ISLINGTON

REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

ADULT PAID CARERS

London Borough of Islington
June 2020

CHAIR'S FOREWORD

COUNCILLOR OSH GANTLY
Chair of Health and Care Committee

Adult Paid Carers - Scrutiny Review

Evidence

The review ran from June 2019 until June 2020, and evidence received from a variety of sources:

1. Presentations from witnesses – Jess McGregor, Jon Tomlinson – Housing and Adult Social Care, L.B.Islington, Simon Bottery – Kings Fund, Sayeeda Ahmed – Snowball Care UK Ltd., Ian Haddington- MiHomecare, Caleb Atkins –City and County Healthcare, Colin Angel –UK Homecare Association, Adult Paid Carers – MiHomecare and London Care, Duncan Patterson – CQC, Stephen Day, Nicola Herrera-Martinez, Direct Payments Team, L.B.Islington, Sweet Tree Specialist Care – Nikki Bones, Denis Repard, Centre 404 – Jo Mackie, Wellbeing Teams – Helen Sanderson
2. Documentary evidence – Letter from Bob Padron – Penrose Care

Aim of the Review

To review the current position regarding paid adult domiciliary care workers in L.B. Islington including; funding, numbers, contractual arrangements, funding, numbers, delivery arrangements, and their effectiveness

To consider other models of commissioning and delivery in place of other parts of the country

To advise on any changes that need to considered/implemented to the strategic direction for providing care support to people in their own home

Objectives of the Review

To consider numbers and profile of paid Carers in Islington, and consider any benchmarking data
To examine the requirements of commissioned providers in respect of adult paid carers, in terms of: remuneration, quality assurance, and risk assessment, training, travel time, payment of LLW, and how cultural/specialist needs are being met
To examine the area of Direct Payments
To examine the effectiveness of the current arrangements
To examine the different models of commissioning and delivery of care at home currently in place elsewhere, including any in house service delivery models
To consider any actions that may need to be taken in the light of the findings of the review, to ensure that L.B.
Islington effectively supports citizens to remain independent, healthy and part of their local community
To consider how local providers can be assisted to bid for contracts for Adult Social Care

How to promote caring as a career choice
New models of care – innovative Local Authorities
Charging Policy

The Scrutiny Initiation Document (SID) is included in Appendix ‘A’ to the report

RECOMMENDATIONS:

The Committee heard evidence that there is scope for new technologies to improve the service for clients, and to reduce costs for commissioners, and providers. Such examples include electronic care plans, electronic medication charts, and the ability to meet some specific service user needs via mobile devices. The Committee noted that the Telecare system is currently under review, with the aim of increasing the use of technology, in order to improve the quality of life for those in receipt of care

(a) The Committee therefore recommend that providers and commissioners investigate, and continue to introduce new technologies, wherever available, to provide a better service to clients, and to improve co-ordination with carers

The Committee heard evidence that carers view is that information is not provided as effectively, and as quickly as possible, in relation to details of clients' needs, especially in relation to discharge from hospital. This lack of timely information impacts on the ability of carers to provide the most effective service possible to clients

(b) The Committee therefore recommend that there should be exploration of the opportunities presented by 'Fairer Together' for improved co-ordination between commissioners/NHS, (see paragraph 69) and providers, and to ensure the conveyance of the correct information to carers in relation to client's needs. This is especially in relation to discharge of clients from hospital to ensure the administration of the correct medication/assistance etc. Opportunities for introduction of new technology, as recommended in (a) above can assist in this

The Committee heard evidence that continuity of care and personalised care and support is important. Carers suffered in terms of loss of pay, from the amount of downtime that they experienced between appointments due to the client's requirements for assistance getting into bed/getting up at similar times. This affected the ability of some carers to maximise their income, and in addition created difficulties/inconvenience for client

(c) The Committee therefore recommend that commissioners and providers consider opportunities for enabling a more personalised and efficient home care system. There should be a focus on overall wellbeing outcomes for service users, rather than a list of specific tasks to be undertaken at specific times of the day. Opportunities may include better utilisation of personal budgets, and geographical zoning, whereby a provider has a set budget for each service user, based on their needs, to deliver a personalised service, which would reduce downtime/travel time for carers, and enable improved efficiency. Continuity of care is important

The Committee heard evidence that there are potential opportunities to improve the quality and speed of discharges from hospital. Providers are sometimes unable to respond quickly and flexibly to clients' changing needs, as they are limited in their ability to make changes to care plans. This should explore how commissioners, providers and social workers can work together, in order to ensure more timely and responsive changes to care packages in line with clients changing needs

(d) The Committee therefore recommend that consideration be given as to how the Council can make best use of the expertise and skills of providers and carers. In addition, consideration should also be given to consider opportunities to empower and place more trust in providers, and carers, to make decisions about the care and support clients require, from discharge from hospital to making adjustments to care packages, as needs change. This may include exploration of new roles given the need to recruit and retain more carers. The Council should also explore opportunities for more regular reviews from providers and the Council, to enable the care needs of users to be checked more frequently, in order to ensure that there is no over/under provision of care.
The Committee are also of the view that given the shortage of home carers, a situation likely to increase, commissioners and providers should investigate possible recruitment/retention measures to help alleviate shortages of carers

(e) The Committee heard evidence that there are 'untapped' opportunities to improve career pathways into home care, and career progression within health and social care. The Committee also recommend that consideration be given to career pathways and progression for carers, as part of the wider efforts of Islington's Health and Care Academy, which aims to support providers to recruit local people. Commissioners should explore which social value clauses and good employment practice stipulations, including for small/local providers, would be appropriate to include in future specifications and contracts. This would enable more local residents to also be employed who will contribute to the local economy

The Committee were impressed with the commitment, and excellent work, that carers provided for clients in Islington. The Committee heard differing evidence as to whether carers wished to be offered guaranteed hour contracts, or whether they preferred the flexibility provided by zero hour contracts. In addition, the Committee heard that carers are unpaid for the time that clients are hospitalised, if alternative work is not available. The Committee also noted concerns that carers often experienced problems when having to claim sickness pay, and that this process in their view, could sometimes be complicated

(f) The Committee therefore recommend that caring should be promoted as a profession, and that providers should offer all carers guaranteed hour contracts, rather than zero hour contracts, even if carers did not then wish ultimately wish to take up a guaranteed hour contract. There should be exploration of the benefits of a discontinuation of 'minute by minute' charging, in order to reflect the recommendations in (c) and (d) above. Please note that there is no requirement to commission on a 'minute by minute' basis and many councils have chosen not to commission in this way.

