Domiciliary Care in Essex

A report by a Task and Finish Group established by the People and Families Policy and Scrutiny Committee

10 March 2021

Essex County Council

Contents

Foreword

This review was initiated by members of the People and Families Policy and Scrutiny Committee (PAF) after receiving a presentation on 17th September 2020 where we were told of an expected increase in demand for reablement and domiciliary care in Essex. Having also had a briefing on the findings of the Newton Europe research into discharges from hospital it was felt we needed certain assurance around the smoothness of process, the consistency for service users and that an efficient and timely provision delivered consistent quality for all. The use of technology, governance of the provision and the domiciliary care market would also need to be included.

The Task and Finish Group began in October 2020 and developed five key lines of enquiry to base the review on. All of this was during a most challenging time…a worldwide Coronavirus Pandemic! Whilst this clearly impacted on the scope of our work, particularly with NHS colleagues, we managed to engage with a large number of contributors to whom we were most grateful. What was so encouraging was the openness and willingness clearly showing the desire to provide a first-class caring service ensuring best value available within the market.

Our conclusions are within this report alongside our recommendations and considering both Pandemic and time constraints a lot has been covered but there is still more to do, particularly around governance and the part the Care Quality Commission has to play. During our discussions, contributors have raised a number of issues to which the Group are not minded to respond via formal recommendations but would like officers assurance that they will still investigate these matters as appropriate.

None of this would have been possible without the dedication of the Task and Finish Group members, officers, staff, providers, carers, voluntary services and service users who gave up time to this important and timely review. Key issues have been raised, with some needing more work, but I am convinced as we move on from the Pandemic these will be tackled too. My thanks to all involved.

I commend this report to you.

COUNCILLOR BEVERLEY EGAN
Lead Member
Task and Finish Group – Domiciliary Care
10 March 2021

Executive Summary

The Group has sought to focus on five key lines of enquiry established in initial discussions with supporting officers in October 2020 which were around discharge planning processes, accessibility and referrals into services, monitoring of performance and service quality, capacity and technological support.

The primary source of evidence has been through face to face discussions with a variety of stakeholders as listed in Annex 2. This evidence has been supplemented by some presentational and written material which is listed in Annex 3.

The conclusions of the Task and Finish Group are at the end of the report starting on page 26. These conclusions comment on the challenges of the pandemic and the increasing focus on supporting people at home and assurance processes around that. The Group has not spoken to anyone from the NHS which, ordinarily, it would have done particularly in relation to discharge processes and this is referred to in a number of places in the report and has formed the basis of a number of recommendations for follow-up scrutiny work to be undertaken. This report to some extent is an interim report which acknowledges limitations placed on it due to the pandemic and imminent elections and that the review is not complete. However, it still manages to highlight issues raised by contributors which the Group would still like ECC officers to investigate further even though many of them have not been formalised into recommendations.

Recommendations

The Group has made seven recommendations and requests that these should be carefully considered for implementation.

Recommendation 1 (page 11): **The Group encourages further work to look at the feasibility and constraints in having a more flexible approach on who can undertake some individual assessments, subject to necessary safeguards, so as to facilitate a more informed and timely assessment process.**

Recommendation 2 (page 12): That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee further review the assessment process for support at home to include a focus on the challenges for the occupational therapist service.

Recommendation 3 (page 14): That, after the County Council elections in May 2021, the Health Overview Policy and Scrutiny Committee, together with the People and Families Policy and Scrutiny Committee, should jointly investigate further the adequacy and safety of discharge processes.

Recommendation 4a (page 15): A simple contact sheet to be given to everyone being discharged from hospital – effectively a 'one-stop shop' contact card with a handful of key numbers giving both telephone and on-line addresses to

signpost support and advice and entitlements and a step by step checklist to help guide next steps.

Recommendation 4b (page 15): the one-stop-shop contact sheet to include some simple tips to consider when looking at a service provider.

Recommendation 5 (page 20): That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee should look at governance processes for user feedback and complaints handling in the domiciliary care sector to include how easy it is to feedback and/or complain, and changes made as a result.

Recommendation 6 (page 22): That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee should seek further assurance about the part of the discharge process undertaken in hospitals.

Recommendation 7 (page 25): That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee reviews the emerging potential of technology to further support people in their homes.

Findings and evidence

Introduction

This review was prompted by members of the People and Families Policy and Scrutiny Committee (PAF) wanting to understand the current arrangements for, and oversight of, the delivery and quality of domiciliary care in Essex. Members had received some limited evidence of issues around the quality of care from family and/or constituents and, whilst acknowledging that these were anecdotal, a review afforded the opportunity to explore further the incidence of these issues. Overall, there was a desire to see if there were opportunities to highlight good work underway to improve the delivery and quality of such care and possibly identify further opportunities for improvement.

On 17 September 2020, the PAF discussed Essex County Council's response to the pandemic and its impact on social care provision and were informed that demand for reablement and domiciliary care was expected to significantly increase. Occupancy rates and levels of demand for residential care had dropped significantly and were not, at the moment, expected to fully recover to pre-pandemic levels. Longer term population demographics project that the number of people over 80 and 90 will significantly increase together with increasing complexity of support needs. However, it can be expected that, as a result of the pandemic, a higher proportion of those will choose to stay in their own home with enhanced support. All of this underlines the importance of having a robust and adequate domiciliary care sector to meet this future anticipated complexity and demand.

The review started in October 2020 against the backdrop of, and through the lens of, a global pandemic which meant that contributors and the local care system faced extraordinary challenges and demand pressures. Throughout the review the Task and Finish Group (the Group) have appreciated more than ever the time granted to them by contributors to help with the review and also the pressures that have prevented other people who the Group had also invited from being able to help the Group at this time. Whilst the Group has, in the end, still spoken to a wide range of contributors (listed in Annex 2), there have still been some issues that the Group would have liked to have pursued further but was unable to do so due to pandemic pressures and the need to close the review ahead of the County Council elections in May 2021. Most notably, the Group has not spoken to anyone from the NHS which, ordinarily, it would have done particularly in relation to discharge processes and this is referred to elsewhere in the report.

Key Lines of Enquiry

The Group has sought to focus on key lines of enquiry established in initial discussions with supporting officers in October 2020. Accordingly, this report has been structured around those five key lines of enquiry.

- To seek assurance that there are adequate discharge planning processes in place, arrangements for reablement (where appropriate) and identify issues for improvement.

- To seek assurance that people will still be able to be referred into services, that access is available, (i) routes/options remain in the normal course, and (ii) assurance that it is still happening during the pandemic (including awareness, signposting and communications are in place) and how to maintain confidence to refer into the 'system'.

- To seek assurance that there is adequate monitoring of performance and service quality of domiciliary care providers and robust processes to monitor, identify and instigate improvement actions

- To seek assurance that there is adequate capacity in place.

- To understand the current provision of technological options available to support people in the home and how that can be further expanded and prevent unnecessary admissions to hospitals.

