NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 19 May 2016 from 13.30 - 15.45

Membership

Present	Absent
Councillor Ginny Klein (Chair)	Councillor Carole-Ann Jones
Councillor Anne Peach (Vice Chair)	
Councillor Corall Jenkins	
Councillor Dave Liversidge	
Councillor Chris Tansley	
Councillor Jim Armstrong	
Councillor Merlita Bryan	
Councillor Patience Uloma Ifediora	

Colleagues, partners and others in attendance:

Fiona Branton	-	Nottingham CityCare Partnership
Jo Powell	-	Nottingham CityCare Partnership
Kate Whittaker	-	Nottingham CityCare Partnership
Steve Oakley	-	Contracting & Procurement, Nottingham City Council
Sharon Ribeiro	-	Contract Performance Care & Support, Nottingham City Council
Jane Garrard	-	Senior Governance Officer, Nottingham City Council
Kim Pocock	-	Governance Manager, Nottingham City Council

55 APPOINTMENT OF VICE CHAIR

RESOLVED to appoint Councillor Merlita Bryan as Vice Chair for the 2016/17 municipal year.

56 APPOINTMENT OF LEAD HEALTH SCRUTINY COUNCILLOR

RESOLVED to appoint Councillor Anne Peach as Lead Health Scrutiny Councillor for the 2016/17 municipal year.

57 APOLOGIES FOR ABSENCE

Councillor Carole Jones (other commitments).

58 DECLARATIONS OF INTEREST

None.

59 MINUTES

The minutes of the Health Scrutiny Committee meeting held on 17 March 2016 were agreed and signed by the Chair.

60 HEALTH SCRUTINY COMMITTEE TERMS OF REFERENCE

Jane Garrard introduced a report of the Head of Democratic Services, detailing this Committee's terms of reference. The Chair asked all members of the Committee to note these.

61 NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2015/16

Fiona Branton (Head of Prevention Control), Kate Whittaker (Head of Patient and Public Involvement) and Jo Powell (Communications), of CityCare Partnership gave a presentation on progress in achieving priorities in 2015/16 and the new priorities proposed for 2016/17.

Key issues highlighted were:

(a) The final Quality Account report will be completed in the week commencing 27 June 2016.

(b) Progress made on 2015/16 priorities is as follows and the work will continue alongside new priorities:
- **Stop the pressure** (pressure ulcer reduction)- as part of the East Midlands campaign a range of initiatives have resulted in a continuing reduction of stage 3 sores, thereby impacting on the quality of life for patients.
- **Duty of candour** – being open and honest underpins a new organisation policy and over 25 services have received relevant training, which continues to be delivered.
- **Patient Experience Group** (PEG) – the PEG has been involved in several initiatives (including the recent changes to urgent care and the establishment of the new Connect reablement facility) and peer reviews (mock Care Quality Commission inspections) through observations, interactions and the provision of feedback. Patients are often more inclined to speak to members of PEG than to service leads.
- **Carers** – a carers' conference has been held and a new carers' strategy developed and implemented. CityCare continues to work closely with the Carers' Federation and other relevant agencies.

(c) A number of engagement events have been held with staff to develop and shape new priorities for 2016/17 as follows:
- **Caring for and supporting staff so they can continue to provide high quality care** - actions will include developing line management skills, implementing an integrated supportive supervision model, as well as developing and implementing a Human Resources and Workforce Strategy.

The aim is to improve employee experience and create a healthy workplace and workforce, so enhancing the quality of services.