The Committee are impressed with the excellent and difficult work that carers often have to do and their commitment to their career. The Committee therefore also recommend providers consider compensating/finding alternative work for carers, in the event of clients being hospitalised. In addition, providers should ensure that the process for claiming and payment of sick is simplified

The Committee heard evidence that the introduction of Individual Service Fund payments (ISF's), into learning disability payments is working well. Direct Payments enable clients to have more flexibility/control over their care and assist in the move to an outcome based service recommended in (c) above

(g) The Committee therefore recommend that commissioners, as part of broader market development, explore the appetite and capacity for delivering personalised services through Individual Service Funds, or Direct Payments

The Committee heard evidence of the benefits of taking a relationship based approach, and a stronger enablement approach, together with integration of different types of support

(h) The Committee therefore recommend that the Council works with clients, their relatives and providers to review the Council services to people in their homes, and to explore opportunities for improvements that will better support residents to maintain independence and improve wellbeing

The Committee heard evidence that carers sometimes suffered racist/physical/verbal abuse from clients. The Committee felt that this was unacceptable, however as the Council has to continue to provide care in such cases there should be appropriate specialist advisers/training provided, in order to ensure that such instances are dealt with in an acceptable manner

(i) The Committee therefore recommend the institution of a zero tolerance approach in instances of verbal/physical/racist abuse, and commissioners/providers should take effective action. Commissioners should engage specialist providers who offer their staff appropriate specialist training, including gender/culturally appropriate training, in order to meet the needs of service users with challenging behaviours, and to minimise the effect on carers. In addition, providers should provide the most appropriate 'matching' of carers to clients as possible in respect of gender/cultural needs

The Committee recognise the excellent service that carers provide, and were concerned that carers, especially female carers, stated that they sometimes experience safety concerns, and attending clients

(j) The Committee therefore recommend that the Council explore the possibility of providing parking permits for carers working late at night that have to use their car. The Committee also support the Mayor of London's election manifesto commitment to provide concessionary London Transport fare passes for carers for the disabled, if he is re-elected

The Committee heard evidence that the increasing elderly population, who have ever more complex and multiple needs, will in the future place a growing need for additional social care resources, whilst at the same time as social care is still not being adequately funded by Central Government

(k) The Committee are concerned that that the Green Paper on Adult Social Care, scheduled for publication many months previously, has still to be published. The Committee therefore recommend that Government adequately fund social care for Local Authorities, and implements a fundamental change to its long term funding position, as soon as possible. There is an urgent need to address the implications of a growing ageing population, who will have increasing and ever more complex needs

The Committee heard evidence that the creation of integrated team work between providers/commissioners/NHS and social care can be utilised to carry out preventative work that may assist in keeping those receiving care out of hospital. This could include ensuring regular hydration, falls prevention, checking for infections etc.

(l) The Committee therefore recommend that a more integrated approach be taken to preventative care in order to reduce hospital admissions, and commissioners should work with providers, social care and NHS in this regard. An example of an integrated approach could include a combined homecare and district nursing team. There are many opportunities to integrate between health and social care and integration could take many different forms.

MAIN FINDINGS

Evidence from Jess McGregor/Jon Tomlinson – L.B. Islington, Simon Bottery, Kings Fund

1. Domiciliary/Home Care is the front line delivery covering personal care, help with washing, dressing and eating, to people with long-term care needs. It is a core service provided by most Local Authorities. Home Care can also extend to reablement services for people leaving hospital, or receiving crisis interventions to avoid hospital attendance in the first place. This can include household tasks, to help people remain independent

2. The core purpose of Adult Social Care and support is to help people to achieve the outcomes that matter to them in their life. Local Authorities must promote wellbeing when carrying out their care and support functions, in respect of a person. The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or making a decision in relation to a person. Wellbeing is a broad concept, but relates to the following areas in particular – personal dignity, physical, mental health and emotional wellbeing, protection from abuse and neglect, control by the individual over day to day life, including care and support provided, and the way it is provided. Also included are participation in work, education, training, or recreation, social and domestic wellbeing, suitability of living accommodation, and the individual contribution to society

3. Local Authorities Care Act responsibilities include market shaping, and commission of adult care/support. Local Authorities should encourage a wide range of service provision to ensure that people have a choice of appropriate services that respond to fluctuations and changes in peoples care and support needs. Local Authorities also have a range of responsibilities around the wider care and support workforce, and must have regard to ensuring sufficiency of provision

4. The estimate in England each year is that there is delivery of 249 million care hours. In 2015 it is estimated that 350,000 older people to have used the service, 25,700 of whom had their care paid for by the Local Authority. A further 76,300 younger people with learning disabilities, or mental health issues were also estimated to have publicly funded home care

5. Home Care agencies employ around 680,000 people, but more carers will be required in the future, as the number of elderly in the population increases. Currently there are around 11,000 vacancies at any one time. The average package of care commissioned is 10.8 hours in duration, and 7% of the packages of care are based on outcome focused commissioning

6. The average lowest price for a care package was £13.64 per hour, and highest £21.69. The average price of homecare across the region is £16.63. 4 Boroughs commissioned 50% or more of their homecare needs for the requested week from 2 providers

7. Adults in L.B. Islington, aged 65 or above, make up 9% of the population. In 2017, there were an estimated 20,786 older adults in Islington, and an estimated one fifth of older adults across Islington and Camden are from BAME communities. By 2035, the older adults figure is set to grow to 12%, a 605 increase in older adults. It is expected that the sharpest increase is to be amongst the very old, people aged 85 or over

8. In terms of package size, large block and spot contracts, over 14 hour or over per week, has an annual cost of £9,793,071.49, with annual hours of 564,068.39. Medium/large contracts/spot contracts of 7-14 hours weekly have an annual cost of £3,966,272.50 with

annual hours of 225,478.75, and small block and spot contracts of 7 hours per week, have an annual cost of £1,993,176.46, with annual hours of 113,276.88. This is a total annual cost of £15,752,523.45, and annual hours of 902,824

9. There are 23% small packages, 19% medium packages, and 40% of large packages placed with spot providers. The hourly rate paid for block- contracted hours is £18. A small package may typically include shopping, lunch calls, supplemented by day centre or outreach support. A large package may include 4 calls a day, meals and a bedtime call

10. Following a procurement process, there had been block contracts awarded to five homecare agencies in September 2018, for a 4-year term, with the potential to extend 2 plus 2 years. Following the failure of Allied Healthcare in December 2018, there are now 4 block contracts and these are with MiHomecare, CRG, London Care and Mayfair

11. Following the collapse of Allied Healthcare, the Council had been able to cope with the situation well, and block contracts transferred to other providers. The Council had needed to ensure that there was an adequate mix of contracts to suit resident's needs, and this is kept under review

12. The Committee noted that the Council, when letting the contracts, had only chosen to contract with 5 block providers through the procurement process

13. Quality assurance for the block contracts is provided by contract officers, who are responsible for holding providers to account, and implementing performance improvement plans, where necessary

14. There is also an LBI reablement team based in provider services within Adult Social Services. Block contractors provide support to around 800 LBI residents, with a projected spend of £9.5m. Spot purchase providers support a further 300 LBI residents, with a projected annual spend of circa £5.2m

15. There are over 17000 hours of domiciliary care commissioned across the borough every week. 1100 people receive domiciliary care packages every week. In one week in March 2019, there were around 400 carers delivering services through block contracts. Overall placements in residential/nursing care, paid for by LBI, have reduced since 2013/14 from 542 to 425 in 2018/19. The biggest reduction has been in standard residential care, where numbers over the same period, has dropped from 84 to 36