Background and context

Domiciliary Care is a term used to describe a range of services provided in people's homes, to support them in remaining in that setting and can include:

- Short-term recovery (reablement) – primarily following a hospital discharge for up to 6 weeks
- Supporting a person to live with / manage a long-term condition (or more likely a set of long-term conditions)
- Supporting a person to live with / manage having memory loss or dementia
- Supporting a person with end of life care
- Supporting a carer who is helping any of the above
- Supporting a person with health care needs

The Care Act

The Council has a statutory duty under the Care Act 2014 to:

- Assess for, and meet, long term eligible needs
- Prevent, reduce and delay needs
- Promote wellbeing
- Ensure effective safeguarding arrangements are in place
- Develop/support diverse, responsive, and sustainable high-quality markets

In order to be eligible for paid support from the Local Authority, an Adult must have difficulty with one or more of the following listed daily tasks - these are known as 'Activities of Daily Living' (ADLs) and are the things which domiciliary care is put in place to support with:

- Managing & maintaining nutrition

- Being appropriately clothed
- Maintaining personal hygiene
- Managing toilet needs
- Being able to make use of the home safely
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community
- Carrying out any caring responsibilities the adult has for a child

Current structure and format of provision in Essex

Reablement is a short-term service to help people regain their independence through supporting them with their personal care and daily living tasks with the aim to enable them to get back to doing these tasks themselves. Most people are referred to reablement services after being in hospital, with the other referrals coming from community services including social care and GP practices. Reablement is provided free for up to 6 weeks countywide by Essex Cares Limited (ECL) which is a wholly owned subsidiary company of Essex County Council (ECC). The current contract with ECL is let in 5 lots mirroring the NHS Clinical Commissioning Group areas within ECC's boundaries. An In Lieu of Reablement (ILOR) service (where ECL is unable to resource the client's needs) is available from five other providers, also mirroring CCG areas and adds capacity to ECL.

> There are approximately 850 people using Reablement and ILOR at any time currently using around 12,000 hours a week of intense short-term recovery support for an annual cost to the County Council of around £20 million.
>
> Source: Domiciliary Care and Support Deep Dive (see Annex 3)

Domiciliary care and support generally is available after a six week period of reablement and is delivered through 125 Live At Home framework providers and approximately 155 spot providers. The primary users of these services are older people but there are also smaller numbers of working age adults with physical and sensory impairments, mental illness, learning disabilities and autism who also use these services.

> Approximately 115,000 hours a week of domiciliary care are used to support around 6,500 people at a cost to the County Council of around £100million per annum.
>
> Source: Domiciliary Care and Support Deep Dive (see Annex 3)

There is a range of providers in Essex, from small niche providers in one geographical location to large national companies, and the Council works closely and collaboratively with them both individually and through the Essex Care Association (ECA).

Discharge planning processes

The Group acknowledges that planning for an efficient, effective and safe discharge is a massive challenge. This has been exacerbated by the pandemic.

Prior to the pandemic

Prior to the pandemic, Delayed Transfers of Care (DTOC) had decreased as a result of joint county council and Health discharge teams operating together at Essex hospitals. Timely and safe discharge was part of that decision-making process. Despite those reduced DTOCs, the Group are pleased that the County Council and local health partners even then had already recognised that there were still issues around discharge and had commissioned Newton Europe to complete a diagnostic of historical cases. As a result of that diagnostic, it was thought that up to 1700 more cases could have benefitted from more independent home care each year if improvements were made to the discharge process. This could reduce the number of temporary residential care settings and residential admissions needed in future. Being more focussed on home first was thought to benefit around 240 adults in Essex a year.

One of the largest delays identified in the Newton Europe review was the time waiting for assessment for ongoing care needs. The sourcing of ongoing care need was another significant delay identified.

New guidance issued during the pandemic

In response to the pandemic, on 19 March 2020 new national guidance was issued which changed the assessment for discharge dramatically as it required a light touch assessment to be undertaken in hospital and then discharge to home for a more detailed community-based team assessment to be undertaken – a Home First principle with the vast majority of discharges now being arranged within a day. Responsibility for discharge from hospital has moved completely to the NHS (who are also responsible for funding support for the first six weeks) including ensuring that conversations are held with families as part of discharge planning. The NHS are now responsible for accompanying people to discharge lounges and their own home - prior to March there would have been social workers involved in this process. The County Council remains responsible for how personal needs are best met and that the right amount of care is brokered within the local system.

The Group was assured by officers that ECC is still working with hospitals to ensure that there is safe discharge and that ECC still sees case details so there is an opportunity to identify and flag up any previous concerns, issues and support provided. This could include knowing that the home environment may not be suitable. However, the County Council's social workers have moved out of the hospital setting with most of them virtual working and it is difficult to reconcile that all the benefits of in-person face to face interaction can be replicated virtually. With the discharge from hospital process now accelerated and the emphasis on home first

there is a danger that something is overlooked through only having virtual contact and that there could be more inappropriate discharges as a result.

Providers can no longer go into the hospital to assess their client's needs before they come home. They are finding that the quality of paperwork completed by the hospital as part of the ISP (Independent Support Plan) is not so good as a replacement for that personal visit and is letting down providers being able to pick up a client's needs quickly.

However, officers have advised that they expect the Home First principle to continue beyond the pandemic and that the core principle around not making long-term decisions about someone's future care in an artificial (hospital) setting should still remain. That may also mean that the quality of paperwork issue identified by providers will need to be addressed long-term and that further attention is needed to ensure that this new way of doing assessments is not a retrograde step.

It can be a fine balance between maximising the empowerment of someone to make their own decisions and what the local health and care system thinks they need or is best for them which may be different. As the focus now is on Home First, agencies need to be more mindful of this and step up their assurance processes where possible and mitigate as much as possible any risks from doing the assessments at someone's home. It could be as simple as asking the patient at the end of the hospital discharge process to call a family member or carer first to check that they are nearby to help before discharge and ask the question –

'is there someone to call before you go home?'

Reablement

If an adult is going home from hospital and is identified as needing some support, then ordinarily they will initially have a reablement package of care - this should usually start within 1 -2 hours of the person arriving home.

> Essex Cares Limited manage to start a reablement package of care for a client within 2 hours of them arriving home 98% of the time.
>
> Source: Essex Cares Limited representative at witness session

When a client is released from hospital an independent support plan assesses their needs and gives a time allocation the social services placement team think is required to provide the care package identified as needed. The reablement provider (usually but not exclusively Essex Cares Limited) will meet the client at the property and discuss and try to agree 'objectives/goals' with them whilst looking at any minor adjustments and equipment that might help. Where there is greater complexity of need then a visit by an Occupational Therapist will be arranged.

In most cases, the contracted time for a care visit will be reduced during the reablement period as the client becomes stronger and able to undertake more of their own care tasks.

> 70% of ECL clients leave their support service after a few weeks with the remainder receiving less ongoing care than when they first started.
>
> Source: Essex Cares Limited representative at witness session

Feedback on reablement was that it is excellent but there could be a 'cliff edge' when it ended after six weeks.

Anecdotal evidence about occupational therapist assessments has been positive insofar as the thoroughness of the assessment, appropriate equipment being put in place particularly for those who were frail, and that they would leave contact details for other support such as the Red Cross for a wheelchair, for example. However, some anecdotal evidence suggested that not all carers coming into the home know how to use all the equipment that has been prescribed through the reablement assessment or were not willing to use it all. Whilst anecdotal, it could be an indicator that information about care needs is not being communicated sufficiently between some reablement and domiciliary care providers.

Waiting times for assessment

Referrals to the ECC placement team to get domiciliary care call visits extended generally do not seem a problem at present. Instead, it seems there are delays for social worker and Occupational Therapist assessments and providers have advised that their own review team and assessors are having to fill the gaps especially when dealing with complex and/or crisis situations. Anecdotally, some people may spend more time in their own bed until assessments are done. It seems that some aspects of the sequencing of assessments may not be right and that assessment review processes may not work as efficiently as they should. This is an issue that was already in existence before the pandemic and seems to have got worse during the pandemic with providers reporting that social workers and occupational therapists are now less visible to them. The Group has also heard that providers often can spend considerable time chasing up progress and timescales for assessments.

The pandemic brings extraordinary challenges and sometimes requires unique and sometimes not ideal solutions but the Group are concerned that there has been reportedly some informal reliance on domiciliary care staff to use the video function on their mobile phones to carry out assessments on behalf of the County Council and this practice should be discouraged.

