Agenda

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Community Care Task Group

Date: **Wednesday 13 July 2016**

Time: **2pm – 4pm**

Location: **Large Committee Room, Kingston Quaker Centre, Fairfield East, Kingston upon Thames, KT1 2PT**

1. **Welcome, introductions and apologies**

2. **Notes of the meeting held on 15 June 2016**
   To approve the notes of the last meeting

3. **Matters Arising**
   Not covered on the agenda

4. **Health & Social Care Work Programme 2016-17**
   To note updated home care project plan **Appendix A**
   To discuss Aim B Progress report **Appendix B**
   To consider Aim C tasks

5. **Adult Social Care Consultation on the Care Contributions Policy**
   To receive an update

6. **Any Other Business**

DATE OF NEXT MEETINGS
Wednesday 31 August 2016 2pm-4pm
Wednesday 5 October 2016 2pm-4pm
Wednesday 16 November 2016 2pm-4pm
Wednesday 7 December 2016 2pm-4pm
Wednesday 18 January 2017 2pm-4pm
Wednesday 22 February 2017 2pm-4pm

Healthwatch Kingston upon Thames

Community Care Task Group Meeting,
Wednesday 15 June 2016 14:00-16:00
At the KQC Large Committee Room

Present:

Ann Macfarlane, Chair	AM	Scotty McLeod, Active Affiliate	SM
Nigel Spalding, Deputy Chair	NS	Victoria Anaele, Active Affiliate	VA
Linda Webb, Active Affiliate	LW	Steve Hardisty, HWK Manager	SH
Eleanor Levy, Active Affiliate	EL	Diva Shah, Research Officer	DS
Caroline Cunliffe, Affiliate	CC		

ITEM		Action
1.	**Welcome, introductions and apologies** 1.1. Apologies received from Glenn Davies. 1.2. As previously noted EL has stepped down as Chair. Those present thanked her for her role and commitment and hoped she would continue to attend future meetings.	
2.	**Appointment of new chair and deputy chair** 2.1. AM was unanimously appointed new chair. 2.2. NS was unanimously appointed new deputy chair. 2.3. Agenda of next meeting will be agreed with chair, aim to get papers out a week prior to meetings.	
3.	**Notes of the meeting held on 17 February 2016** 3.1. Amendments made to minutes of last meeting will be published on our website.	
4.	**Matters arising** 4.1. There were no matters arising not covered in the agenda	
5.	**Health and Social Care Work Programme 2016-17** 5.1. SH introduced new project plan for year ahead, including its strategic context. 5.2. It was agreed that HWK public documents should be kept as simple as possible, yet as clear as possible. 5.3. Details of project plan were discussed. Any additions were to be sent within two weeks to DS 5.4. Group discussed that whilst RBK has commissioned three companies to provide care, there was still spot-purchasing going on, therefore the full picture was not provided	CCTG

		5.4.1. Group raised concerns whether providers fully understand what it means to be "independently living" 5.4.2. AM noted the appreciation of both sides: carers and service users. Also recognised the lack of co-production by RBK – they don't sit with the user to design the care plan. 5.4.3. Group agreed that assessors don't fully assess individual needs for those who really need them. 5.4.4. The group acknowledged how frontline staff know what they should do but are frustrated by what they have to do by their employees rather than the service users	
	5.5.	VA stated that agencies commissioned to deliver services to provide care according to tasks – it is not person-centred like KSIL. Independent living care plan is different to commissioned care. Care should be self-satisfying care with the service user at the heart of care and care plans – care provided should be satisfied by the user not the provider. For example, if your care plans says you can make tea and you ask for a cup of tea, then your carer will refuse – this raised further concerns: 5.5.1. It would seem system does not take account of fluctuating needs and feelings of individuals on a care plan, for example you may be fit one day to make a cup of tea, but the next day you may not be able to, but your carer may refuse to make you tea because on your care plan it says you are able to make tea. Therefore they system does not take account of individual needs nor does the system fully appreciate and understand certain illnesses including mental health and emotional and physical wellbeing. 5.5.2. It would seem boroughs like to tick boxes – those commissioning services should have better understanding of tasks and needs. 5.5.3. VA: whilst carers can be flexible, it has to be within the care plan. Thus we should aim for quality of service. These agencies are over-subscribed which creates problems for example, carers don't drive cars they take buses, under this reality carers are always leaving before time has ended because their employees don't allocate enough time for travel between care. VA reiterated that service should be done up to the satisfaction of service users. There's no monitoring of this within services – care is therefore not being provided accurately 5.5.4. EL: needs change over time, but the service must ensure the quality of the service and the risks associated with changing needs. Services impose their overall objective on the client and carer. There needs to be clarity of objective at service level and individual level. It is a fallacious argument for service providers stating that they are restricted to their	LW

commissioning – at an individual level this is different: you have to provide person-centred care

5.5.5. AM: we need to get closer to co-production. Independent living does not mean that you can do everything yourself.

5.5.6. NS: services state their provision of person-centred care but they don't seem to have the capacity and time to do so.