16. Islington carers are well- remunerated, in comparison to other providers, and block providers paid the LLW. Work is also taking place to investigate the payment of the provision of the LLW to spot providers, as spot provision is quite high

17. Some block providers found it difficult to meet specific needs, however there is no evidence that residents are going without care. However, it is felt that there is a need to assess care requirements at an earlier stage, when a resident is hospitalised. The Committee noted that the Telecare system is currently being reviewed, with the aim of increasing the use of technology, in order to improve the quality of life for those in receipt of care

18. Nationally, there are differences between the rural, and urban market, for care. It is often more expensive to provide care in rural areas, due to the travelling distance times. In affluent rural areas, it is more difficult to attract staff, as pay rates needed to be higher. There are currently 9,000 home care providers, but there is a high turnover, as it quite easy to set up a company,

however a large number of these new companies experience problems in operating a service, and then cease to be viable

19. In terms of commissioning and rates of pay, this varies across the country. In the North - East it is about £14 per hour, rising to £18 in the South West. Greater London is roughly £16 per hour, however Islington is the third highest payer in London, paying £17.71 per hour. The trend nationally is that hourly rates are rising faster than inflation

20. With regard to the carers' workforce, there are 50% of carers employed on zero hour contracts, and 38% of carers leave their provider within a year of starting employment. However, they often move to a different provider for an increased hourly rate. There is approximately a 10% vacancy rate across the profession. The payment rate for carers is complex, and different providers calculated pay rates in a different way. The Committee noted that in the view of providers many carers favoured zero hour contracts, as this gave them more flexibility

21. BREXIT is likely to have an impact on the workforce, at a time when the projection is that the elderly population will increase. This, combined with the 10% vacancy factor that already exists in the care service will be problematic

22. 92% of home care is provided by the independent sector, and the other 8% are mostly reablement services. In house service provision tended to be twice as expensive as private provision however, provision of reablement services may be a factor in this. In addition, Local Authorities had certain overheads that they had to incur, such as pension costs, better terms and conditions etc. than are available from private providers

Evidence from UK Homecare Association – Colin Angel Policy Director

23. The Committee also received evidence from the above.

24. The number of people affected by state funded market failures has shown a significant increase due the number of contracts 'handed back' by providers, or in instances where a provider has ceased trading. This has been a feature in both in the residential, and home care sectors

25. The current practice of the majority of Councils is to have a high usage of zero hour contracts. In order to achieve economically efficient guaranteed hours contracts for carers, Councils would need to recognise and pay the full costs of contact time, travel time and costs, as well as down time. Councils would need to pay the employer the costs of the entire span of the carer's duties, and their travel costs. Council's would also need to commission services in a way which increases workforce utilisation, e.g.by zoning areas, and moving away from framework agreements, to contracts with guaranteed purchase

26. The Committee heard evidence that flexible/zero hour contracts were popular with the majority of the workforce, even when there is an offer of the option of guaranteed hour contracts to the workforce. The reasons include that it enables workers to combine work, and other responsibilities. However, this results in carers' income being less predictable. Zero hour contracts also enable providers to respond to peaks and troughs in demand for services, and maximises the ability to recruit workers who want to work flexible/unsocial hours. However, there is a higher risk of short notice of cancellations from workers, if their contracts are not managed well

27. A guaranteed hour contract has advantages in that it gives workers a predictable income, and it is easier for them to obtain loans/mortgages/credit. However, it is often harder for them to arrange the hours to fit in with personal commitments, and there is less choice, as the worker needs to accept all the necessary arrangements within guaranteed hours. Younger workers generally prefer guaranteed hour contracts, and whilst they may increase staff loyalty, the provider bears the risk of financial loss if the purchasing pattern of the Council changes. Guaranteed hours are also generally more politically acceptable to elected Members, but there are increased costs, as the Council pays all the downtime

Evidence from City and County Healthcare – Caleb Atkins

28. City and County Healthcare are the foremost healthcare provider in the UK, providing 50,000 hours of care a day. It has 12,500 care worker staff at 170 locations, and operates in all homecare segments, home care, additional care, live in, supported living, complex care, and temporary staffing (agency). It has a diversified contract base, across more than 250 contracts, with Local Authorities and Clinical Commissioning Groups

29. There is a financially challenging environment, and there is the need to comply with the Ethical Care Charter Commitment, which is contractual. The Committee noted that it is considered that there is poor integration with health providers, and there is no local incentive for providers to invest and change delivery models. Partnership working has historically been poor, and the biggest challenge at present is to recruit, and retain, carers for the workforce

30. Care needs are rapidly growing, and the forecast is that the number of over 65's will increase from 11.8m in 2016, to 17.5m by 2036. This group will have increasingly complex medical conditions, and a reducing supply of informal care. Whilst some funding, and commissioning challenges remain however, the environment appears to be improving, and the outlook is more positive. There are still some areas of commissioning pressure, and there were issues, such as reassessments, the length of calls, and the minute by minute charging models that still needed to be addressed

31. The last 3 years have seen increased spending by Local Authorities, due to statutory care obligations. Local Authorities have redirected funding from more discretionary areas of public health funding, and there has been an additional £10 billion funding for social care, over the last 4 years

32. The supply and demand of the sector favours larger stronger suppliers, and it was stated that there is an acceptance by Local Authorities that charging rates must continue to rise. Commissioners are also struggling to secure quality care provision, and 78% of Social Care Directors are concerned about their ability to meet statutory duties, and to ensure market stability

33. The Committee noted that in terms of the price of providing care, carers wage remuneration is at the bare legal minimum, and noted that wage related costs need to be covered as well as travel for carers reimbursed. The Local Authority purchases the service at the lowest cost it can achieve, however a fair price needs to be paid, in order to attract and retain the workforce, to ensure that all costs are covered, and that a profit generated for the provider, which will support innovation, and reinvestment in services. This is needed to ensure that public money is spent on a service, which supports citizens well

34. The Committee noted that whilst carers needed basic literacy skills to read instructions for medication, residents' requirements etc., they all also had to undergo a 12 weeks training

course, and to obtain a Carers Certificate. Carers also had to be aware of users cultural needs, and it was noted that the workforce tended to be representative of the local community

35. Homecare is key to balancing overall health budgets, as there is the need to achieve break even point, when this is compared to hospital and residential care costs, and typically has better outcomes. Nearly 80% of adults prefer to live at home

36. Technology based solutions are transforming homecare, and there has been investment in digital technology and data, electronic care plans, electronic medicines management, full mobilisation of carers, digitalisation of operations, and improved data capture. The platform also uses an electronic hearing management system

37. In addition, technology to improve care has been introduced, and there are better measures of reporting from system derived data, rather than this being self-reported. There are electronic care quality plans, active tracking and alerts, and near real time data at the click of a button. This frees up time to provide care, and reduce administration and inefficiency, and reduces paperwork

38. There is also a remote audit and improved management opportunity, and daily call reconciliation. It was noted that if everyone reconciled on a daily basis, this could free up £10m of working capital to reinvest in the service