The assessment process is a key area of focus in the CONNECT Programme (which has now re-commenced). Officers have acknowledged that there could be the opportunity to identify slightly different processes that might allow people other than a social worker to make some kinds of assessments as they may be more familiar with a service user and be able to make a more informed and timely decision.

Recommendation 1: **The Group encourages further work to look at the feasibility and constraints in having a more flexible approach on who can undertake some individual assessments, subject to necessary safeguards, so as to facilitate a more informed and timely assessment process.**

The Group recognises that the assessment process itself could form a significant scrutiny study and it does not have the time, nor with the ongoing pandemic is it the right time, to do this now. However, our conclusion is that, notwithstanding the current pandemic pressures, that further scrutiny is required to highlight the challenges being faced by the occupational therapist teams, in particular, and the overall assessment process more generally and how to help address issues raised.

Recommendation 2: That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee further review the assessment process for support at home to include a focus on the challenges for the occupational therapist service.

Role of the community and voluntary sector

If there is any doubt about the ongoing suitability of the home environment, and capability to re-engage with the local community, colleagues from local community and voluntary organisations may be asked to help to provide some further support. The new statutory guidance on discharge from hospital is focussed on getting more community input into that process and a far better-balanced view of the individual needs but it requires cultural shifts and changes to relationships with local providers. There seems to be a significant expectation and emphasis on the local community and voluntary sector to 'step-in' where needed, sometimes as a bridging service and sometimes for longer term support. Yet members have concerns about that expectation and the capacity to operate and respond in a timely manner to such demands.

ECC and NHS directly commission some services across the county to help people settle back in at home. In addition, there is other non-commissioned volunteer support available but that will significantly vary between areas. ECC are currently reviewing what needs to be in place that can be directly commissioned, how it should link with specialist and statutory services and what else is out there that ECC can contact when they identify further support is needed but it is not formally commissioned. ECC officers acknowledge that some work is still needed on how community and voluntary services can wrap around and add to formal commissioned support without being too prescriptive.

The differing roles and activities of the community and voluntary bodies in Essex are very noticeable with some being directly commissioned to provide services whilst other similar organisations in other areas are not. For instance, ECL have recognised that people in long-term care often also needed help with such issues as housing and pensions advice. Castle Point Association of Voluntary Services (CAVS) have one person specifically commissioned and subcontracted to ECL to provide this help and guidance.

> An advice and guidance service provided by CAVS has been in place for over 3 years and has reportedly helped approximately 360 people and realised £1.9m of extra allowances for which they were qualified.
>
> Source: CAVS representative at witness session.

However, a similar arrangement to the CAVS advice and guidance service does not exist in other parts of Essex. Whilst there is an ECC commissioned countywide Essex Befriends service, local community and voluntary bodies may also provide other befriending schemes that could lead to some differences across the county.

Community and voluntary bodies have different models and different grant awards and it may be wrong to automatically make assumptions about differences across areas. However, whilst community and voluntary organisations who do not provide any commissioned services will seek to work in partnership with other organisations who do and refer people into other support agencies, the Group is concerned that there is significant potential for inconsistency in services available across Essex.

In particular, there seem to be some differences between community and voluntary organisations as to their responses (if they are able to) to step in and/or escalate support if it is identified as needed. Some organisations indicate they are more likely to formulate their own community response instead (using their own membership connections to day centres and community agents to find support) as they do not feel they have sufficient links with Adult Social Care or the NHS or that they did not have capacity to provide the support. A caveat here is that there is an acknowledgement that sometimes such reluctance to engage with Adult Social Care or NHS may partly be due to lack of available information to help them signpost effectively.

The Group feels that it would be beneficial to community and voluntary organisations if there can be greater information sharing and more regular dialogue between them at a local level. There are some mechanisms for this already in place but, of course, this has been particularly hindered during the pressures of the pandemic and the Group would like to encourage them to re-invigorate those meetings and processes.

The Essex Wellbeing Service has been established to help provide some support for people being discharged who do not need more formal support. This is welcomed and can fill some of the gaps in informal care. In terms of further support for the community and voluntary sector, the model of County Council funding has moved from direct grant and is now focussed on commissioning specific services. Whilst officers have stressed that when the community and voluntary sector is asked to provide a particular service then usually there will be specific funding to accompany it, there will be times when non-commissioned informal support may be needed and that is where the Group thinks it highlights concerns about capacity and consistency.

If the County Council wants to facilitate further care support from the community and voluntary sector then there also needs to be further movement in the current mindset towards them, so that they feel that they are an equal business partner and consulted and involved in discussions and planning at an early stage and not be perceived as the last resort. At the moment, there is an impression within the sector that it is treated as the 'poor cousin' in the system but they are a valuable resource that is sometimes being over-looked. Perhaps there are too rigid demarcation lines between what the community and voluntary sector can do and what other providers can do, and to what extent the community and voluntary bodies can fill in the gaps between domiciliary care visits - such as providing pastoral support and how such support could be requested.

Further review

It is a difficult and challenging period of time at the present and the Group have been mindful of this whilst hearing about people's experiences of the discharge process. The pandemic is putting extraordinary pressures on the local system and so some allowance should be made for that. However, there is concern that these pressures are leading to more permanent changes in the discharge process with a focus on discharges being made more to see if people could cope at home rather than that they had been thoroughly assessed that they could cope at home and perhaps this process needs more assurance built into it. The Group is acutely aware that there could be differing interpretations and approaches between hospitals and in not being able to speak to the hospitals due to the pandemic pressures, the Group has not been able to clarify this further.

Members have challenged whether it is now significantly less likely that one can still have inappropriate and unsafe discharge from hospital. However, it is difficult to make solid conclusions based on some relatively limited anecdotal evidence but the more cases that are highlighted where there have been problems then the more likely there may be a systemic issue impacting on a minority of patients. As stated elsewhere, the Group has also chosen not to pursue discussions with the NHS at this point due to the pressures of the pandemic and, therefore, in the current circumstances the Group is not able to be fully assured on this matter. However, it is pleased to see that the review work under the County Council's CONNECT Programme on how well discharge is working and looking at the experiences of service users and staff has re-commenced.

Recommendation 3: That, after the County Council elections in May 2021, the Health Overview Policy and Scrutiny Committee, together with the People and Families Policy and Scrutiny Committee, should jointly investigate further the adequacy and safety of discharge processes.

Finally, it is also apparent that someone receiving reablement or domiciliary care before being admitted into hospital may after discharge not necessarily return to that same care provider but instead have a reablement service with another provider, or an in-lieu of reablement service or be part of a winter pressures support scheme - this range of routes out of hospital/schemes can be confusing and takes away continuity of provider for the service user. Whilst recognising the immense pressures on the system at the moment, this current practice would seem to be not only detrimental to the service user's confidence and experience but could also be sufficient to hinder their recovery and may not be best value for money either.

Accessibility and referrals into services

Navigation of the health and care system is complex. Members have heard that it can be a minefield to know how to find agency carers and this becomes more bewildering and onerous if people are on their own. Family carers often do not know where 'the system' is and how to navigate it – and then having to still make multiple phone calls and repeat their story.

"where do I start and what do I need to do?"

This situation seems to have been exacerbated for some people soon after the first lockdown had started when Age UK Home Help stopped its services and some people may have felt abandoned. Other agencies have also scaled back some of their activities due to the pandemic at a time when more capacity was actually needed. Day centres closing during the pandemic has made it a particularly difficult time as they are a lifeline for some and it has been reported that there has been a marked deterioration in people's health as a result.