5.5.7. SM: wrote his own care plan and now needs care for only 3 days – down from 7 days a week.

5.6. With regards to desktop review on appendix B, SH noted the ambiguities on the service providers' website. Also noted the ambiguities in the response provided from commissioners. Questioned the meaning of "how many people are on a managed service" – this needs to be clarified. Further clarification needed on whether 25% was part of 658 or additional to 658 people on a managed service. Further clarification needed on whether independent support is also provided for self-funders.

5.6.1. Group agreed that the sample on surveys was small.

5.6.2. NS on appendix B (1.5d): if respondents are older than it may be explainable that they are white British and thus represent a higher proportion of the community.

5.6.3. DS on appendix B (1.5e): amount of care received per week does not say anything about the quality or satisfaction of service provided.

5.6.4. SH on appendix B (1.6): results don't say much about anything.

5.6.5. EL commissioners need evidence based reports not statistics for example, how many cups of tea were made. Should be more detailed data.

5.6.6. SM: relationships are important with AM acknowledging the importance of boundaries

5.6.7. El: quality of communication is top and should be at the top of all service provision – what are the top 10 things that need to be monitored? LW suggested looking at Quality of Life Scales

5.7. NS on appendix A (B 1.1 and 1.2) suggested:

5.7.1. Sending progress report to stakeholders to respond to accuracies, etc.

	5.7.2. Find out who are spot providers.	
	5.7.3. LW suggested visiting HomeInStead for benchmarking. NS will try and provide list of care agencies in Kingston.	NS
	5.7.4. DS to contact HomeInStead and other private care providers for benchmarking, including KSIL	DS
	5.7.5. LW suggested contacting groups with specific conditions for example, Neuro-conditions, for surveys and focus groups. Targeting specific groups of people, this will also help identify unmet needs.	DS
	5.7.6. SH: we do not know what commissioners think of these services.	
	5.8. With regards to appendix A, Aim C – evidence gathering:	
	5.8.1. NS: send out questionnaires to different groups of people to identify themes.	
	5.8.2. VA: visit day centres, elderly team in Kingston.	
	5.8.3. NS: within the next two weeks identify places we should visit. Also look at questionnaire for next meeting.	DS
	5.8.4. LW: we should talk to carers. EL: carers are source of information. NS: are carers susceptible to disciplinary action? VA: we should meet with carers in a neutral place. SH: facilitating a talk with care agencies.VA: Kingston is not monitoring the providers.	
	5.8.5. LW: also visit homes that provide respite care for people who do receive home care.	
	5.8.6. SH: press release, Google surveys,	
	5.8.7. AM: targeting people aged 18 and over.	
	5.8.8. NS & LW: Aim C needs to be devised further, a list of all names / stakeholders should be provided.	
	5.8.9. CC: it would seem social care is a two-tier service, if you pay £20 for care you receive better care. But health isn't a two-tier service.	

6.	**Any Other Business** 6.1. EL appreciated the support provided as Chair and gave thanks to the group.	
7.	**Date of Next Meeting:** The next meeting will be held on Wednesday 13th July between 2pm-4pm at the Kingston Quaker Centre, Large Committee Room.	

Health & Social Care Work Programme 2016-17 **Appendix A**

Domain: Social Care Services

Priority 1 - Home Care (To contribute to an understanding about how well home care services perform and use this information to make recommendations to commissioners of the service) VERSION 2 amendments [updated 6/7/16]