39. The Committee were of the view that there had been significant introduction of new technologies, and that there is further scope for new technologies to improve the service to clients, and reduce the cost to commissioners, and providers. Such examples include electronic care plans, electronic medication charts, and the ability to change service user needs, via mobile devices. The Committee noted the previous evidence submitted that the Telecare system is under review, with the aim of increasing the use of technology, in order to improve the quality of staff available for those in receipt of care. The Committee therefore recommend that providers and commissioners investigate, and continue to introduce new technologies, in order to improve the quality of life for those in receipt of care

40. The Committee also considered that giving the increasing elderly population, with ever more increasing complex and multiple needs, this will mean in the future a growing need for additional social care resources, whilst at the same time as social care is not being funded adequately by the Government

41. The Committee noted that the Green Paper on Adult Social Care that was due for publication a considerable time ago is still unpublished. The Committee therefore recommend that the Government adequately fund social care costs for Local Authorities, and implements a fundamental change to its long term funding position, as soon as possible. There is an urgent need to address the implications of a growing ageing population, who will have increasing and ever more complex needs

42. The Committee therefore recommend that the Government fund social care adequately, and implements a fundamental change to its long term funding policy, as soon as possible. There is an urgent need to address the implications of a growing, ageing population, who will have increasing and ever more complex needs. Whilst a long term goal would be to consider in house provision, as this would provide a better service for clients, more control for the Council and better employment for carers, the current funding levels provided by Government for funding social care does not allow this. If this situation changes the situation will be kept under review

Snowball Care UK Ltd. – Sayeeda Ahmed

43. Snowball are a care agency that provide domiciliary care and support, to people who have learning and physical disabilities, mental health problems, and also to elderly people

44. Snowball offer carers and support workers for residents who need extra support, and aim to ensure clients get the care and support that they want. Different types of care offered include waking night care, sitting service, and 24- hour care etc. Services include personal care, financial care, domestic support, social care, administrative, and nutritional care

45. Staff are criminally record checked, and recruited through a robust process, with references taken up, and full employment history. Staff have to undergo a comprehensive training schedule, and training updates are routinely given. Homecare managers and co-ordinator meetings review all carers weekly, in order to check performance, and ensure communication channels are maintained

46. Snowball works with learning disability clients, and this means a personalised service that supports and guides clients to achieve their full potential, in a friendly and safe environment, that enables them to learn new skills, increase confidence, develop life skills, and gain employment experience. In addition, attempts are made to engage clients in a wide range of different activities, that they find interesting and enjoy

MiHomecare – Ian Haddington

47. MiHomecare has delivered home care for over 20 years, and employs 3,000 staff, including 2,800 support workers. It delivers over 40,000 hours of care a week across SE England and Wales, from 15 registered branches to over 4,000 service users. It provides services in 15 London Boroughs, and has contracts with 50 Local Authorities, and CCG's/CIW. There is a consistent focus on quality, with all services rated Good/Compliant by the CQC/CIW. 61% of MiHomecare business is in London

48. In terms of the relationship with Islington, as mentioned earlier, a new 4 year contract (with the possibility to extend - 2 plus 2), was agreed in April 2018. There is a strong relationship with Islington, both at branch level and through senior management. MiHomecare successfully mobilised 3,500 hours of care delivery, to 360 residents in 9 days, following the Allied Healthcare failure in December 2018. It was pleasing to note that here has not been one missed episode of care, or of a service not delivered, following mobilisation. There are currently 211 care staff delivering c.4100 hours of care per week to Islington residents. These are 98% Local Authority funded, 1.3% CCG funded, and 0.7% privately funded

49. The Committee noted that the majority of visits to residents were usually around 30 minute duration, and that this did not always allow enough time for carers to discharge their duties effectively

50. There are a number of key challenges to the home care sector. This includes a need for further large increases in the numbers of care workers by 2022, nearly double the current number. There are other challenges, one being that the industry turnover of staff is 37.4%, and

that in addition less than 10% of the workforce is under 24 years of age. The minimum price for homecare is £18.93, and there is an increased need for specialist home provision. Partnership and collaboration are the key to a future successful approach. A recent example of this was at Cutbush House, where 3 different providers were providing care for 3 different clients

51. In terms of an operational model, care workers are the organisation's greatest asset, and there needs to be ongoing innovation and efficiency, value for money, effective leadership and experience, and a community focused approach, all underpinned by 'good' quality ratings

52. A recruitment strategy is in place targeting postcodes with the highest unemployment, and the aim is to attract staff, and reinforce care working, as a good and positive career choice. The payment of the London Living Wage (LLW) is a contractual requirement, and flexible contracts and work patterns, including guaranteed hours for all permanent care workers are available. There is a clear focus on retention of staff, and offering career progression, and the Committee were informed that MiHomecare felt that it has a strong reputation as a good employer

53. There has been investment and the introduction of the People Planner/Mobizio, (care management software), which includes the introduction of electronic care plans/risk assessment. Electronic medication charts and risk assessments has been introduced. In addition, there is now the ability to change service user needs, via mobile devices, and policies and procedures can be available at all times

54. There are a number of benefits to embracing innovation. These include increased local capacity, a valued workforce, with safer, more confident care workers, better service user visibility, real time monitoring, reduced hospital admissions, earlier intervention. In addition, there is improved prevention, fewer complaints, better safeguarding, and communication, with the ability to look after both the care user, and carer in a better way

55. In terms of partnership working, there is a need to provide ongoing involvement in future procurement, and to look at an alternative approach. This will enable a better understanding of each other's challenges, at an earlier stage, and will embed enablement into all services, where appropriate. Pilot contracts offer bespoke services to solve specific problems, and there is a benefit from increased frequency of commissioner, and provider engagement, with the ability to share technology

56. The Committee noted that one of the problems in providing care tended to be that users of the service wanted care packages at the same time, or at similar times, and this led to periods of downtime for staff. We noted however, that as Islington is a small borough, this enabled block providers to plan more easily to plan travel for carers, although spot providers found it more difficult to obtain such efficiencies

57. In terms of 'on costs' that are included in the care provider's business model, the costs for inner London, in terms of rent and rates, are obviously higher than other parts of the country. In addition, there are incorporated staff training costs. The introduction of technology could be able to reduce costs in some areas. However, 75% of costs were staff related costs. There were also other models of care that could be looked at, where costs could be reduced, whilst at the same time enabling clients to be more independent, and improving outcomes

58. MiHomecare stated that it felt that there needed to be provision of more individualised contracts, to create care plans that better met the needs of clients, and to give more autonomy to both clients and providers. There is a need to look at an 'outcomes based' approach that enables the verification of the provision of quality of service. Technology can assist in this process, as it can alert providers where an introduction of a change in care needs is required,

and independent quality assurance provided. Technology introduction will also enable carers not to have to manually complete 'log books' on visits, and information can be immediately transferred

59. In terms of improvements that are required to improve the service, providers were of the view that the most important measures that could be introduced included improving the experience of the workforce, pay rates and provision of a more effective service. In addition, there needed to be a focus on recruiting younger carers, as most carers are in the 45/50 age range). A better perception of the workforce is needed, and the 'minute by minute' charging system that is currently in use needed to be reassessed by commissioners, with more flexible methods of delivery, and a less prescriptive delivery of service

Evidence from Adult Paid Carers – (MiHomecare/London Care)

60. The Committee received evidence from a number of Adult Paid carers, who attended a meeting of the Committee

61. The Committee noted that many carers had begun working in the caring profession, after initially caring for a relative or friend. Carers informed us that they enjoyed caring for the elderly, however they did not feel adequately financially remunerated, especially for working at weekends, or after 6p.m.

