PROVIDER ENGAGEMENT EVENT - Residential & Nursing Care Re-commissioning Project
31st August 2016 09:00 – 13:00

Feedback from Resident Engagement – Sarah Jones
Sarah gave a presentation on the Care Home Consultations for an outcome based service, the presentation is included in the presentation attached.
Clarification was sought around people's expectations of a Care Home as felt that the '16% who expected good quality of care/ to be looked after' was very low. Sarah explained that a lot of the people asked 'did not know what to expect' or 'had little expectations' of going into a care home, this didn't mean they thought the quality of care would be bad they just were unsure as to what to expect.
A query was raised in regards to why only 8 homes were visited. Sarah explained that this was due to the short time frame, a letter was sent to all homes and those who replied requesting a visit were contacted and visits were put in place, there were only 2 days that Torbay Voice and Healthwatch could undertake the visits. Although only 8 care homes were visited 45 residents/ family members were asked questions and the feedback was really useful.
Care Support (Extra Care Housing Provider) – Usman Sheikh
Usman gave a presentation on Extra Care, presentation attached
A query was raised in regards to the cost of Extra Care Housing - response to follow
Arts and Cultural Workshop Kate Farmery
A PDF copy of the Arts and Cultural Network booklet is attached.
Kate Farmery gave an Introduction to Arts and Cultural. All attendees were split into groups. Red: Hugh – Composer and Musician Yellow: Claire – Dance in Devon Green: Kate - Sound Communities Blue: David – Wren Music Each group then feedback their thoughts around the workshop they undertook: A discussion took place regarding concerns of booking something like this and then not all residents being interested on the day. Kate explained how todays workshops were a really good example of how it can work, when everyone was allocated to their groups many were really daunted and unsure of what the workshops would entail, but even people who thought they would hate it came out feeling really positive about the experience, which is something they find a lot. Some quotes from the workshops: "I absolutely loved it - it was so refreshing to experience those different types of activities and sensory exercises just from a chair"

"Uplifting – cares drifted away very empowering"

"Opened our minds that we are always capable, felt group dynamics lifted self-esteem"

"Felt there would be a strong clinical benefits from this as it boosts wellbeing"

"Benefits in a group – sometimes it's the first time somebody is being listened to."

Workshop 1 – Key points discussed at each table regarding the Fee model and the Quality Framework

Group	Fee Model	Quality Framework
1	Staffing – 60% to 70% of the total cost of running a nursing home is made up of staffing costs. The cost of nursing care is rising and it is a challenge to recruit nursing staff (having to spend time/money travelling abroad to attract nursing staff). The fee model must reflect the true cost of care, a 'reality based' model. National Living Wage must be reflected within the model and known increased costs factored in up to 2020. Self-funders vs. supported residents – aiming for equity in cost of placements, no cross subsidy. Geographic variation within Torbay as to the proportion of self-funders per home. Hotel costs need to increase each year to ensure they reflect rising running costs. Hotel costs would vary from provider to provider due to business model/building state etc. Dependency Profile – adjusting the care hours for a resident needs to be a quicker/more efficient process (in particular, delays currently experienced for CHC cases). Social activities are not included in the fee model – wellbeing activities.	Training – health and social care training, 50% of care staff @ level 2 (not sure this target would be met, must consider other ways of assessing care staff competency). CQC no longer monitor this. Need to move away from blame culture (i.e. if safeguarding incident or provider judged as requiring Improvement, some feel unsupported by LA/CCG). Don't feel current practice is a true partnership approach. Be conscious of not over burdening providers if additional information (on top of CQC requirements) is requested for quality framework. Quality framework should go beyond CQC 'good' judgement – this will provide greater flexibility for providers to enter/remain on the framework. CQC re-inspection takes too long – wouldn't want to be excluded from the framework until judged as 'good' again. Include family feedback in the quality framework – critical. Family/resident view of care can be good whilst CQC judgement lower. CQC standards for care homes can be higher/more rigorous than for NHS services such as GP practices, therefore already scrutinised closely. Training – providers could do more with the Council/CCG, such as accessing clinical training for nurses. Training recommended by the Council/CCG is helpful as providers know that it is quality assured. QAIT/Business Improvement Teams –

