APPENDIX

HELP TO LIVE AT HOME

ENGAGEMENT MEETING 25 NOV 2014

Contents

1 WHAT ARE THE CURRENT DIFFICULTIES AND CHALLENGES WITH SUPPORTING PEOPLE AT HOME FROM YOUR PERSPECTIVE?

1.1 FLEXIBILITY

The ability to purchase the care that you want/need i.e. an appointment, a go to a football match

People receiving care are not the same every day

Not flexible at the moment – it all depends on the care plan

Care plans are not regularly reviewed

Need for an appeals process if people are not happy with the support plan

Reviews don't happen regularly enough

1.2 CARE DELIVERY

Everyone wants the service at a 'key' time (i.e. getting up in the morning)

Anything is possible but logistics make scheduling difficult

Logistics of scheduling care – mileage, wages

Client base changes very regularly

Dependent on organisation size (planners + staffing)

Care not provided locally – not having my care provided by someone who is from a local organisation that cares

Up to 10 care providers in a small area

Continuity of care (example given of 13 carers in 19 days) - challenge of scheduling over 3-4 calls - carers don't work all hours

'Time & Task' may not give adequate time to provide care

'Time & Task' – fine balance needed to give flexibility in a support plan

People with substantial + critical needs may not be able to be reabled

Current care system is reactive – responding to a need when it becomes obvious – not proactive

Lack of home help impacting on care, carrying out non-care tasks (washing clothes, ironing)

Lack of flexibility in a support plan to meet a changing level of need, not flexible, not in control

There needs to be a robust system to support people

1.3 JOINED UP CARE

Are adaptations provided promptly to meet the need? Timely interventions needed.

Care at home service needs to be provided quickly

Home needs to be a safe place people can be discharged to – local convalescence

Health & social care not joined up, leading to assessments not coordinated

Lack of communication between agencies – not helpful for families

Works well locally in some areas

Cannot always meet demand

Health & Safety: restricting what tasks the provider can/will do (e.g. giving medication)

Health services and Care services don't always join up on the Care Plan

Hospitals struggle to discharge patients: free health care moves into charging for social care (except if the patient qualifies for Continuing Health Care)

Physical and mental health care services are not joined up

1.4 PERFORMANCE MANAGEMENT

Adult Social Care is missing targets

Capacity problems

Difficult areas: Harborough, Melton, rural Leicestershire

1.5 BUSINESS RELATIONSHIP

Depends on who the commissioner is

Large inconsistencies in what is commissioned across the county

LCC is not aware of how flexible current service providers can be

1.6 FINANCE

Is there any more fat to cut from the bone?

Older people not spending because they are saving their money for their children, and not prepared to pay

1.7 FAMILY/CARERS

Change in family support – expectations from carers and family change

1.8 HELP TO LIVE AT HOME PROGRAMME

Bigger companies more impersonal

Doesn't matter how big a provider is, quality and training is what matters

1.9 STAFF TRAINING

Staff training is variable across the county (NVQ2, medications, etc)

Need to have training at a standard level

1.10 SAFEGUARDING

How to ensure safeguarding of vulnerable people across the county?

1.11 WORKFORCE ISSUES

Providers are unable to compete with LCC's HART Terms & Conditions

Recruitment & retention are a difficulty

Staff worry about job security – wages, sick pay, terms & conditions

Is this really cost effective?

Shortage of people coming into the care industry

Providers cannot get 'trained' carers

2 WHAT WOULD YOU WANT A NEW MODEL OF SERVICE TO DELIVER – WHAT DOES 'GOOD' LOOK LIKE?

2.1 SELF-DIRECTED CARE

Client to have a copy of the care plan

Care folder kept in the client's home

Client to make their inputs to the care plan

Meals: good choice of food

"I go out shopping and I choose what I'd like"

'Good' is defined by the client, not by the council/ agencies/ staff

"My confidence is getting stronger"

"I decide what tasks need doing today. I am not locked into a task list."

I can say "I prefer that staff worker X doesn't give me care any more"; Agencies can also have right of refusal id the client's behaviour is unacceptable. But do this with 'no fault, no blame'.