62. The Committee questioned carers on whether they favoured guaranteed hour contracts or zero hour contracts, and it was stated that carers were broadly in favour of more guaranteed hours contracts, as zero hour contracts did not give security of income. It was stated that if a client went into hospital then a carer would lose their pay, as the Local Authority care package is not required when a client goes into hospital

63. The Committee were informed by MiHomecare, and London Care that they did offer guaranteed hour contracts to all carers, once they had passed their probationary period, but carers had to commit to working 30 hours per week, and this could involve late night or weekend working, which some carers did not wish to commit to. Many carers wished to work a 9-5 working pattern, and this was not always possible with a guaranteed hours contract

64. In addition, some clients did not want to go to bed until 10.00 p.m. This led to a long day for carers, as often they would also have to start early in the morning. Most of the carers' duties took place within set hours, during mornings and early evenings, and there was a lot of downtime for carers, if a client wished to put to bed late at night. This led to carers having to work a long day, however they felt that their remuneration did not reflect this

65. The Committee recommend that there should be a focus on overall wellbeing outcomes for service users, rather than a list of specific tasks conducted at specific times of the day. Commissioners and providers should consider opportunities for a more personalised, as well as an efficient home care system. Opportunities may include better utilisation of personal budgets, and geographical zoning, whereby a provider has a set budget for each service user, based on their needs, to deliver a personalised service, which would reduce downtime for carers, and enable improved efficiency. Continuity of care is important

66. Carers informed us that they also suffered from instances of abuse, violence or racist attitudes, towards them by clients, and that this should not be acceptable. The view was expressed that there should be a zero tolerance policy introduced to prevent this type of behaviour. However, the Committee noted that if clients did exhibit and persist in this behaviour, Local Authorities are in a difficult position, as they could not just withdraw care. It

was noted that present, where a client provided difficulties, it appeared the client was just passed on to another provider, without necessarily solving the problem

67. The Committee therefore recommend the institution of a zero tolerance approach in instances of verbal/physical/racial abuse, and commissioners/providers should take effective action. Commissioners should engage specialist providers who offer their staff appropriate specialist training, in order to meet the needs of service users with challenging behaviours, in order to minimise the effect on carers

68. Carers also informed us that there appeared to be long periods when there are reported concerns about clients, and action taken by Social Services. MiHomecare informed the Committee that they did report concerns relayed by carers, however whilst Social Services took action quickly in some cases, because of pressures within the system, this was not always the case. The Committee noted that carers were of the view that they were often the best placed to know the concerns, and problems of clients. Carers expressed the view that in some instances, actions are not 'put in place' within an adequate timescale by Social Services. There appeared to be no timeframe for dealing with concerns expressed and there needed to be better sharing of information processes

69. The Committee are of the view that there should be exploration of the opportunities presented by Fairer Together, which is a part of the Local Authority, NHS and for improved co-ordination between commissioners/NHS/Voluntary and Community sector partners/ stakeholders, with the aim of enabling residents to live a healthy life on their own terms. Work should also take place to ensure the conveyance of the correct information to providers/carers in relation to clients' needs. This is especially in relation to discharge of clients from hospital to ensure the administration of the correct medication/assistance. Opportunities for the introduction of new technology, as recommended in (a) above can assist in this

70. The Committee also noted that carers did not feel the travel time allocated for visits to clients and that payment for late working and weekend working is sufficient. The Committee were informed that contracts that were agreed between the Local Authority, and providers

71. The Committee heard evidence on the Trusted Assessor model and informed that there are potential opportunities to improve the quality and speed of discharges from hospital. Providers are sometimes unable to respond quickly and flexibly to clients changing needs, as they are limited in their ability to make changes to care plans. This should explore how commissioners, providers and social workers can work together, in order to ensure more timely and responsive changes to care packages, in line with clients changing needs

72. The Committee therefore recommend that consideration is given as to how the Council can make best use of the expertise and skills of providers and carers. In addition, consideration should also be given to consider opportunities to empower and place more trust in providers, and carers, to make decisions about the care and support clients require, from discharge from hospital to making adjustments to care packages as needs change. This may include an exploration of new roles. The Council should also explore opportunities for more regular reviews from providers, and the Council, to enable care needs of users to be checked more frequently, in order to ensure that there is no over/under provision of care.

73. The Committee also heard evidence that there are 'untapped' opportunities to improve career pathways into home care, and career progression, within health and social care. The Committee also recommend that consideration is given to career pathways and progression for carers, as part of the wider efforts of Islington's Health and Care Academy. Commissioners

should explore which social value clauses and good employment practice stipulations would be appropriate to include in future specifications and contracts

74. Carers also expressed their concerns that they had to visit estates, or areas, that they felt to be unsafe, often late at night. Many carers are women, and they felt especially vulnerable. The provision of parking permits for carers would assist them in being able to take their cars, if necessary, and be of minimal cost to the Council. There may be other benefits that the Council could also offer to make carers feel more valued by the Council, for the particularly difficult job that they performed

75. Some carers also expressed concern that there should be a review of the procedure for payment for sickness as it is unfair, and it is complicated to claim. MiHomecare informed the Committee that all care workers employed by MiHomecare receive statutory sick pay. A care worker will not receive any pay for the first 3 days of sickness absence, known as waiting days, but will receive pay for the fourth day of sickness onwards. Care workers are required to complete a self-certification form for the sickness pay to be processed. After a 7 day sickness absence, carers are expected to submit a sickness certificate form from their GP

76. London Care informed the Committee that all employees are entitled to receive statutory sick pay during a period of sickness, on the proviso that employees comply with sickness reporting procedures. Carers will be required to produce appropriate evidence of any period of sickness. London Care pay carers £94.25 per week for a period up to 28 weeks. A return to work interview is mandatory before staff are allowed to return to work

77. The Committee were impressed with the commitment, and excellent work, that carers provided for clients in Islington. The Committee heard differing evidence as to whether carers wished to be offered guaranteed hour contracts, rather than a zero hours contract, or whether they preferred the flexibility provided by zero hour contracts. In addition, the Committee heard that carers are unpaid for the time that clients are hospitalised, if alternative work is not available. The Committee also noted the concerns expressed above that carers often experienced problems when having to claim sickness pay, and that this in their view sometimes can be complicated

78. The Committee also recommend that given the evidence above in relation to safety, that there should be provision of parking permits for carers working late at night that have to use their car. The Committee also support the Mayor of London's election manifesto commitment to provide concessionary London Transport passes for carers for the disabled, if he is re-elected. The Committee are of the view, that given the shortage of home carers, commissioners and providers should investigate other possible recruitment/retention measures that could be put in place to help alleviate such shortages

