respects dignity or working with people with dementia.

7.1.4 Although personal safety was covered in basic training, the extent to which care staff felt equipped and supported in dealing with situations where people behaved, or might behave, in a challenging or inappropriate way varied. On the one hand, care staff at one of the agencies we visited told us that the agency would only ask staff to do what they felt able to do. On the other hand, we were told of an instance where two female workers had been sent to an individual who had previously assaulted another member of staff.

Currently, only some agencies have an electronic system that enables them to monitor the whereabouts of their staff.

7.1.5 The extent to which care staff were supported, valued and properly supervised varied. The agencies that we visited had regular team meetings and the staff were positive about the support that they received, for example in dealing with a difficult situation or with the death of a client.

This was not however true of other care staff, who felt that they were often not supported or valued, and that the focus of appraisals was on what they were doing wrong rather than praise for doing well. Care staff were not always able to attend a client's funeral.

7.2 Recruitment and retention

7.2.1 Demand for care staff exceeds supply. Agencies find it very difficult to recruit and retain sufficient staff of the right quality, and always had vacancies, particularly in the Cambridge area, where there are plenty of other job opportunities. While recruitment drives would generate enquiries, only a small proportion of these would become long-term employees – though both agencies we spoke to felt that once new staff had gone through the initial period, they tended to stay. One agency estimated that only 10% of enquiries led to a formal job interview – partly because people, particularly those referred via the JobCentre, initially do not understand what the job entails.

7.2.2 The shortage of staff, combined with pressure of demand, led to pressure on both office and on front-line care staff, and it could be difficult to find cover if a staff member was sick, or had to stay with a client because of a crisis.

7.2.3 Staff rotas routinely allowed insufficient time to get between clients. This was an issue both for staff working in Cambridge, where there was traffic congestion, and in rural areas, where staff had to travel long distances. This resulted in staff frequently having to shave time off some clients, run late, and/or work beyond their paid hours, in order to get through their list. There was considerable reliance on staff goodwill for the system to be workable.

7.2.4 The shortage of staffing, particularly in the Cambridge area meant that there was a waiting list for home care provision for new clients living in the community, including those coming out of reablement. It was also very difficult to arrange urgent care

7.2.5 Both the agencies that we spoke to asked for Council support in marketing and recruiting. Suggestions included a recruitment roadshow; working with colleges; a recruitment drive in Eastern Europe, where there were well-qualified people needing work.

7.3 Staff pay and travel costs

7.3.1 Despite the level of responsibility associated with home care work, basic pay levels for care staff could be below £7.00 an hour; one care worker we spoke to was paid the national minimum wage (currently £6.08 per hour) regardless of time of day. The agencies we spoke to had higher rates in some cases, for example for weekend working, working in Cambridge, or short calls.

7.3.2 Agencies did not generally pay for travelling time between clients, which could be considerable in both urban areas (due to traffic congestion) and rural areas where the population was scattered. If travel time was factored in, it is likely that some staff were being paid below the minimum wage, working several hours for a few hours pay. Staff were paid mileage; but the rates, which ranged from 20p to 33p a mile, barely covered maintenance and fuel costs, especially as the latter were increasing. One carer, who did cover work and had a large round, routinely travelled 50 miles a day, and sometimes over 100.

7.3.3 These were major concerns for care staff, and likely to be a factor in recruiting and retaining good quality staff, especially when staff can earn the same or more money in less demanding jobs.

7.3.4 Both the Council and the agencies we spoke to recognised the need for rationalising rounds, which would help address the issue of travelling time, as well as reduce costs.

7.3.5 A number of local authorities, including the Greater London Authority and some London boroughs, other public sector bodies, and some private sector companies have committed to paying their staff a living wage, defined as one which enables a worker to earn enough to provide their family with the essentials of life. Some authorities are also seeking, as far as is legally permissible, to build the living wage in to their contracts with suppliers.

The national living wage (outside London) is calculated by the Centre for Social Policy at Loughborough University. It is currently £7.20 an hour.

7.4 Staff and career development

7.4.1 Members consider that career development, including a clear pathway to obtaining qualifications, is key to encouraging the recruitment and retention of care staff, and to ensuring that care services that are able to meet future challenges as well as current demand. Opportunities for career development were however limited, with implications for the retention of skilled care staff. Both the agencies we spoke to encouraged their staff to obtain NVQ qualifications, and sought to promote internally, but this was not universal.

7.4.2 While there were opportunities for staff to undertake more advanced training this was unlikely to be rewarded by higher pay.

7.4.3 One agency requested that the Council provide more information e.g. on a website, on what training was available, and what providers are accredited, particularly in relation to more specialised training.