- **Focus on mental health knowledge and skills with reference to the mental capacity strategy** – actions will include developing a mental health strategy and a primary care mental health service with improved signposting and support. More recognition of low level concerns and appropriate referral will prevent patients becoming high risk.
- **Self-management; promoting long term behaviour change and increasing awareness** – actions will include using social prescriptions to meet wider needs, introducing Enablement Care Co-ordinators (Council employees) into neighbourhood teams and improving co-ordination of care by bringing together health and social care staff to equip people with the skills to retain independence and reduce unnecessary hospital admissions. There will be a focus on developing a new care pathway for type 2 diabetes patients.
- **Reducing avoidable harm** – actions will include establishing patient focus groups to explore what it means to be safe, patient safety walkabouts by directors to identify issues to address and peer reviews. The aim is to increase the confidence of staff and patients to report concerns and so reduce avoidable harm incidents.
- **More integration with partner organisations in service delivery** – actions will include integration of Health and Social Care Reablement and Urgent Care Services by March 2017

The following points were raised in discussion:

(d) Establishing the role of Enablement Care Co-ordinators will enable services to pick up those who fall just below the threshold for adult social care. Early involvement and prevention will address needs before a situation becomes more serious. Patients will be identified through neighbourhood teams, which include GPs and district nurses and through adult social care assessments.

(e) Further work will be done to ensure that GPs are part of discussions and planning to ensure that a patient's needs are viewed widely rather than focusing on the one issue that is presented for a GP appointment. Social prescriptions are being piloted in Bulwell and are working well.

(f) Members of PEG are largely lay people and while there is good representation across disability and age, there is more work taking place to improve BME representation. In order to ensure a diverse population is consulted, CityCare also does consultation work with a range of forums outside PEG.

(g) CityCare will be looking at end of life care access at weekends, following the scrutiny review carried out last year.

(h) CityCare discusses new ideas and pilots etc with commissioners before putting them into action.

(i) An easy to read summary document of the Quality Account will be available when it is published.

RESOLVED to

(1) thank Fiona Branton, Kate Whittaker, and Jo Powell for their presentation on the Nottingham CityCare Partnership Quality Account and to note the positive progress;

(2) agree that Jane Garrard, Senior Governance Officer would draft comments to be included in the CityCare Quality Account to be circulated to members of the Committee by email and signed off by Chair prior to submission to CityCare.

62 HOMECARE QUALITY

Steve Oakley, Head of Contracting and Procurement, Nottingham City Council gave a presentation to the Committee, highlighting the following:

(a) **Framework Providers.** Six framework providers are currently contracted to provide Homecare and they deliver about 75% of provision. These contracts have approximately 18 months left to run. Spot providers pick up 25% of work ie when framework providers cannot pick up packages. Approximately 56,492 hours of care are delivered each month.

(b) A **Quality Monitoring Framework tool** is used to measure quality of provision, using 43 indicators, on an annual basis and the results are published. The same framework is used for all types of care eg residential care, day care etc. Robust guidance is given to providers outlining expectations and required evidence and outcomes. A scoring system is used to highlight excellence as well as poor performance. Commissioners are looking for a steady improvement in quality. Visits in 2015/16 to providers revealed a 3% - 35% improvement in performance from 2014/15. All providers are achieving performance rates of at least 65% up to 84%. Top performance would be considered 85%+ and all providers are seen to be moving in the right direction with the likelihood that the majority will perform in this band over the next year.

(c) **Performance Management**. Performance is actively managed through monthly meetings with providers. Where there is under performance, action plans are put in place. The Council works closely with Nottingham City Clinical Commissioning Group (CCG) through monthly contract meetings and with other agencies across the city to ensure that information is shared, eg Safeguarding, Health, Social Care. Where performance issues are identified, the most appropriate agency will pursue the improvement action.

(d) **Contract Compliance Escalation**. The Council participates in investigations where these are necessary and leads on the Provider Failure Procedure, ie the process for improving and terminating arrangements. Very few contracts are terminated but the process exists for issuing a notice of requirement to improve, contract suspension (where the provider continues with existing work but receives no new work) to termination of contract. The process can be activated at any stage.

(e) **Working Together**. The Council is working with NHS Commissioners and the County Council to look at quality provision. It can be difficult to know what the markers for concern are in people's own homes, so it is helpful to work together with others to identify these. Working together also streamlines processes for managing poor performance. Working closely with providers helps commissioners to understand the challenges and pressures of service delivery.