79. The Committee therefore recommend that there should be promotion of caring as a profession, and that providers should offer all carers guaranteed hour contracts, rather than zero hour contracts, even if carers did not ultimately wish to take up guaranteed hours contracts. The Committee consider that there should be exploration of a discontinuation of 'minute by minute' charging, in order to reflect recommendations (c) and (d) above. There should also be consideration by providers to compensate/find alternative work for carers, in the event of clients being hospitalised. In addition, providers should ensure that the process for claiming and payment of sick pay by carers is simplified

Evidence from Penrose Care – Bob Padron

80. The Committee received documentary evidence from Penrose Care, who are a recognised provider of ethical home care services. The Care Quality Commission have rated Penrose Care as outstanding. Penrose Care has received a number of awards, including twice named as a Living Wage Champion, and internationally recognised for its innovations in Home Care. In July 2019, Penrose Care became one of the first 16 private businesses accredited with the Mayor of London's Good Work standard, an initiative to promote decent work in London

81. Penrose Care made a number of suggestions that they felt would be beneficial to keeping home care users healthy and improve the sustainability of services from the provider perspective. These include reforming the timing and geographic location of services to make job roles more attractive. Home Care providers struggle with attracting new social care workers to provide frontline services, and complying with their statutory obligations to their employees. Councils can alleviate the pressure on home carers by booking home care visits sequentially, and allocating users to groups of providers by small geographic regions. Currently it is the standard practice for social workers to book home care visits generally at the same times e.g. morning, lunch and evening, which can result in systematic underemployment of home care workers, as they may be without work between the standard visit times. By booking visits sequentially, providers can offer home care workers, full daily loads of work, making it easier to attract new home care workers, and reduce staff turnover, which is chronically high in home care. Users, who independently cannot have time sensitive medications administered, should have priority for visits during the peak morning, lunch and evening visit times. However, responsible bodies must assess whether it is prudent for public social care services to be supporting individuals who are unable to manage their medications independently, or whether such persons need consideration for residential social care options, such as assisted living centres, care homes or nursing homes. Furthermore, home care providers have historically struggled complying with National Minimum Wage statutory obligations, due to the need to compensate employees for travelling between clients. Social Care commissioners can alleviate this pressure by allocating users by small geographic regions to small groups of providers

82. Social Care professionals can also make easy positive impacts on users' lives in the areas of falls prevention, hydration, and early detection of infections. Falls prevention can be achieved by social workers, and ensuring the adequate allocation of an occupational therapist, and physiotherapist. Social care professionals can assist by checking if visits, by health care professionals have taken place. Social workers can improve hydration levels by encouraging users to switch to decaffeinated tea and coffee. Undetected infections can cause users' health to take steep declines. As a result, social care providers and the CCG should explore the provision of regular urine tests for users, who consent to provide the early detection of infection (See recommendation (j))

83. Furthermore, the Council can prevent adverse developments by having an in-house team check that social care workers have arrived to their visits, so that if a provider misses this it will not be missed, and then the Council can arrange a back-up social care worker to attend. This would require the Council to mandate a uniform time and attendance software across the provider base

84. The Committee, given the evidence given above on preventative action that can be taken, therefore recommend that a more integrated approach be taken to preventative care, in order to reduce hospital admissions, and commissioners should work with providers, social care and NHS in this regard

Direct Payments – Stephen Day/Nicola Herrera – Martinez –L.B.Islington Independent Living Team

85. The Committee also received evidence from the Independent Living Team in relation to Direct Payments

86. A personal budget is the amount of money the Council will pay towards any social carer and support a service user needs. Personal budgets are determined following an assessment of needs under the Care Act. The assessment will confirm what kind of care and support is needed, how much it will cost, and how much the service user is able to afford to contribute following financial assessment

87. A personal budget is payable to the service user or carer, to enable them to make decisions about how it is spent. This is a Direct Payment. Direct Payments have been in use in adult care and support since the mid 1990's. The Care Act 2014 confirms personal budgets in law for people with eligible assessed needs and carers, including the right to a Direct Payment. In order to ensure that people are supported to use and manage the payment appropriately, local authorities must provide relevant and timely information about direct payments

88. Direct Payments give individuals greater choice and control over the support that they receive, and the provision of such support. For example, a person can choose to hire care workers, or personal assistants who are always the same people and available when needed, speak the same language, have experience working with a person's care needs, or is a specific person that has been recommended

89. There are choices a service user can spend the money. The service user can make a choice, as long as the person spends the personal budget on things that meet their needs, and are detailed in the support plan

90. The benefits of direct payments include – choice and control, flexibility, empowerment, consistency, person centred, creative, enable more specialised support, savings to the Local Authority, which enables more funds to be spent on servicing clients, local job creation, improved service provision, less prescriptive care, and a variety of sources of service provision

91. Feedback from the 2018 user survey shows that the Direct Payment recipients felt that they had the most choice, and control, over their care and support services. Currently 22% of all Islington community care and support is provided through Direct Payments

92. The Council is trying to improve the offer to encourage people to move on to Direct Payments. Personalisation is a key stream of the Adult Social Care Plan 2019-22. Building on evidence from research, the aim is to improve the offer to people who choose a Direct Payment. The aim is to increase uptake to make it the default choice, and are looking at how the market can meet the needs of those who choose Direct Payments. A current review is currently taking place of processes and policies, and work is taking place across departments, and the CCG, to ensure an integrated and co-ordinated approach to personalisation, and updated policies and

procedures. The aim is to develop a new training offer for social work staff, regarding the approach to personalisation, and update policies and procedures

93. Work has already started to reintroduce the Direct Payments Forum to engage with all recipients, gather feedback, and guide plans for improvement. Feedback has been very positive. There has been an active working group established with service users, and carers, to shape future forums, work on the actions from the forums, and engage Direct Payment recipients to network and offer peer support. The working group is developing a training offer for Direct Payment employers, and PA's, engaging current providers, and building the local market

94. The Direct Payments services provide the following assistance – information, visits, and joint visits with practitioners to prospective new Direct Payment users to explain about flexibility, choice and responsibilities for Direct Payment employers. The team also provides employment set up and advice, assistance with payroll, employers' liability insurance, DBS checks, redundancy, employment contracts, etc. There is ongoing support provided to existing, and new, Direct Payment employers. There is no administration charge imposed by the Council

95. The Direct Payment team is also working with the CCG to set up personal health budgets, and service users who are on continuing care or have long- term conditions, can now access Direct Payments. They are health funded, and are called personal health budgets and they have commissioned the Social Services Direct Payment team to deliver them. The Direct Payment team complete the following tasks for the CCG – information visit, costing care plan, completing personal health budget agreements, adding the support plan and provision to LAS, support with employment, recruitment etc. Personal health budgets can be virtual budgets

96. The Committee noted that changes in the situation in the condition of a service user is usually detected either through notification from a social worker, GP, carer or family member. Although there is an annual review, vulnerable clients are visited more often, in order to check on them, and this is often done every 2 weeks

Evidence from Centre 404 – Jo Mackie

97. The Committee also received evidence from Jo Mackie of Centre 404, in relation to traditional contracted services as opposed to personal budgets, and the introduction of Individual Service Funds (ISF)