There seems to be some frustration in the system about lack of awareness of support services that are available. The Red Cross Home Support service should be offered to everyone as part of the discharge process but it is not clear that this is well enough known. There has been some acknowledgement that information available on discharge has not been good enough in all cases and perhaps clearer messaging is needed. As acknowledged elsewhere in the report, these extraordinary times have meant that the Group has not spoken to NHS bodies to clarify the exact information available at time of discharge. However, if not already in place then there is an overwhelming need for a simple contact sheet to be given to everyone being discharged from hospital – effectively a 'one-stop shop' contact card with a handful of key telephone and on-line addresses to signpost support and advice and entitlements and a step by step checklist to help guide next steps.

Recommendation 4a:
A simple contact sheet to be given to everyone being discharged from hospital – effectively a 'one-stop shop' contact card with a handful of key telephone and on-line addresses to signpost support and advice and entitlements and a step by step checklist to help guide next steps.

One of the biggest barriers facing family and carers when looking for a domiciliary care provider is knowing if they are any good. The Group has heard anecdotally that the names of recommended providers can often be passed around by word of mouth between carers which is not an ideal or a comprehensive process. Whilst recognising that there may be issues around being able to actually recommend (and implicitly not recommend) some providers, the Group would like to see further thought given to developing guidance that can aid families in deciding on their provider of services.

Recommendation 4b: the one-stop-shop contact sheet to include some simple tips to consider when looking at a service provider.

Whole family approach

The system may still be overly focussed on the immediate need being presented and this is understandable at times of peak demand pressure. Yet, when people contact domiciliary care services, the initial questioning by the potential service provider should be "do you look after someone or is someone looking after you"? and then look at the local system developing a whole family approach and not just respond to the patient and their symptoms. In the end this may be a more efficient use of local

resource and prevent other issues arising later. The Group has heard of examples of community and voluntary organisations trying to work with local GPs and developing a system that looks at a family holistically. GP surgeries in some areas have been provided with information packs on support options available by some community and voluntary organisations as part of focussing on trying to get information available at more places/points of contact. Every GP practice should now have a social prescriber and they are a good way into the local support system and perhaps this needs to be signposted and utilised more than it is currently.

Shared care record

The County Council are working with health partners in developing a shared care record. Since October 2020, ECC's ASC management system has been able to process patient information from the NHS - an ECC decision is to be taken to start a 12 week consultation process so that ECC can move towards being able to share its records with the NHS. Once this done then people should not have to continually tell the same story to multiple health and social care agencies. The Group fully supports this and encourages further progress as it has still been hearing stories from some witnesses about this still being a significant issue.

Monitoring of performance and service quality

Any person (individual, partnership or organisation) who provides regulated care and support activity in England must be registered with the Care Quality Commission (CQC) who will monitor their fitness and compliance with various regulatory regulations and rate a care provider on their overall quality of care. The Group have not considered the role of the CQC but instead wanted to focus on what else was in place to oversee quality and standards on a day-to day basis and the mechanisms and processes that the County Council has in place as commissioner of domiciliary care services.

Key performance indicators

Providers reported that they have invested heavily in information technology solutions. Care visits are electronically monitored with care workers using apps to log tasks and outcomes and they cannot leave the property until all tasks have been ticked, including confirmation that all medication has been given in a timely manner. Providers have their own internal governance structures but commonly present their performance data against key performance indicators to their respective internal committees and boards, often overseen by a compliance function. The Group would expect the County Council, as commissioner, to seek assurance that providers of all sizes have such controls in place. Reassuringly, providers have confirmed that during the pandemic there has been an escalated and further increased focus on infection control.

Provider Quality Team

The Group are pleased to hear that the County Council's Provider Quality Team (PQT) works closely with the CQC. Action plans for providers are developed where improvement has been identified as being needed. The PQT undertakes assessments and inspections of care homes and domiciliary care to evidence that robust processes are in place around:

- staff recruitment;
- staff training and supervision;
- care and support plans;
- records keeping;
- medicines management;
- staff rotas and mitigating against missed calls/late visits; and that
- having the right structures so that the provider is fit to work in the sector.

A vital part of the PQT assessment is talking to people who receive the services - scrutinising rotas and ensuring that clients were receiving care at the time and duration that they should be receiving it. The PQT also talk (in confidence) to staff to gain insight into how they are being managed. An On-line tool will then generate a score and highlight areas for action and discussion with the care provider.

Not every other upper tier authority has a PQT or similar. The establishment of the PQT by the County Council has enabled ongoing relationship building with providers that in other local authorities might need to be done by the procurement function instead.

The Group has been keen to understand which clients are contacted as part of PQT's assessment of a provider and have been advised that they will be selected both on need (using MOSAIC) and also a random sample element. Whilst a care provider may provide a list of potential clients for ECC to contact, ECC may not necessarily use it and instead will seek a cross section of users and will expect to talk to at least 5-10% of service users. If an issue is identified, then ECC may widen the inspection and speak to more service users.

There is an acknowledgement that there might be other mechanisms other than full assessment for smaller providers. CQC inspections also will share concerns with ECC. Sometimes an issue flagged may be just an individual issue that can be solved by social worker or other mechanism.

The Group have been advised that the PQT continually assesses the quality of commissioned domiciliary care and support services in Essex. However, members have had some concerns about the whether the size of the PQT is sufficient bearing in mind it oversees both care homes and residential care, and care for those with learning disabilities, as well as domiciliary care providers. Whilst there is a broadly similar assessment process for all the settings, there are slightly different things that also need to be looked at that are specific to the setting - for example, with domiciliary care providers ECC will need to look more at rotas, the number of missed calls and similar which would not be so applicable to a residential care setting. The

limited PQT resource means that the PQT need to use local intelligence efficiently and work with colleagues across the ECC organisation to help identify concerns and focus ECC resource where it is known there are problems, where ECC was doing most business, and where ECC was commissioning the largest care packages. Members feel that this seemed to emphasise an over-reliance on receiving complaints and issues of concern and that the team does not seem to have the capacity to be proactively inspecting and monitoring on a scale that would fully align with the size and cost of the services being commissioned and the responsibilities as a commissioner for high quality and safe services.

Induction and general training

The Group were assured by all the providers they spoke to that there is broad agreement between them on the elements of core induction training, and that consistent and robust training processes are in place to ensure properly trained and qualified care workers are providing the service. Care staff are expected to have completed mandatory training, some in classroom settings, in core competencies such as manual handling, safeguarding, medicines management, first aid, health and safety and infection control. New recruits will then job shadow for a period followed by being observed on home visits by an experienced carer before they work unsupervised supporting people in their homes. Whilst the Group only spoke to a small sample of provider representatives, the messaging was strong, aligns with ECC's expectations and forms a key part of ECC's assessment of providers undertaken by the PQT. The Group were assured that this was re-enforced through the PQT's close work with the Essex Care Association and should continue to be.

Providers are challenged by increased complexity of individual health needs and the County Council is working with providers to understand where the gaps are and develop different training and mentoring for providers. Often there can be a lack of confidence around providing care for certain conditions (like dementia, End of Life Care). Some additional training for other aspects of care will be done by the supervisor accompanying care workers on visits and training them on the job.

ECC are keen to find a more coherent collaborative strategy for training, particularly induction training, across the sector. If there are more shared approaches across different providers, then you can take away some of the fear and challenge of losing your staff as you should be able to recruit comparable replacements more easily. ECC have been talking to ECA to look at developing a passporting arrangement to avoid, for example, repeated induction training when changing employer. In addition, ECC are looking to ensure adequate management quality is also in place in provider companies as that can impact the quality of service being provided.