8. MONITORING AND SAFEGUARDING

8.1 Members were concerned that the County Council continue to monitor the quality and safety of the services provided by care agencies effectively and on an ongoing basis, and that there was sufficient staff capacity to do so. They considered this an area of risk for the Council.

8.2 One of the concerns was the extent to which Council officers were getting sufficient information to identify poor practice, given the reluctance of some service users, particularly older people, to complain. The system is very reliant on agencies integrity in informing the Council of the complaints, concerns and customer feedback that they receive.
Members were shown one example where a user feedback form had been completed by the care worker.

8.3 There is potential for the Council to work more systematically with independent organisations to obtain intelligence about how well services are working.

8.4 It is important that service users and carers who do want to complain or raise a concern know how to do so, can do it easily, and have access to independent support.

8.5 Members were particularly concerned at the lack of advice and support available to people who arranged their care privately, and their potential vulnerability, for example to financial abuse, especially if they lived alone and/or with no friends or family nearby. At present, the Council will supply on request a list of providers that it contracts with, and refer people to the information held by the Care Quality Commission.

8.6 Such individuals and their carers should have easy access to information that will guide them on what they should expect from an agency, what they can do if problems arise, and what they can expect from the Council in terms of support or safeguarding. One approach could be to work with independent organisations such as Age UK, so that people did not need to contact the Council directly.

8.7 The Council's intensive contract monitoring and follow up work with agencies during 2010 and 2011 had resulted in some improvements. This covered areas such as recruitment and selection, induction and training, staff support, user records, complaints and representations, and feedback from service user questionnaires. Officers had also visited a small number of users of each agency.

However, the current focus of home care monitoring is on resolving problems, and there is limited officer capacity for routine monitoring, which could identify issues at an early stage. It is intended to focus attention on monitoring residential care contracts during 2012.

8.8 Members were concerned that there was no consistent policy on encouraging staff to have flu jabs, or other preventive inoculations, which would help protect the health of both users and staff. At present, policies on flu inoculation are only included within pandemic flu planning.

9. INTERAGENCY RELATIONSHIPS

Respondents identified the following areas where interagency working and communication needed to be improved:

9.1 <u>Hospital discharge</u>

9.1.1 Poor co-ordination between the hospital and the agency was identified by both care agencies as an issue.

Examples included:

- being asked to provide urgent post-discharge care with insufficient knowledge of the patient and what they need, especially if the discharge

took place out of hours
- lack of information about medication
- lack of information about specialist care needs such as a stoma (an abdominal opening with a pouch from which waste products are collected) or PEG feeding (where a feeding tube is implanted in the stomach).
- There was one instance where a care worker only found out that a person had to be fed soft foods because she looked at the letter from the hospital to the GP.

9.1.2 Transport delays on discharge need to be communicated to the care agency. If transport to take the patient home was delayed, care staff were not necessarily told and could make a wasted visit.

9.1.3 Essential equipment such as hoists or pressure mattresses should be in the patient's home by the time they arrive. People were being discharged without equipment, or incontinence pads, so that the care worker had to phone the contact centre to arrange them.

9.2 Relationships with primary care

9.2.1 Direct communication between GPs and care staff is crucial. There was room for improvement in communication and procedures between care agencies and primary care, particularly around medication, end-of-life care, dealing with crises and clarifying expectations of care staff.

9.2.2 As GPs increase their involvement in service planning and commissioning, there is potential for working relationships to be developed between primary care commissioners and agencies, particularly at locality level, that would enable new ways of delivering services.

9.3 Urgent care

9.3.1 There needs to be a straightforward, universally understood pathway to enable a rapid response to changes in a person's care needs. One agency highlighted that if a care worker found during working hours that a client needed an urgent increase in care, the care worker had to raise it with the contact centre, then wait for a response. Agencies needed direct access to someone who could make a rapid decision.

10. DEVELOPING THE SERVICE: PERSONALISATION AND INTEGRATION

10.1 As highlighted in the recent Audit Commission Report, Joining up Health and Social Care, collaborative working across health and social care is of increasingly important in enabling financial savings to be made and improving outcomes for people.

There is potential for home care services to make a much greater contribution to the development of more integrated and personalised services than is the case at present. This will however require different contractual expectations, and development work with agencies to build their capacity.

Specific areas include:

10.2 Personalisation

10.2.1 At present, care agencies are generally not geared to achieving outcomes for users in creative ways, such as enabling people to socialise or to pursue their interests.