98. Traditional contracted services paid money to the provider as a lump sum to pay for support/care for more than one person, provided in terms of hours. The provider manages the overall budget to balance the needs of the clients, and the client is reliable on one provider to meet all outcomes on a long term agreement basis

99. Personal budgets enable monies to be available to the client, or a nominated person. The funds paid are for the support/care of one individual based specifically on their needs. There is support/care is provided within a financial budget, rather than hours, and a client or nominated person manages the funds for the individual. Clients can choose how to use their budget and spend on different services, activities, providers and equipment. In addition, how the personal budget is used can change over time

100. There is an assessment process for personal budgets for people with learning disabilities, where needs and desired outcomes are assessed, how best to work to establish outcomes,

agree funds required to meet these outcomes (personal budget), and then to decide how the personal budget will be managed

101. Individual service funds operate on an agreement between the client, Council and organisation, and an online bank account, and a pre-paid card made available. An annual budget is agreed and split into 4-weekly payments, and the organisation keeps all the paperwork, and is liable for the management of the account. The organisation manages all payments out and in, including invoices for support, paying payslips and tax for personal assistance, activity reimbursements for clients, travel reimbursements for support workers and course and activity fees. The Council has access to the account, and recovers surpluses and runs reports, and the organisation monitors, and follows up, the payment of assessed contributions, and this is a chargeable service

102. For clients, the benefits of individual service funds are that they are more flexible and personalised, used for different ways of meeting outcomes, relieves pressure on families/clients to manage finances, and enables payments and reimbursements to be made more quickly. It also enables changes to support and activities to be made quickly, recurring payments can be set up, smoother processes for arranging support and activities, and payments are smoother if the provider has oversight and management of Individual Service Funds, and support

103. Individual Service Funds also enable a more creative and proactive approach to be taken, with support planning, and the ability to respond to new opportunities, leads to reduced involvement with social services, the ability to review surplus and look at how unused funds can be used, and is cashless

104. For providers Individual Service Funds provide an oversight of what budget is available for a client, enables them to respond to support and activity requests more speedily, reduces face to face auditing, and the workload of having to contact social workers or finance teams. In addition, there is more joined up and person centred support, clear support plans, ability to assist a client with managing a budget and spend across the year, enables feedback to the social worker on the balance of the budget when looking at new support or activity requests. There is also the possibility of a more holistic and creative approach, with a focus on outcomes, rather than the provision of fixed hours. Networks and communities can also be built with other providers being used and be able to share information about opportunities for clients. It also assists with internal debt management, and can be followed up with the ISF manager if payments are not made

105. Individual Service Funds benefit social services, as it reduces strain on in-house services, reduces incoming day to day work and enquiries, reduces the need for meetings due to a change in circumstances, there is less face to face auditing, and a reduced risk of financial abuse. Individual Service Funds also provide the facility to upload documents, there are fewer third parties to deal with, and gives the ability to report on payments of assessed charges. In addition, it facilitates more responsive and dynamic social care provision, and can potentially find savings by identifying creative ways to meet people's needs

106. The Committee were informed that to work well, individual service funds need a good relationship between, providers, social work, and finance teams and clear support plans that are flexible, and not over prescriptive, be outcome based, provides guidance around the use of personal budgets, and are well thought through for all potential costs

107. The Committee were of the view that evidence received has shown that Individual Service Funds into learning disability payments is working well, and enables clients to have flexibility

and control over their care. This would assist in the move to an outcome based service, as recommended earlier in the report

108. The Committee therefore recommend that commissioners, as part of a broader market development, explore the appetite and capacity for delivering personalised services delivered through Individual Service Funds, or direct payments.

109. The Committee heard evidence of the benefits of taking a relationship based approach, and a stronger enablement approach, together with the integration of different types of support. The Committee recommend that the Council works with clients, their relatives and providers to review the Council's services to people in their homes, to explore opportunities for improvements that will better support residents to maintain independence and improve wellbeing

Sweet Tree Home Care Services – Nikki Bones and Denis Repard

110. Evidence was also received from Sweet Tree Home Care Services, who are rated Outstanding by the Care Quality Commission

111. Sweet Tree support all general home care needs, and have 6 specialist services, all individually led by highly experienced clinical managers providing 2 - 24 - hour care at home. This includes general home care, dementia care, end of life care, learning disability support and complex care, acquired brain injury, and neurological conditions

112. There is a clinically led circle of assessment and support to deliver Sweet Tree's vision, including early diagnosis, shared assessment, knowledge and information, care and support and regular reviews, shared with the person and their family, with input from internal and external experts

113. Sweet Tree employed 3% of all applicants in 2017, and all those employed must have 6 month minimum experience, and all team members are hired to individual services for their knowledge and skills experience

114. Sweet Tree is an accredited training academy, with a wide range of expert internal and external trainers. There is investment and recognition for the value of Learning and Development for each team member. There are Sweet Tree Manager Induction standards, a new learning management system, and mission values are taught, and reinforced and there is customer service training for all

115. Compliance and regulation is a whole team responsibility, and there is clinical expertise and specialist knowledge. The in-house teams consist of Registered General Nurses, Registered Mental Health Nurses, social workers, a clinical psychologist, physiotherapists, and qualified trainers. Each service is managed by specialists who recruit specialist teams to each service

116. Sweet Tree work with many partners, learning from and supporting each other playing a part in research projects, work on Committees, and building a national Dementia Carers Day

117. Governance provision is through an Advisory Board, which opens the company to external scrutiny and, in this way sets a precedent within the industry, and is a model available for

adoption by others. In addition, it addresses how the company is operating, and considers methods of best practice, and in this way the Board will become a catalyst for innovative thinking, enabling the company to reach new levels

118. Sweet Tree seek to provide a quality service, and support worker wages and travel, and training is initial and ongoing. There is support provided to families and clients, and there is continual improvement. Sweet Tree also works with many partners, providing learning and support for each other

119. In terms of quality assurance, Sweet Tree also commissions an external provider to do a mock inspection, has an internal and external audit process, and monitors calls for quality assurance. There is also a variety of consultants, who assist on projects, and monthly meetings of the senior leadership team, and an external audit

120. Sweet Tree informed the Committee that it has a minimum two -hour visit time for clients, and that carers allocated blocks of 6 or 12 hours. Sweet Tree were of the view that to develop a good client/provider relationship a two - hour visit is required, and this could not be provided in a 15-minute visit

121. Sweet Tree has a manager who provides support to 15/20 support workers, which allows better support for clients, support workers and families. However, there are many different models of support that providers supply, but they did not feel choice, quality of care, and flexibility could be achieved by 'minute by minute' commissioning

122. Sweet Tree stated that they had a workforce that is representative of the local community, and that clients are 'matched' to support workers, as much as possible. Where there is not a direct match, training is given

Wellbeing Teams – Helen Sanderson

123. The Committee received a video presentation from Helen Sanderson, as to a new model of care developed relating to Wellbeing teams, and that this involved the creation of self-organised teams in health and social care. There is a different way of approaching support in that plans are co-produced, there is a whole person focus, and there is capacity building and connections made

124. The support sequence involves self-care, wellbeing workers, community and services, assistive technology, and friends and family and community circles and the client

125. There is value based recruitment, and an induction process, and ongoing development and learning, with a focus on quality delivery of services. Workers for the wellbeing teams were not solely recruited from the home care sector, but also from industries such as retail, where good customer service skills were important

126. The Committee were informed that two wellbeing teams had been set up with Thurrock Council, to support the Local Authority to bring together community support, and home care, and this requires a different type of commission than the normal outcome based commissioning

Duncan Patterson – CQC

127. The Committee at its meeting on 21 November 2019 considered evidence from Duncan Patterson of the CQC

128. The CQC is the independent regulator of health and social care in England, and ensures that health and social care services provide people with safe, effective, compassionate, high quality care, and encourage care services to improve

129. In terms of Adult Care 80% of care settings were found to be good, 4% outstanding, 15% require improvement, and 1% are inadequate.