Aim (what do we want to achieve)	Tasks (that will achieve the aims)	Person / People responsible (who will undertake each of the tasks	Timescale (by when the tasks should be completed)	Progress as at 15/6/16 (what's been achieved so far)
A. To learn about current service provision and what quality assurance processes are in place	**1. Undertake a desktop review of existing service provision to determine:** 1.1 Who currently provides home care for Kingston residents 1.2 What quality assurance processes do they have in place 1.3 When was their last CQC inspection and what was the outcome 1.4 What information is available from RBK about home care services 1.5 What was the outcome of last RBK home care service user satisfaction survey 1.6 What does the last adult social care user survey say about home care 1.7 What regional/national information is available about home care that can be used for benchmarking purposes	Diva Shah	June 2016	Progress report shared with community care task group meeting held on 15/6/16 Update shared with community care task group meeting held on 13/7/16
B. To develop proactive relationship with key stakeholders to support the delivering of the project	**1. Contact stakeholders to:** 1.1 Notify home care providers of our project and request information about their services and how they are performing 1.2 Share project plan with stakeholders such as Staywell and Kingston Centre for Independent Living to obtain feedback and request participation at task group meetings 1.3 Share project plan with CQC to request latest	Diva Shah	July 2016	Progress report shared with community care task group meeting held on 13/7/16

	intelligence about home care provision 1.4 Request RBK input to help develop the project and support evidence gathering processes 1.5 Request input from Kingston Carers Network to find out the views of informal carers **1.6 Contact stakeholders such as condition specific support groups (e.g. mental health, dementia, neuro-conditions)** **1.7 Contact other stakeholders who may add value to the project (e.g. Healthwatch Network)**			
C. To gather evidence to support better understanding of home care provision	**1. Identify and implement processes to understand how well home care services are performing such as:** 1.1 Survey/questionnaire 1.2 Focus group 1.3 Social media/local press publicity 1.3 Enter &View visits to care homes 1.4 Outreach to day care services and sheltered accommodation schemes 1.5 Role of Kingston Coordinated Care Programme	CCTG	July-October 2016	To be confirmed by community care task group
D. To produce a report detailing project findings and recommendations for commissioners	**1. Use the report to:** 1.1 Explain why the project was carried out 1.2 How feedback was gathered 1.3 Identify key themes 1.4 Provide a conclusion and recommendations 1.5 Include responses from providers and commissioners	Diva Shah	December 2016	To be confirmed by community care task group

PROGRESS REPORT @13/7/16

Health & Social Care Work Programme 2016-17 **Appendix B** Domain: Social Care Services Priority 1: Home Care Project Plan Aim: B (To develop proactive relationships with key stakeholders to support the delivering of the project)	
1.1 Notify home care providers of our project and request information about their services and how they are performing	1.1.1. Following on from the Progress Report of Aim A (to learn about current service provision and what quality assurance processes are in place), there were three home care service providers in the borough of Kingston: a) Alpenbest Care b) Eleanor Nursing and Social Care c) Supreme Care services However, HW Kingston was informed that Eleanor Nursing's contract came to end due to capacity issues. 1.1.2. Therefore, HW Kingston contacted Alpenbest Care and Supreme Care Services: a. Informing them about HW Kingston's home care project b. Inviting them to attend the next Community Care Task Group Meeting. c. Requesting advice about how to engage with their service users d. Facilitate a conversation with their workforce
1.2 Share project plan with stakeholders such as Staywell and Kingston Centre for Independent Living to obtain feedback and request participation at task group meetings	1.2.1. Staywell and Kingston Centre for Independent Living were contacted: a. Informing them about the home care project b. Inviting them to attend the next Community Care Task Group Meeting c. Requesting advice about how to engage with their service users
1.3 Share project plan with CQC to request latest intelligence about home care provision	1.3.1 Project has been shared with CQC, including a request for latest intelligence about home care provisions and inviting them to attend next Community Care Task Group Meeting.

1.4 Request RBK input to help develop the project and support evidence gathering processes	1.4.1. Contacted RBK lead on home care provision and the RBK lead on transforming home care in the borough requesting input to develop the project and to share knowledge on home care provision. 1.4.2. Meeting has been requested to support evidence gathering processes.
1.5 Request input from Kingston Carers Network to find out the views of informal carers	1.5.1. Kingston Carers Network has been contacted to find out the view of informal carers. 1.5.2. Views of informal carers will be part of evidence gathering that will make up the final report.
1.6 Contact stakeholders such as condition specific support groups (e.g. mental health, dementia, neuro-conditions)	1.6.1. Awaiting full list of support groups to make contact and share project.
1.7 Contact other stakeholders who may add value to the project (e.g. Healthwatch Network)	1.8.1. Having reviewed HW reports on home care from Dorset and Central West London, HW Kingston has contacted HW Dorset and HW Central West London requesting information on their home care projects. Successful dialogue has been opened with information sharing. 1.8.2. All reports and contacts from HW Dorset and Central West London will be credited and appreciation given in final HW Kingston report.