Responding to changing client needs

It was reported that providers would expect a care worker to report back to the office if they were seeing increased frailty, and/or increased medication needs and the care provider would then report back to Adult Social Care asking for an increased hours

allocation under the contract. If the evidence is accepted, then the allocated length of the care visit will be extended. Anecdotally the Group has heard that these can be approved the next day but sometimes it can take weeks and it is not clear to providers why that is the case. Providers have suggested that it may be down to insufficient initial evidence and perhaps more clarity is needed here.

ECC talk to providers about their respective business continuity planning when they come onto ECC's Live At Home framework contract - this should enable them to mitigate and respond to increased care needs and to be able to plan for the unexpected. ECC would expect providers to have a policy around accidents and incidents in the home which might necessitate a carer having to stay for longer on a particular day and the carer knowing what to do to escalate the issue.

Quality concerns

However, whilst hearing some good stories, the Group have also heard some concerning anecdotal evidence that, at least with some providers, there is not adequate oversight of quality standards and controls – these have included:

- carers coming into the home seeming to need more instruction on how to fix day and night packs for a catheter as they were not used to doing it (changing of the catheter is done by a district nurse).

- carers visiting times being inconsistent and not always at the appropriate point in the day.

- no proactive approach to ask if anything else needs doing and seemingly always pushed for time.

- an agency carer arriving who was pregnant and could not undertake some of the required care tasks.

- some care workers have had to be specifically asked to give a client a shower or shave.

- whilst there is a client folder prepared which identifies care needs, do carers follow this or even have time to read it when they first visit?

A challenge for the Group has been to assess how typical these concerns are. Anecdotal evidence is just that, it cannot suggest in itself that there is a systemic issue but it should alert commissioners and providers to cases where the system has not worked well and that focus is needed to ensure that they are blips in the overall provision of care in Essex. Officers have acknowledged that there is some variance in the quality of services across the county. This is addressed through robustly measuring and monitoring the minimum quality standards and the PQT carries out deep dive audits to ensure these quality standards are adhered to. In addition, a risk-based approach to managing service delivery and managing quality is undertaken,

based on the review of a range of indicators, including key performance indicators, provider concerns, financial risk indicators and safeguarding enquiries/concerns.

Members have challenged officers on how they monitor and respond to complaints and feedback about providers. It has been acknowledged that in terms of monitoring some evidence-based data driven activity it was still early days. However, ECC's Insight Team have been using surveys and Zoom calls to seek some user feedback during recent months. The Group are pleased to hear that there has also been a lot of proactive welfare calling during the pandemic to those known to be self-isolating and/or vulnerable and that this had been highly valued and re-assuring for users even if they did not actually need anything. It has been highlighted that the pandemic has been especially difficult for those with physical and sensory impairments as they are still finding it difficult to access their local community as it has not been possible for them to socially isolate properly at this time.

Officers have been keen to emphasise that there is ongoing work to move away from strict responsibility for welfare lying with just one organisation towards a more collaborative arrangement where everyone has responsibility for patient outcomes. It is expected that the Connect project will help design that change and genuinely hold people to account rather than just what happens in individual services/organisations.

During discussions with officers there seemed to be an acknowledgement that it was possible people could fall through the cracks and that frail people may be too scared to make a complaint about the quality of the service they were receiving. Skilled social workers do have conversations with vulnerable people and talk to relatives to try to tease out issues. Sometimes issues raised may meet the threshold for safeguarding concerns and Essex has a dedicated specialist safeguarding team to undertake enquiries.

Recommendation 5:

That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee should look at governance processes for user feedback and complaints handling in the domiciliary care sector to include how easy it is to feedback and/or complain, and changes made as a result.

Care worker feedback

The second annual care workforce survey has recently closed. The Group has looked at the high-level results from 394 care workers and other care workforce staff and noted that the Council has developed a workforce strategy with over forty commitments for ECC, and more than 30 for care providers (of which three are mandatory). These commitments will be embedded in Social Care service contracts going forward.

Some evidence was received from the Group from care workers around the use of zero-hours contracts and insufficient travelling time between visits. However, this was anecdotal and there was also confirmation from providers that zero-hours

contracts were only offered to those that wanted them for flexibility and that travelling time was paid from the time staff left their first call until their last call of the day. Clearly the Group has only had contributions from a small number of care workers and provider organisations but the Group recognise there may be differences between employers.

Capacity

Population demographics, increasing complexity of health and support needs and the greater focus on supporting people at home means capacity in the domiciliary care sector seems to be stretched and this has been exacerbated by the pandemic.

Sustainability of the domiciliary care market will partly depend on efficient use of resources and managing costs. However, over-emphasis on managing costs arguably can impact on the resilience in the provider market and this market now feels very fragile. Elsewhere in this report, there is mention of a range of reablement services available at the time of discharge which are perceived to reflect an increasing trend of smaller, add-on contracts which have been used to fill gaps and make-up perceived shortfalls - Reablement; In-lieu of Reablement; Provider of Last Resort; Winter Pressures, for example. It is arguable whether this is more of a fragmented rather than co-ordinated approach, driven largely by extreme demand pressures at times, and perhaps flags up that more attention is needed to build a stronger and larger capacity care provision locally that can fully meet the demand. This could reduce hand-offs between services and reduce delays due to assessment.

Essex Cares Limited provides the majority of reablement services. It has had the additional challenge to ‘ramp up’ capacity to take on the case load vacated by Allied Healthcare and it would be fair to say that it took time to do this and the County Council had to purchase extra capacity from the market to meet the shortfall in the meantime. The ECL service has grown significantly since –

> ECL provided approximately 6000 hours a week of care at the time of the Allied Healthcare insolvency and now provides close to 10,000 hours a week.
>
> Source: Essex Cares Limited representative at witness session

Talking to providers there are times when a service cannot meet all the demands placed on it in one day. It does not seem that this is happening frequently although it is an indication that the sector is stretched at times. The pandemic has brought extra pressure onto providers with staff sickness and absence rates significantly increasing and thereby exacerbating the pressures. Providers tend not to use agency staff and instead have a 'bank' of their own staff who do not have set shifts and can use them as flexible resource.

Providers assured the Group that on days when they were unable to fully undertake care visits on their usual schedule they would use risk ratings allocated to each client

to prioritise visits for those most in need and often providers would then ask family members to step in temporarily for those who have been rated with a lesser priority.

Providers have to be able to provide safe care and if they feel they cannot do that due to lack of resource then they must decline the case. ECL advised that they now decline less cases than they used to. Whilst it has been acknowledged elsewhere that the feedback on ECL reablement services is good, the Group is more concerned about what happens to people ECL cannot take on and the arrangements for alternative services.

Demand pressures and resources do vary between different parts of Essex. Currently, the most challenging area seems to be mid Essex, where ECL, in particular, has highlighted that they get more referrals than they can meet. The consequence of this is that it may mean that people stay in hospital for slightly longer and that there is a short delay before a care package is put in place. In the case of reablement, sometimes the case may be referred to other providers (such as domiciliary care providers) as alternative care provider. The exact reason why there seems to be particular pressure in mid Essex at the moment is unclear although it could be down to a slight variation in discharge process from hospitals in that area compared to others. Officers have assured the Group that they will be investigating this further. As mentioned elsewhere, due to the pandemic the Group has not had the opportunity to talk to the hospital trusts about their respective discharge process which would have helped understand any differences between areas, and there should be further scrutiny of this after the County Council elections.

Recommendation 6:

That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee should seek further assurance about the part of the discharge process undertaken in hospitals.