130. The Better Lives report highlighted organisations that are focus on individual drivers for success, rather than systems thinking. For people to receive a high quality service there is need for strong vision, governance, culture and leadership. There is also a need to work together to focus on the same metrics for success

131. There is a need for organisations to have a consistent, passionate, workforce and limited/structured use of agency staff. Staff need to be empowered, and there should be good leadership and strong links with the community. Common success factors include committed leaders, putting principles into action, culture of staff equality, staff being viewed as improvement partners, people who use services being at the centre, utilisation of external help, and continuous learning

132. The CQC encourages improvement by discussing best practice through an independent voice, publishing findings of inspection reports, publications, blogs, learning from incidents, etc. In the next year CQC Business Plan, there will be prioritisation of the development of a robust and consistent approach to regulating innovative, and tech enabled, care provision with complex cross sector providers. As technology and provision evolves, the CQC will work alongside people who use, and deliver services, to encourage improvement and stay abreast of technological innovation, refine the statutory approach, and welcome discussion with those who use such services and providers in the private sector. This will lead to technology improving care, whilst safety, and quality of care is ensured

CONCLUSION

The Committee received evidence from a number of witnesses, and especially found the evidence from the carers, extremely informative. Carers perform an extremely difficult job, and we are grateful for the work that they perform on behalf of both residents and the Council

The Committee are aware that social care has not been funded adequately over a significant number of years by the Government, and that this has led to Local Authorities having to seek to commission services at a cost that they can afford, whilst trying to ensure that carers at least in L.B. Islington receive the LLW

The Committee are of the view there are benefits that, in addition, the Council can offer, such as parking permits for carers, that can help carers to carry out their work more safely and efficiently, and demonstrate that the Council values greatly the work that they perform for residents

There are also technological advances that can be utilised by providers that should assist in the ability of providers to deliver a better service, whilst delivering on cost savings for commissioners.

The ‘minute by minute’ charging system is in our view a disincentive to both providing an efficient service, and penalises carers, as they are not paid for travel time, on whom the service depends. The Committee are of the view that geographical zoning would produce better outcome focused service provision for clients, and the recommendations that we have made we feel will also improve the conditions and benefits of carers.

The Committee hope that its recommendations will provide an improved work/life balance and financial reward for paid carers, whilst at the same time delivering a better service for residents

APPENDIX A

SCRUTINY INITIATION DOCUMENT (SID)
Review: Review the current arrangements for commissioning and delivering domiciliary care services within LB Islington
Scrutiny Review Committee: Health and Care
Director leading the review: Jess Mcgregor
Lead officers: Marisa Rose and Jon Tomlinson, Ray Murphy
Overall aim: To review the current position regarding paid adult domiciliary care workers in LB Islington including: funding, numbers, contractual arrangements funding, numbers, delivery arrangements and their effectiveness. To consider other models of commissioning and delivery in place in other parts of the country. To advise on any changes that need to be considered/implemented to the strategic direction for providing care support to people in their own home.
Objectives of the review: • To consider numbers and profile of paid Carers in Islington and consider any benchmarking data • To examine the requirements of commissioned providers in respect of adult paid carers in terms of: remuneration, quality assurance and risk assessment, training, travel time, payment of LLW, and how cultural /specialist needs are being met. • To examine the area of Direct Payments. • To examine the effectiveness of the current arrangements. • To examine the different models of commissioning, including best practice that can be adopted and examples of innovative Local Authorities. • Delivery of care at home currently in place elsewhere. • To consider any actions that may need to be taken in the light of the findings of the review to ensure LB Islington effectively supports citizens to remain independent, healthy and part of their local community. • To consider how local providers can be assisted to bid for contracts for Adult Social Care. • To consider how caring can be promoted as a career • To consider charging policy and comparison with other Local Authorities • In house service – is this a practical delivery model – costs, level of service provided • To consider whether joint action with Health providers on care packages can lead to reduced admissions to hospital/reablement packages that meet the needs of those in receipt of care, and if savings can be achieved through a more integrated approach
How the review is to be carried out: <u>Scope of the review</u>

The review will focus on the commissioning, delivery and effectiveness of the current arrangements for delivering home based care to support citizens in their own home. It will also focus on workforce challenges and how to encourage increased local employment of paid carers and how caring can be promoted as a career. Also, it will review the impact of staff attrition and sickness levels on the provision of care. The review will also consider other models of care successfully deployed elsewhere and its applicability to Islington – including joint arrangements with health where delayed transfers of care have been reduced. Some focus will be given to ensuring individuals who need support get it in a timely manner.
Applicability and effectiveness of the in-house service will be examined in some detail as will the Islington approach to charging.

<u>Types of evidence</u>

1. Documentary evidence including:
    a. DH guidance, advice and findings from reports published by specialist and advisory organisations
    b. Service information in relation to commissioned and directly delivered provision.
2. Witness evidence including presentations from:
    a. Commissioned (2 block, 1 spot), non- commissioned/ in-house providers.
    b. Paid carers.
    c. LBI/NHS commissioners.
    d. LBI Care Management Team.
    e. Domiciliary care national provider trade organisations – UK Homecare Association.
    f. Service users, carers and families from within Islington as appropriate.
    g. Colleagues from other areas currently delivering services through alternative models.
    h. CQC.
    i. Skills for care.
    j. Direct Payments team.

Additional information:
Timescales: (*to be confirmed*)

9 May 2019 Presentation and sign off of updated SID
June 2019 to February 2020 Witness Presentations
March 2020 compilation of report.
April 2020 Final Report

In carrying out the review the committee will consider equalities implications and resident impacts identified by witnesses. The Executive is required to have due regard to these, and any other relevant implications, when responding to the review recommendations.

MEMBERSHIP OF THE HEALTH AND CARE SCRUTINY COMMITTEE – 2019/20

Osh Gantly – Chair

Nurullah Turan – Vice Chair
Jilani Chowdhury
Tricia Clarke
Joe Calouri
Roulin Khondoker
Martin Klute
Sara Hyde

Co-opted Member

Substitutes:

Satnam Gill OBE
Anjna Khuruna
Mouna Hamitouche MBE

Co-opted Member:

Vacancy- Healthwatch

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