10.3 End of life care

10.3.1 Most people want to die at home, but most people die in hospital. The proportion of people dying at home in Cambridgeshire (2008-10 figures) is well above the national average of around 20%, ranging from 24% in Fenland to over 29% in East Cambridgeshire – (Source: National End of Life Care Intelligence Network – South West Public Health Observatory). There is potential to build on this achievement by developing more holistic end of life care that would enable people to die at home, with trained and supported home care staff being part of an integrated 24/7 service.

10.3.2 End of life care needs to be written into individuals care plans, and kept up to date, so that care staff can be part of the total care provision for that person throughout this period. When GPs review people's end-of-life plans, agencies should be routinely informed of any changes.

10.3.3 There is also a need to ensure that there are clear arrangements with partners to cover the situation where a care worker finds that a client is close to death

10.4 Falls prevention and admission avoidance

10.4.1 There is potential to develop initiatives, which could be piloted on a locality or practice level basis, involving joint working between skilled care workers, district nurses, and GPs.

10.5 Reablement

10.5.1 Care agencies should be seen as a partner with the NHS in providing integrated and seamless reablement, both in relation to people being discharged from hospital, and those in the community

11. ELECTRONIC CALL MONITORING

11.1 Members support the proposal that the Council purchases a single electronic call monitoring system which all agencies are required to use, as this could help to address some of the issues arising from the review. The system could fulfil a range of functions including:

- Time management – identifying how long the worker spends with the client. This would enable the Council to contract with agencies for the time actually needed to do the job, rather than in 15 minute blocks. It would also enable the agency to identify and follow up issues relating to both management of staff and changes in client needs.

- Ensuring that the Council pays for the service that is actually delivered
- Helping to ensure care workers personal safety
- Monitoring travel time and distance – highlighting inefficiencies and where staff rotas or pay needed to be changed.
- Instant reporting of changes and additional services required
- Tool for crisis management
- Orders for supplies
- Monitoring of level of continuity/change of care staff going to an individual
- Identifying and communicating any need for review, and enabling constant re-assessment
- Recording of what has been done .e.g. providing medication. The system should require staff to put their name to what they record they have done. Other care workers should be able to access this information
- Responding to last-minute timetable changes
- Enabling the agency to have live map of where carers and clients are.

11.2 In order to be effective, the system needs to operate alongside good quality management, which includes flexibility and good communication between management and staff. It should not simply be viewed as a tool for policing staff. Care agencies should introduce and use the system on the basis that staff can be trusted to use their time sensibly, for example in allowing for some calls on occasion taking less or more time than scheduled if the situation warrants it.

11.3 The system should as far as possible be compatible/able to connect with other systems e.g. Cambridgeshire Community Services NHS Trust

11.4 The Council should bring agencies together to look at how they can work with each other and with the Council to promote best practice in the development and use of the new system.

12. A HUMAN RIGHTS APPROACH

12.1 The EHRC report 'Close to Home' drew on evidence from service users, carers, voluntary organisations local authorities and service providers to find out the extent to which the human rights of older people receiving care in their own homes are fully promoted and protected. While around half the older people expressed satisfaction with their home care, the evidence revealed many instances of poor care that raised human rights concerns. It considered that many of these problems could be resolved if local authorities promoted and protected human rights in the way that they commissioned services, and the way that contracts were procured and monitored. Issues highlighted include:

- Commissioning for quality and not just on price
- Flexibility of services, moving away from a time and task approach
- Monitoring that focuses on outcomes and not just processes
- Addressing the low pay and status of care workers – including payment for travel time
- Information that would enable people, including those making their own

care arrangements, to make informed choices about what care they wanted and from whom.
- Opportunities for people to raise issues about their home care services without making a formal complaint
- Support and brokerage for people interested in self -directed personalised home care.

13. RECOMMENDATIONS

13.1 A human rights approach

Recommendation 1
The Council explicitly promote and protect human rights in the way that it commissions home care services, and procures and monitors contracts, and report back to the Adults Wellbeing and Health OSC how it has implemented the recommendations of the EHRC Close to Home report

13.2 Contracting for quality

Recommendation 2
Agencies bidding for contracts should be required to provide evidence of how they will be able to achieve what is expected of them, and deliver a safe high quality service. This includes how they will ensure that:

- they have the capacity to deliver the service throughout the year, including holiday periods and periods of high demand
- they have the capacity to provide urgent care
- they have the management capacity and processes to underpin a high quality service
- staff are trained to a level that enables them to meet the assessed needs of the clients that they care for, including those with dementia and other specialised needs.

Agencies should be required to set out what staff should expect from the agency, and what the agency should expect from staff, in order to achieve this.

Recommendation 3
The contract should clearly specify what is expected of the agency in terms of ensuring personal safety for staff, and the agency should evidence how it will address this.