Some geographical areas will have other challenges, such as Uttlesford being very rural, and the Group are encouraged that ECC recognises that and discusses with providers more localised staffing arrangements where appropriate to make it easier for care staff to travel. ECC knows there are harder to source areas where travel and distances can be significant issues and care services can be less economic to provide and are showing flexibility towards their rates offered to providers for existing packages where there is a need for that supply and the provider evidences financial difficulties. The Council will discuss with providers how to support more difficult and sometimes unsustainable rounds of care visits. These arrangements continue to emphasise the challenges and fragility of the market in being able to provide a consistent service across the county.

Responding to the pandemic

The Covid pandemic has presented additional challenges to care providers in terms of keeping abreast of, and responding to, guidance, personal protective equipment, infection prevention and control, testing requirements and risk managing staff

and service users who are shielding. In response to the pandemic the Council has set up Care Market Hubs and meets regularly with domiciliary or intermediate care providers, to discuss what support they may need, share any information or concern and take appropriate action. Providers have welcomed this support and the putting in place of some financial measures to support the sector. Partly this was mandated by Government, but ECC have also used some discretionary funds.

The Group heard that Providers have shown resilience and resourcefulness and have generally maintained support to people over the crisis period. Business continuity and contingency plans were enacted, and technology has been used (such as Alcove tablets) to maintain contact and for welfare checks. As mentioned elsewhere, in some cases the RAG rating system for all clients was used to prioritise care for those with greatest needs. Working closely with ECC, and where necessary, some providers did temporarily combine some scheduled visits - carers have also been doing more hours than they normally would do. Office staff who were also trained as carers also went out on visits.

Community and voluntary organisations have redeployed staff during Covid-19 more towards providing community support and liaison. After the pandemic it is likely that they will go back to more project-based work so there could be resulting capacity issues as a result.

Recruitment

> I tell carers off for saying "I am just a carer". Instead it should be "I am proud to be a carer" – domiciliary care provider representative at a witness session

Recruitment in the sector will continue to be a challenge particularly around making it an attractive proposition for people to want to work in the sector as it is not possible to incentivise solely by pay.

Providers have highlighted that it is a challenge to get young people entering a career in reablement and domiciliary care as often they do not drive or have access to their own transport. However, ECL did highlight that they do offer apprenticeships in equipment centres and in Day Centres as they are fixed work locations and those without their own transport can use public transport to get to them instead. ECL have not found an economic way to provide staff vehicles yet.

There are NVQs for carers (nationally recognised) to take which they can then use to build and progress their careers into social work or healthcare.

As mentioned elsewhere, ECC are working with the ECA at passporting skills between employers which may make recruitment easier for those switching within the sector but, unless such passporting could be extended to other related care related sectors, then this will not assist attracting people from outside the domiciliary care sector.

Technological support

Care technology is a broad term that includes assistive technology, telecare and other types of technology connected to promoting health, wellbeing and independence.

There is now more emphasis on technological innovations, improving equipment and general wrap around services to help meet the increasing demand for, and expectations of, home support. It is fair to say that the sector had fallen behind in the use of technology compared to some other sectors although the County Council had started to prioritise it pre-pandemic. The Group are encouraged that the County Council now has a vision of integrating technology into day to day life and increasing the confidence of clients in using it.

The pandemic has emphasised the need for greater and faster use of digital and technology. However, whilst some clients may now prefer to use some aspects of technology, you do lose the benefits of face-face interaction and it needs to be part of a service 'blend' to facilitate contact with people. Important hands-on-care should still happen when needed. Some contributors to the review were particularly concerned that too much focus on increasing the use of technology could make people more isolated.

Technology to monitor safety and quality

Electronic home care monitoring is intended to be part of the Live at Home procurement framework which can include being able to spot in real time when visits are being made and when missed. The Group acknowledge that there is still some ongoing work in connection with this as the re-procurement is finalised.

Supporting family carers is one of the priorities for future commissioning arrangements and technology is now available that can help monitor care visits being made to give added assurance to family carers. Similarly, response mechanisms, such as fall alerts, are included in the re-procurement.

Technology to provide support

During the pandemic ECC has delivered 2,000 Alcove Video Care phones to vulnerable people in Essex with the aim to supplement face-to-face contact, aid social distancing and support emerging needs related to COVID-19. There have been good levels of engagement in getting the video care phones out to various locations but there was a delay in actual deployment and use as the County Council needed to make sure everyone was confident in using it. Whilst activation has had to be done remotely during the pandemic, a more hands-on support in activation should be possible post pandemic when it should continue to supplement face to face contacts. The aspiration should be that local providers get to a stage with using this technology where people who are close to going back to self-caring can deliver their final stage of supervised care via this technology. Tablets can also be used to check

up on those being supported and help supervise medicines management and receive on the spot feedback.

ECL have been discussing with Amazon about adapting the current Alexa device so it can turn on lights, for example, and see how it can be incorporated into the ECL service.

Objectives for the use of technology

Fundamentally, commissioners need to be clear on the objectives for encouraging and expanding the use of technology. Is it to prevent isolation and ensure safety monitoring mechanisms are in place for care visits? is the latter the most important objective to ensure quality? This is still a significant emerging area for domiciliary care and the Group feels that more time should be spent reviewing the potential of technology. In particular, whilst there seems a reasonable level of assurance that there is now information technology available to monitor the thoroughness and quality of home visits, technology that directly supports the service user needs more development so that it is truly interactive and can communicate and give advice to those being supported and help prevent unnecessary admissions to hospitals. This would then need to be incorporated into a variable service offer much like a menu of technical assistance that is available, recognising that not one size fits all.

Recommendation 7

That, after the County Council elections in May 2021, the People and Families Policy and Scrutiny Committee reviews the emerging potential of technology to further support people in their homes.

Live At Home contract

The County Council is currently in the process of procuring a new Live at Home framework, with its go live date originally scheduled for April 2021 now delayed due to the pandemic. Whilst not reviewing the contract provisions directly, the Group has had some issues raised particularly from domiciliary care providers.

Arising from the re-procurement, the intention is to move to a two-tier framework with up to ten high quality providers who are CQC rated good or outstanding on Tier 1 in each lot, through whom most of the support will be sourced. This will reduce the overall number of providers that the County Council engages with and the County Council believes this will allow more robust oversight around quality of provision, whilst still retaining some price control. However, such increased control may come at a price as it is not clear that this necessarily aligns with the County Council's strategic aim to enhance partnership working if it becomes so concentrated in a few providers.

The new framework has an increased focus on quality when assessing the bids received from providers (split 60:40 on price: quality from the previous 70:30 split)

and providers in tier 1 are required to have good or outstanding CQC ratings. Key Performance Indicators, which are linked to CQC Key Lines of Enquiry, are also included. However, the Group remains of the view that the focus still seems to be on price and notes the concerns raised by some providers that the framework could push higher quality providers down the list of preferred providers. There may be further discussions necessary to enhance a more collaborative and partnership view of the framework.

Whilst the tender process has been temporarily deferred due to the pandemic, the ECA would like to see further time allocated to 'draw breath' to take on board all the challenges faced and possibly remodel domiciliary care for a post-pandemic world. Again, there may be further discussions necessary to enhance a more collaborative and partnership view of the timing of the re-procurement.

Conclusions

The review has been undertaken against the backdrop of, and through the lens of, a global pandemic which meant that contributors and the local carer system as a whole have been facing extraordinary challenges and demand pressures throughout. The Group wants to acknowledge the immense contribution and dedication being shown by everyone in the local system in meeting the challenges faced in the last twelve months. With this in mind, the Group have appreciated more than ever the time granted to them by contributors to help with the review. The Group has not spoken to anyone from the NHS which, ordinarily, it would have done particularly in relation to discharge processes and this is referred to in a number of places in the report and has formed the basis of a number of recommendations for follow-up scrutiny work to be undertaken by the People and Families Policy and Scrutiny Committee when it is reconstituted after the May 2021 County Council elections.