		consider wide sources of information/feedback – range of professionals visiting providers. Act on this information as well as on CQC judgements.
2	Felt the fee structure misses out on some core functions i.e. activities and "luxuries" feel there is a substantial gap between costs and actual costs so are unable to provide the extras. They felt the best way to set fees would be to ask the market and not set costs, the pricing structure would need tiering to the type of care, and to take into consideration a different rate to different room	CQC doesn't get involved in personal assessment. They all agreed it is best to keep it simple and make it smart for both the Care homes and trust.
3	Felt the fees don't match the level of care needed for residents. In the present fee structure wellbeing is a luxury as there is no provision for it Private funded residents subsidising council funded Care doesn't make a profit any more from a business point of view.	Feel the 50% level 3 and level 5 is a too rigid structure. The qualification does not quantify good care. Quality recruitment is really hard to find, people can earn more wages working at Tesco. Managers need more support and networking.
4	Feel the actual cost to get a resident into a home including the induction and settling in period needs to be taken into consideration as currently there is no provision for this in the costs. Think it is really important the fee structure is right. Assuming the trusted assessor model is in place a cost per hour or maximum they can charge per hour would need to be agreed then agree top ups where required.	CQC report covers goods and green means a pass, feel very conscious about duplication and feels some of the things the ICO and CQC ask are very similar. Fran added that they are aware of this and are currently looking how to co-ordinate and triangulate this better.
Workshop 2 – Key Points discussed at each table regarding the Trusted Provider/ Assessor Model and the option of Block Contracting		
	Trusted Assessor Model	Block Contracting
1	CHC assessments and social care assessments for nursing placements are currently done separately – frustrating and time consuming for providers. The Trusted Assessor Model could be a significant time commitment for providers, but… Homes currently provide all the information required for an assessment anyway.	Choice is difficult to achieve for emergency placements. A Respite block contract paid at nursing rates would be advantageous. The current respite voucher scheme means there is a significant shortfall in costs. Home reported receiving 2 to 3 calls per week for nursing respite care.

	Families are always invited to assessments – the relationship that families have with providers help with the assessment, they know the day to day detail/issues/concerns. A simple tool would be required for the Personal Dependency Profile – providers should be involved in developing this. Need clear roles/responsibilities and contact mechanisms for the Trusted Assessor Model: QAIT could be the link for contract/business issues, plus operational/care management named contacts need to be in place per provider so that professional input/advice can be sought when needed. Named operational contacts also required for 1st 2 months of placement when resident/family settling in – issues may arise that need addressing by a third party (not provider or resident). A streamlined process is required. Need clarity re roles and responsibilities across the system (GP, hospital, provider, social care operational staff, ICO) – to prevent unnecessary delays in hospital and the potential for mixed/delayed messages to resident and family. Family/friend involvement is essential. New models of care – voluntary sector worker, trained and supported/supervised by operational staff, could act as constant/advocate throughout journey (i.e. hospital to re-enablement to residential) and support the patient into new placement(s). Challenge – communication skills, co-ordination across the system, advocate for patient.	Wider promotion of blocks for respite would be required – online video of home, resident/family interviews – look at more innovative solutions to promote, such as… Hiblio – Torbay Hospital – could they conduct interviews with care homes if block respite contracts introduced. Nursing respite very important to families – blocks would work better for respite than for standard res/nursing placements.
2	Concerns were raised in regards to litigation issues around Nursing home assessments. Feel a good relationship between provider and trust would be really important so there is a joined up approach and more regular assessments.	The group felt that the fee will influence who will be able and willing to do a block contract. Feel more information would also need to be sought around right of refusal and flexibility would need to be built into the contract.

		Feel it may work well for respite beds in Nursing homes as could be valuable for intermediate care.
3	Care/ care plan reviews by social workers to include written evidence over past months from care home Universal electronic system for reporting bed state, would work for some homes but not for all Any systems in place are purposeful and useful and relevant? Feel it is important to remember that one size doesn't fit all, can't ask homes to do too much more as takes away from front line care, again some homes would be able to do but not all are the same.	When this was discussed the groups consensus was no at first. Had some questions regarding how helpful a block contract is to a home, is it efficient? Is it viable? Feel at the moment the whole system including intermediate care and over flow is not running smoothly so this would need to be addressed first.
4	Feel this is a good idea but needs to work both ways, trusted suppliers would need to have trusted commissioners too. Feel the trust bit is pertinent to this working.	Felt if everything discussed previous to this happened and rates are agreed the block booking would be good, they feel more so for Residential homes rather than Nursing. They felt current arrangements with a flat fee wouldn't work. The right of refusal was also discussed as the homes would need to manage the total of home, if there were 5 beds in the block contract but 3 beds had very complex people in they couldn't take a further 2.