(f) **Pricing for Care at Home services**. Financial modelling was carried out for 2016 using a range of consultation activity and proposals were agreed as part of the Budget by full Council. Nationally, recruitment and retention present challenges in this market which can impact on the ability of providers to deliver services in line with their contract. There is ongoing discussion between senior managers and the portfolio holder on whether prices should be further increased.

(g) **Moving forward** – The current Framework Agreement is due to end in December 2017. The Council is in discussion with the County Council as they have contracts due to end at a similar time. The aim is to establish a dynamic purchasing system which supports a more formal process for spot purchasing to run alongside the Framework Agreement.

The following points were raised in discussion:

(h) There can be a tension between the quality desired and the funding available to pay for services. One of the key issues is stability of the workforce. Recipients would generally prefer a relationship with their carer ie the same person coming to their home as often as that is possible. However the turnover of staff in the homecare market is high – approximately 20%.

(i) The current hourly rate paid to carers is usually only just above minimum wage. There are high sickness levels, which may be affected by the nature of the work. Carers may work for a number of providers and the work is often done by people for a short period in their work lives. One of the lowest paying providers has been the best performer and retainer of staff so it is difficult to identify the influences on staff retention. The Council is looking, with providers, at a range of issues which could affect retention of the workforce, including pricing, provision of quality training, standards and accreditation processes.

(j) Many carers are on zero-hour contracts. This suits some carers but not others. Other types of contract have been considered, but it can be difficult to get the balance right as care needs can vary for the provider. Carers' forums are being used to tackle the isolation of carers, which is inherent in the nature of the work, and to encourage them to raise their concerns and discuss issues such as sickness schemes and how to ensure that they are equipped to deal with what can come up in their work.

(k) Some carers do report that they don't have enough time allotted to do what is required in the home visit. Better pay and contracts may mean more security which could alleviate this. Visits under 30 minutes are now only used for wellbeing and medicine checks. Outcome based commissioning would focus on what is delivered not on the time spent. This model is being considered but is complex and will take at least six months to develop.

(l) The Quality Assurance Framework uses the same 43 indicators for all types of care but the guidance to providers differs depending on the type of care.

(m) Spot contracts require more monitoring than Framework contracts as there are not regular monitoring meetings and the contractual arrangements are different. From an administrative point of view they are more labour intensive as well. Whilst spot contracts will always be needed as all eventualities can't be planned for, the intention in the long term is to reduce the number of spot providers and to better monitor the standards of spot providers.

(n) The performance target of 85% and higher is a challenging target in the light of high staff turnover (management and seniors as well as carers) but it is aspirational to demonstrate that there can always be improvements.

(o) All safeguarding concerns are logged and information is shared between agencies on a regular basis. The intention is that homecare will be integrated with safeguarding support and social care support in the future.

RESOLVED to

(1) thank Steve Oakley and Sharon Ribeiro for their presentation to the Committee;

(2) schedule a future agenda item to look at homecare quality from a safeguarding and social care perspective.

63 REVIEW OF END OF LIFE/ PALLIATIVE CARE SERVICES - RESPONSES TO RECOMMENDATIONS

The Chair noted that responses to the Committee's recommendations from the End of Life Care Review, carried out last year have now been received. Six recommendations have been accepted and 1 partially accepted. Organisations responsible for implementing the recommendations have been asked to keep the Committee updated as actions progress.

RESOLVED to schedule a review of progress in implementing the recommendations of the End of Life Care Review for the November meeting of the Committee.

64 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2016/17

RESOLVED to

(1) Add to the work programme:
(a) follow up the issues raised by the ME Self Help group last year in relation the provision of services to ME patients; and
(b) consideration of services and support available for lupus and sickle cell;

(2) note that any councillor can propose an item for scrutiny by speaking to the Chair of the Committee or to the Senior Governance Officer for discussion by the Committee as part of its work programme planning.

65 FUTURE MEETING DATES

The Committee agreed to meet on the following Thursdays at 1:30pm:

- 30 June 2016
- 21 July 2016
- 22 September 2016
- 20 October 2016
- 24 November 2016
- 22 December 2016
- 19 January 2017
- 23 February 2017
- 23 March 2017

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