In the meantime, this report to some extent is an interim report which acknowledges limitations placed on it due to the pandemic and imminent elections and that the review is not complete. However, it still manages to highlight issues raised by contributors which the Group would still like ECC officers to investigate further even though many of them have not been formalised into recommendations.

A Home First Principle has been established as a result of national guidance issued in March 2020 which changed the assessment for discharge dramatically. ECC is still working with hospitals to ensure that it can still input any previously identified concerns and support issues for a client about to be discharged but it is unclear how well this is working and what happens if the County Council is not fully satisfied with the process. In particular, an inadequate quality of discharge paperwork identified by providers will need to be addressed long-term and further attention is needed to ensure that this new way of doing assessments is not a retrograde step.

During discussions the Group have questioned whether the overall objective of providing domiciliary care is clear and what outcomes are being sought. So, for instance, at one level one can say that the service is to support people to live as

independently as they can in their home environment and focus is then put on delivery to achieve that. However, at another higher level if there is the aspirational system-wide objective to also get people out of hospital and keep people out of residential care (both of which costs the tax payer the most money) and domiciliary care does not work well enough then it defeats these objectives. If domiciliary care is better and more consistent then tax-payers money is better spent. Therefore, the Group believes that there needs to be further attention paid to improve domiciliary care as there is evidence, albeit some of it anecdotal, that is not consistently good enough at the moment for all service users.

Throughout the review, there seems to have been a disconnect between cases members hear about where some care provision has failed and some contributors who are suggesting that cases which go wrong are very isolated. This may be the case but the Group feels that there needs to be an acknowledgement that 'bad things can happen' even if it is a minority of cases and that a clear process is established to say this is why and this is what is being done to correct it. At the same time, the Group acknowledges that a majority of service users may still be getting a good service so it may be specific types of support or issues where the system does not quite work for everyone. The commissioning of Newton Europe to undertake a system diagnostic of hospital discharge cases is some acknowledgement that further work is required and the Group has welcomed the recommencement of subsequent work on this through the CONNECT programme.

The feedback on ECL reablement has been positive but the Group notes that demand pressures has meant that other alternatives have to be in place to fill the gaps when ECL does not have capacity to take a case. Perhaps, some of the quality issues raised may reflect those instances when a case does not get referred to ECL for reablement and where services do not fully join-up.

The Group has noted that re-procurement of the Live At Home Framework was paused due to the pandemic but is due to recommence and complete later this year. It would be fair to say that there is not universal agreement about the recommencement. The domiciliary care providers the Group spoke to were looking for the pause to be extended to allow for a more considered review of the impact of the pandemic and new ways of working whereas the County Council believes that the pandemic has reinforced its thinking and the trends previously identified. The Group understands both viewpoints although the pandemic is likely to throw up some lessons learnt. There may be further discussions necessary to enhance a more collaborative and partnership view of the timing of the recommencement of the re-procurement.

Recruitment remains an issue in the domiciliary sector although the Group has noted some differences between providers in how significant an issue that is for them. Promoting career opportunities in future needs to highlight not just being able to undertake care tasks but also to feel an emotional connection to their job and that clients feel that people care about them and are treated with dignity. Contributors have stressed that there also needs to be greater recognition that care work should be viewed more as profession and that training and qualifications should increasingly reflect that.

Glossary

Adult Social Care/ASC	System of support designed to maintain and promote the independence and wellbeing of disabled and older people and informal carers. It is often associated with the provision of personal care (such as eating, washing, or getting dressed) and accomodation. For the purposes of this report it may also refer to the functional part of the Essex County Council organisation that commissions the above services.
Age UK Home Help	A paid for face to face service which provides help in the home with tasks such as vacuuming, cleaning, changing beds, assisting with food preparation or sitting with an elderly person for a chat. The service does not provide any kind of personal care. In Essex this service closed in June 2020. Age UK home-help-service-closure
Alcove	Alcove video phones>
Care Quality Commission/CQC	The independent regulator of all health and social care services in England. It monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services. CQC
Clinical Commissioning Group/CCG	NHS body to organise the delivery of services in an area. It will commission most of the hospital and community NHS services in the local area for which it is responsible.
Connect Programme	A redesign programme to transform support for older people in hospital and at home including reablement and discharge from hospital processes. Connect Programme
CVS /Community and Voluntary organisations/sector	Community and voluntary groups running either as registered charities or non-charitable voluntary bodies working in the public interest undertaking activities that benefit the community.
DTOC/Delayed Transfers of Care	This occurs when a patient is ready to depart from a care setting but is still occupying a bed after a clinical decision has been made that it is safe to discharge them.
ECC/the County Council	Essex County Council. Essex County Council
Essex Care Association	An independent voluntary ‘not for profit’ organisation representing the interests of social care providers. It offers members a range of support services and a mutual support network. Essex Care Association
Essex Cares Limited	Provides care and support services in Essex for people to live safely and independently within their own homes and local communities. Essex Cares Limited
Essex Wellbeing Service	Supports Essex residents to access information and facilitate easy access and referrals to wellbeing services. Essex Wellbeing Service
Healthwatch Essex	Independent organisation representing the views of health and social care service users- Healthwatchessex
ISP/Independent Support Plan	A care and support plan for anyone who needs care or cares for someone else. It is prepared by the social

	services function at a local county council or other upper tier local authority responsible for social care. Each patient should get a personalised discharge plan before leaving hospital. Care and Support Plans
In-lieu of Reablement	Services offered to those eligible for a non-chargeable enabling/reablement service, usually provided upon discharge from hospital and where there is not enough capacity for it to be provided by Essex Cares Limited. The service should mirror that provided by the Essex Cares Limited main reablement service.
Integrated Discharge Team	Joint NHS and social care multi-disciplinary team based at hospitals to help with facilitating improved patient care and efficient and safe discharge of patients when they are medically fit to do so.
Live At Home contract/framework	A framework agreement for participating providers to work strategically with the County Council in developing the domiciliary support market in Essex. Providers who are part of this framework also receive care package offers ahead of other providers. Live at Home Framework
MOSAIC	Case management system to manage all social care on one platform and integrate health and social care data.
Newton Europe	Business consultancy company - Newton Europe
NHS/Health	Generically in the context of this report to mean the local health service. Usually it will mean health commissioners and providers collectively.
NVQs	National Vocational Qualification. A work-based qualification based on the skills and knowledge a person needs to do a job. The qualification is achieved through assessment and training.
People and Families Policy and Scrutiny Committee (PAF)	An Essex County Council Committee, comprising elected Councillors, that scrutinises the planning and provision of children and families services, education services and social care services in Essex.
PQT/ Provider Quality Team	Supplies a broad range of support to care providers in the form of training, coaching and mentoring opportunities to help support improvement. Provider Quality Team
Provider of Last Resort	This service ensures that support is available at very short notice or where there is no capacity in the market and the vulnerable Adult is at risk if a service is not provided.
Red Cross Home Support service	Support service to help someone live independently at home or when they return after a stay in hospital. Red Cross Support-at-home
Zero-hours contract	Employment contract with no minimum work time. The employer is not obliged to provide any minimum number of working hours to the employee

Annex 1 - Terms of Reference and Membership

Terms of Reference

To consider the current arrangements for, and oversight of, the delivery and quality of domiciliary care in Essex and identify any further possible issues with, and improvements to, such provision.

Key Lines of Enquiry

- To seek assurance that people will still be able to be referred into services, that access is available, (i) routes/options in normal course, and (ii) assurance that still happening during pandemic (including awareness, signposting and comms are in place). How maintain confidence to refer into the 'system'.