"I give my feedback on changes I want to my care and how the service ought to work"

"I can request a review of my care package, and I take an active part in the review"

2.2 FAMILIES AND CARERS

Family also to see the care plan and folder

Family to have input (at the start, and ongoing) especially if the client doesn't understand everything

Training for carers – how to give care to people with complex needs

Training for carers – how to employ someone/ handle a personal budget

Capacity of carers is allowed for

2.3 FLEXIBILITY

Flexibility of activities done each day

"I get my care at times I'd like"

Flexibility of care, so I can flex care as I wish

2.4 QUALITY OF CARE

Conversation is in itself caring.

Continuity of staff

Gaps in staffing are covered

“My carers always turn up”

2.5 JOINED-UP CARE

Hospital discharges link seamlessly with care at home

Assessment, equipment needed, care – all to be joined up

Help people to avoid having to go to hospital

2.6 REABLEMENT

2.7 COMMUNITY LIFE

“I get out and about, not stuck in my house all the time”

“I join in with activities in the community”

Staff accompany the client to go out (some agencies already do this, informally, unofficially)

Clients are helped to get out of the house, and to re-engage with community activities

Volunteers may have a role e.g. taking the person out of the house (but not for personal care tasks)

2.8 COMMUNICATIONS

Written assessment, risk assessment, care plan

Good daily record-keeping of what activities have been done each day

Plain English in all written documentation

Information to be widely available in all communities about what services are available

Good signposting to it is easy to link with care services

2.9 GOOD STAFF

Attributes needed: personality, practical, communication, active listener, friendly, welcoming, compassionate, cheerful, emotional intelligence, ‘salt of the earth’, not academic, not rules-bound

Staff know the clients really well

2.10 STAFF TRAINING

The right skills to meet the needs of each client (e.g. dementia, mental health, frail elderly)

Regular refresher training

Praise & support for the staff

2.11 STAFF TERMS AND CONDITIONS

Paid for travel time

Reasonable mileage rate

Access to mobile phone to call in visits

Better pay for staff

Salaried contracts

Workforce more stabilised

Performance monitoring of quality care staff

2.12 MORALE

Low staff turnover

Less staff sickness, particularly at key seasonal times

Staff feel more satisfied (valued, supported, trained, etc)

Staff supported if a client's behaviour is difficult

Staff supported if the client dies and it affects the carer

2.13 BUSINESS RELATIONSHIP

LCC to provide guaranteed volume of business to agencies

Agencies to monitor the performance of their staff

LCC's managed service continues (not all clients/carers are able to cope with self-managed care)

3 HOW DO THE AGENCIES WHO PROVIDE HOME-BASED SOCIAL CARE NEED TO DEVELOP TO MEET PEOPLE'S OUTCOMES?

3.1 BUSINESS RELATIONSHIP

LCC needs to trust the service provider agencies

Reduce the amount of evidence required to be submitted to LCC

Support from LCC to allow agencies to increase or decrease packages of care as may be needed

Stable hours for providers

Longer contracts (more than 5 years, ideally 7-10 years) due to the level of change and investment

Increase the hourly rate paid by LCC

3.2 EMPLOYMENT TERMS AND CONDITIONS

Standard hours not zero hours

Help staff with spoken English difficulties to improve how they speak

Pay the 'living wage'

Standard improved terms of employment

Travel time paid for

3.3 CARE MANAGEMENT

Electronic monitoring is an issue

More flexible service user reviews, at least yearly, even if only a 5 minute phone call

3.4 CARE QUALITY

Local solutions: same carers for the clients

Same staff for service users, leads to a more positive experience

The staff who comes to my home should ideally be able to do everything, social care + health care

Clear care plan for each service user

Providers/agencies to work to outcomes

3.5 TRAINING

Training for staff for specific types of clients (physical, mental health, reablement)

Train staff to deliver quality care

Well trained – NVQs

Train in reablement

3.6 COMMUNICATIONS

'Trip Advisor' ratings for carers, feedback on providers, part of quality reviews

Agencies (social care; health care) to provide a clear statement of what they can/cannot do

3.7 WORKFORCE DEVELOPMENT

Expertise required

Training

Will need funding

Make a career structure

3.8 HELP TO LIVE AT HOME PROGRAMME

Regular consultation with service users and providers as the model develops