13.3 Training and Development

Recommendation 4
The Council work proactively with agencies, training providers and partners to ensure that :

- care agencies can access appropriate and affordable training for their staff, including training provided by the Council, which will enable them to meet the needs of the clients that they care for. This includes:

- Generalist training. which should include adequate training in personal safety
- Specialist training, including end of life-care; caring for people with dementia and caring for people with mental health issues.

This includes working with the NHS to ensure the availability and provision of specialist dementia training.

- care agencies have easy access to Information about what accredited training is available e.g. through a Council website.

13.4 Staff pay

Recommendation 5
The Council:

- ensure that every agency it contracts with pays at least the minimum hourly wage including time spent travelling.

- work proactively with agencies as far as legally permissible to encourage them to pay at least the national living wage.

This should be linked with an open book approach, in which agencies are asked to provide a breakdown and explanation of their costs, including overheads.

Recommendation 6
The Council works with agencies, as far as is legally permissible, to identify and implement pay strategies that recognise the need for differential pay in different parts of the County, are realistic about mileage costs, and that rewards staff who increase their skills and qualifications, and undertake more skilled work.

This includes identifying where agency contracts with staff need to be changed in order to ensure there are sufficient staff of the right quality to provide the services required, for example guaranteed hours rather than zero hours contracts.

13.5 Payments under the contract

Recommendation 7
The Council:

- require agencies to give a clear breakdown of their costs

- examine this information to identify whether the rate the Council pays to agencies needs to be changed, and/or differential rates paid for different types of activity or for services in different parts of the County, in order to meet the assessed needs of service users

- allocate resources in the light of the above

13.6 Staff recruitment and retention

Recommendation 8
The Council work with agencies to develop career pathways for staff, including the opportunities to develop and utilise specialised skills.

Recommendation 9
The Council work with agencies to actively promote care work as a career. This could be, for example, by arranging recruitment events, liaising with colleges, or facilitating recruitment from other EU countries.

13.7 Service monitoring and safeguarding

Recommendation 10
The Council ensure there is sufficient monitoring officer capacity to review and provide evidence of the quality of care provided by all agencies on an ongoing basis, including visits to individual users, thus ensuring that issues can be identified and addressed at an early stage, and that standards of care are maintained. This would enable the Council to build on the focused monitoring work undertaken with providers during 2010-2011.

Recommendation 11
The Council reviews its safeguarding arrangements for home care users to ensure that they are as robust as possible.

Recommendation 12
The Council work more systematically with partners and with voluntary organisations to ensure that concerns about quality of care are identified and communicated back to the Council.

Recommendation 13
The Council work with independent organisations to develop mechanisms by which service users and carers, including those who arrange their care directly, can easily feed back concerns to the authority or to an independent body, and have support in doing so.

Recommendation 14
The Council work with independent organisations to ensure that Individuals who arrange their own care have easy access to information that will enable them to make informed choices, know what to do if problems arise, and have access to support if quality or safeguarding issues arise.

Recommendation 15
Agencies should be required to actively promote and pay for flu jabs, and other inoculations as appropriate, for their staff, and ensure that staff do not come to work while sick.

13.8 Electronic call monitoring

Recommendation 16
The Council take forward its proposal for electronic call monitoring, incorporating the comments made in Sec 11 of the report, working with agencies to promote best practice in the development and use of the new system

13.9 Interagency working

Recommendation 17
The Council work with care agencies and partners to improve co-ordination and joint working in relation to

- hospital discharge arrangements
- primary care, including arrangements for medication
- rapid arrangements for urgent care

Recommendation 18
The Council work with care agencies and GP leads to develop the working relationship between agencies and primary care commissioners, at both County and locality levels.

13.10 Personalisation

Recommendation 19
The Council work proactively with agencies to develop their capacity to provide more personalised and outcome focused services, tailored to what people wanted, such as going on outings or taking part in activities. This includes

- using the tendering and contractual process to commission a wider range of services
- building flexibility into the care plan, for example by allowing for variation in the times when services are provided, where this accords with user choice.

13.11 Service Development

Recommendation 20
The Council

- proactively explore with agencies, GPs and other partners ways in which care workers can play a greater role in developing integrated care, particularly in relation to end of life care, admissions avoidance, and falls prevention.

- work with partners and agencies to take forward service development initiatives in relation to the above, by developing and evaluating locality based pilot projects.

13.12 Efficiencies

Recommendation 21
The Council work with agencies, and encourage them to work with each other to identify efficiencies, with particular reference to:

- rationalising staff rotas and travel times
- shared purchasing.