- To seek assurance that there is adequate monitoring of performance and service quality of domiciliary care providers and robust processes to monitor, identify and instigate improvement actions

- To seek assurance that there is adequate capacity in place.

- To understand the current provision of technological options available to support people in the home and how that can be further expanded and prevent unnecessary admissions to hospitals.

- To seek assurance that there are adequate discharge planning processes in place, arrangements for reablement (where appropriate) and identify issues for improvement.

Membership

Councillor Beverley Egan (Lead Member)
Councillor Jenny Chandler
Councillor Mark Durham
Councillor June Lumley
Councillor Peter May
Councillor Ron Pratt
Councillor Pat Reid

Declarations of interest (relevant to the review)

Councillor Mark Durham – family relationship to witnesses sharing first-hand experience of domiciliary care.

Councillor June Lumley – Chairman of Rayleigh and Rochford District Association for Voluntary Service

Annex 2 - Contributors

Members would like to thank the following who contributed to the review.

Name	Title and organisation
Matthew Barnett	Head of Strategic Commissioning and Policy, Essex County Council
James Clarke	Chief Executive Officer, Action for Family Carers
Joe Coogan	Director of Operations, Essex Cares Limited
Sam Crawford	Head of Provider Quality, Essex County Council
Peter Fairley	Director, Strategy, Policy & Integration (People), Essex County Council
Nick Flemming	Director and owner, Premier Care
Ann Forrester and Ruth Durham	First-hand experience of domiciliary care being received by a family member at the end of August 2020
Simon Harniess	Director of Development, Essex Care Association
Tanya George	Managing Director, Caremark Chelmsford & Uttlesford
Zoe Harriss (twice)	Category and Supplier Relationship Lead, Essex County Council
Christine Horn	Dementia Team Leader/Befriending Team Leader, Age Concern Colchester and Tendring
Janis Gibson	Chief Executive Officer, Castle Point Association of Voluntary Services
Simon Griffiths	Director Local Delivery (South), Essex County Council,
Lorraine Jarvis	Chief Officer, Chelmsford Centre Supporting Voluntary Action
Rebecca Jarvis	Head of Strategic Commissioning and Policy, Essex County Council
Shani Levy	Interim Director of Care and Support, Swan
Victoria Marzouki	Chief Officer, Rayleigh and Rochford District Association for Voluntary Service
Catherine McBride	Managing Director, North London Homecare
Moira McGrath (four times)	Director, Commissioning, Essex County Council
Michael Plant	Integration and Partnership Locality Lead, Essex County Council
Christine Richardson	Director of Operations, Forest Homecare
Jo Rogers (four times)	Commissioning Manager, Essex County Council
Sarah Troop	Director, Maldon and District Community Voluntary Service
Sharon Westfield de Cortez	Healthwatch Essex
Russell White	ASC Service Manager (Head of Connect Programme), Essex County Council
Care supervisor in Dengie area	Evidence provided on anonymised basis
Three care workers	Written evidence provided on anonymised basis

There were 11 evidence sessions (some with more than one witness present). Most evidence was oral although some written material was also considered. Advance questions from the Group were used to help structure some discussions. Some officers attended more than one session (as indicated above). Sharon Westfield de Cortez also was present at discussions with some of the other witnesses.

Annex 3 - Written evidence

1. Domiciliary Care and Support Deep Dive – introductory report prepared for the Task and Finish Group by ECC officers (October 2020)
2. Transforming Integrated Intermediate Care Pathways – Essex Health & Care – January 2020 Update (Essex County Council and NHS) (eight pages);
3. Essex County Council Care Worker Survey 2020 – Summary Report and Top-Line results (18 pages);
4. In lieu of Short-Term Enablement – Performance Standards – labelled Schedule 2 (Essex county Council) – 52 pages
5. Live At Home Service Specification – labelled Schedule 1 (Essex County Council) (50 pages);
6. Live At Home - Annex 1 to Schedule 1 – titled Objectives (six pages)
7. Care Quality Commission – About Us – what we do and how we do it (eight pages)
8. Cabinet Decision Paper dated 15 September 2020 – Transforming Community Care FP/776/07/20 – To award a contract to Newton Europe Limited to provide consultancy services.
9. Cabinet Decision Paper dated 15 September 2020 – Procurement of a Framework for Live At Home Domiciliary Support FP/778/08/20.
10. Cabinet Decision Paper dated 18 October 2019 – To go to market to procure services In Lieu of Reablement FP/529/09/19.
11. Cabinet Decision Paper dated 21 March 2017 – Direct Award of a New Short-Term Support in the Community Service FP/699/12/16.
12. Domiciliary Support Commissioning & Category Plan 2021 – power point presentation (72 slides)
13. ASC Covid-19 winter plan 2020-21 https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021
14. Healthwatch Essex - Insight into contacts from individuals regarding Domiciliary Care to Healthwatch Essex between March 1st 2020 to October 31st 2020 – 18 case studies (presented to the Group during November 2020).
15. Three anonymised written submissions from local care workers (presented to the Group during December 2020 and January 2021)
16. Discharge Briefing prepared for the Task and Finish Group – ECC officer Power Point briefing and presentation – dated 11 December 2020
17. How are we using technology/thinking about use of technology to support people at Home – ECC officer briefing prepared for the Task and Finish Group – Power Point presentation (presented on 18 December 2020).
18. Written submission from Essex Care Association (February 2021).

Annex 4 - Limitations of the review

The Group is content that it has received a range of views and collected evidence from a number of key witnesses to help it have reasonable oversight of arrangements for domiciliary care in Essex, service user and care worker views, and the overall co-ordination of services. This has enabled it to come to some reasonable evidence-backed conclusions. However, the Group also acknowledge that, due to time and resource constraints, they have only just 'dipped below the surface' on some of the associated issues identified.

There were further investigations that could have been made and other witnesses with whom the Group could have consulted. Some of these are acknowledged within the body of the report and notably includes the NHS which has been under immense pressures as a result of the pandemic and a decision was taken not to try and engage with the NHS during this time.

The Group spoke to two witnesses who had first-hand experience of domiciliary care being received by a family member. Through additional discussions with Healthwatch Essex and provision by them of anonymised recent case studies of people contacting them who were trying to access or were receiving domiciliary care, and discussions with representatives from the community and voluntary sector who provided advice and support for those receiving domiciliary care or were carers and/or family members for those receiving domiciliary care , the Group believes it has received a reasonable representative evidence base of service user views and experience.

The Group acknowledge that it would have liked to have spoken to more community and voluntary sector witnesses. However, the Group recognise and appreciate that the pressures of the pandemic limited the number of organisations who felt able to or were able to respond and accept the invitation to participate in the review.

The review did not look at the re-procurement of the Live At Home framework in any detail but, as acknowledged elsewhere in the report, some concerns raised by providers in connection with the re-procurement have been highlighted.

This review did not include Extra Care and Supported Living or the procurement exercise to establish a new framework for the ongoing commissioning of supported living services for adults with learning disabilities and/or autism, and physical and/or sensory impairments.

The review also did not look directly at eligibility or thresholds for receiving domiciliary care although at times some discussion may have referred to these areas.

This information is issued by:
Essex County Council
Democracy and Democracy

Contact us:
cmis.essex.gov.uk
03330 139 825

Democracy and Transparency
E2, Zone 4
Essex County Council
County Hall,
Chelmsford
Essex, CM1 1QH

Sign up to Keep Me Posted email updates: **essex.gov.uk/keepmeposted**

Essex_CC
facebook.com/essexcountycouncil

The information contained in this document can be translated, and/or made available in alternative formats, on request.

Published March 2021.