**COLLATED NOTES FROM PROVIDER WORKSHOP EVENT AT COLCHESTER FOOTBALL STADUIM MONDAY 29TH APRIL 2024 ON THE FUTURE OF THE IRN FRAMEWORK FROM 2025.**

**KEY POINTS SUMMARY**

**CONTRACT AND SERVICE SPECIFICATION**

* Formal process and timescales required for 1-2-1 and higher and exceptional needs payments
* More funding required for community based / external trips and gender specific activities within the care home.
* Referral response and placement times need to be more realistic and in the best interest for adults.
* Improved information, communication and streamlined process is required for referrals and assessments, particularly D2A referrals.
* There can be delays in support from external services such as mental health, dementia support services and district nurses, impacting homes ability to meet need
* Confusion over Hospital Escorts process and contractual obligations. A clearer process and payment definition required.
* Funding and provision of equipment for D2A placements is an issue that needs to be resolved.

**PREFERRED SUPPLIER RANK LIST (PSRL)**

* Mixed responses to whether a matrix of rates is desired or a single locality / district / countywide rate.
* KPI’S, PAMMS, CQC to all be used to assess quality ranking. Not just CQC rating due to time taken to re-inspect.
* Homes want to be informed where they are on the rank list – a more transparent approach.

**SOCIAL VALUE & CLIMATE**

* Retrospective reporting on social value. Differing opinions on reporting time scales
* Mixed views on the benefit of reporting on social value from a care home. perspective, view that already do as much ‘added value’ activity as able to do within funding and time constraints.
* Not all care homes hold a valid Energy Performance Certificate or have a current carbon reduction plan.

**DETAILED NOTES**

**WORKSTREAM 1: CONTRACT AND SERVICE SPECIFICATION**

**What needs changing/What is missing?**

* Formal process required for getting paid for1-2-1, and exceptional needs payments. Care must continue but often unsure if it is going to be paid. Random emails as an audit trail. Need a formal process.
* Tighter controls over issuing of p/o’s
* Funding not realistic, need not reflected in payment level.
* Joint funded adults difficult to know who the funder is.
* Process for requesting exceptional needs payment too long.
* Exceptional needs and Higher needs payments worthless as does not fund any additional care, equates to 3 hours per week.
* Prefer to have vacancies than take the LA adults.
* No named social worker an issue
* Seeing more and more high-level needs and Dementia adults
* Limited funding for activities which means not as many options as we would like.  Its felt LD/PD home get a lot more funding than OP. Likewise domiciliary care have additional funding for community activities but this isn’t considered with residential contracts.
* It was mentioned that hospice support to homes in key to enabling EOL adults to remain at the home in their last days, without this support adults would either have to move to a hospice or hospital (unfamiliar surroundings and not usually their last wish) yet very little work happens to ensure homes have hospice support.  Many families are also not aware that remaining in the home EOL is even an option.
* There is a lack of Mental health support for OP placements, quite often we get a referrals OP and then it is realised they also have MH, and when we reach out for support it’s just not there or take a long time to get.  As a result this creates a huge barrier to accepting such adults in the future as we have no confidence in getting support
* Hospital communications needs improving
* If someone is hospitalised from a home and sent with their meds, quite often upon return they won’t come back with meds.
* Information missing when hospital discharge adults.
* Incorrect information of ISP/discharge notes
* A big barrier to career progression is language, we see staff come to work at the home as domestics and would really like to progress their career to carer, and we feel they would be very suitable; however, adults struggle to understand them as English not their first language – is there any support for English lessons?
* It’s felt the 1hour response time for homes is too short a time – could we consider increasing this to 2hrs? It’s very rare that a member of staff in the home will be sitting at a PC awaiting emails and therefore the 1hr deadline is often missed.
* Feel that many placements now arrive as a D2A (no guarantee they will stay long term/perm) and the admin work that goes in to admitting them and care plans is A LOT when they could only be with you a few days/weeks.
* Find that ISPs are not always accurate to actual needs – even when trusted assessor used (Lincolnshire run a very good, trusted assessor programme and we would like to see similar in Essex)
* ISPs mention meds but they are not always sent in with adult.
* Equipment – this is a barrier, again many people are now admitted under D2A but also have a need for equipment that homes may not have, but are expected to pay for, and there’s no guarantee adult will stay, do big outlay and you don’t know if you will re-coup costs.
* Feel there is a culture of “they are in a care home so safe” mentality when there are issues which mean they do not get support/resolution in a timely manner
* Health products – such as continence pads – hospital will often discharge with only a couple, which is not enough, and then regular supply isn’t enough and therefore the home end up having to buy more for each adult, which is very costly.  How is the quota per day calculated and can this be reviewed? Or we have had instances where they say they are not eligible for health products as they are a temp placement (and most placements fall into this initially as D2A)
* We get lots of push back from District Nurses to attend someone placed in a residential bed if home has dual registration, as they say “you have nurses on site” however the adult has been placed in a residential bed and therefore the rate we are receiving doesn’t cover the cost of a nurse on site – how can we improve this?
* Referral/placement times – different for new and existing residents
* 4 hours response time for referrals, after 3pm, response by 10am next day
* Homes to say whether can accept referrals on a weekend.
* ECA trusted assessor model in Havering. Colchester TA is an improvement but still biased to hospitals.
* Homes don’t know where they are on the framework.
* Still get lots of referrals even though at top of the matrix
* For referrals there should be 4 hours for homes to say if there is a possibility that they might be able to accept
* Lots of wasted time where home goes out to visit adult to assess and the adult has already left hospital and gone to another care home.
* Referrals should be between 10am and 4pm
* Placements by 3pm for new residents. Can be later for adults returning with same needs / meds.
* Care homes would like a key contact to go to for any issues – don’t know who their contract manager is from ECC or ICB
* Response time for referrals and 7 days a week are a concern. Could do this but at additional cost. Difficult to get managers to work at weekends as core work with stakeholders is during the week.
* Could consider emergency placements.
* Response time of 1 hour is impossible – much better to assess face to face. Info on referral documents rarely matches actual needs. Social workers need to be honest, provide an updated ISP.
* Acceptable 4-hour response time, stating whether happy to assess.
* Time is wasted, home may look at referral only to find already accepted by another home.
* Need 48hours to go out to do an assessment.
* Admissions 10-7pm not acceptable as no senior to write an assessment.
* Issues with medications as out of hours
* Would accept a returning resident but not a new admission on current contracted timeframes
* Adults can arrive in poor condition and not dressed.
* Beyond 4pm is difficult
* Criticism of dementia support service only available between 9-5. Homes left without support in emergency situations when out of hours.
* Criticisms of expectancy of homes to fund specialist equipment i.e bariatric bed or moulded chairs
* Escorts to hospital appointments, who supports and what is reasonable.
* Hospital appointments – these are a struggle.  Unless we pay for taxi, staff etc to go there/back which is costly. We have to rely on hospital transport, but the problem with this is a 1hour appointment ends up taking an entire day due to bus timetables there and back. Ideally family should escort as cannot supply staff.
* If adult has capacity no escort, transfer of care is between care home and ambulance.
* Staff if they attend can get stuck in hospital.
* Homes charge the family if staff attend.
* Cost of care is about care in the care home not hospital appointments.
* Family should be responsible for hospital appointments.
* How can the cost of appointments be put in the contract?
* Health only fund 48 hours @ admission versus social care continue to fund.
* Additional funding should be available if appointments are regular.
* There should only be an expectation of a staff accompaniment when the adult doesn’t have capacity.

**What meaningful activities are provided?**

* We have seen an increase in male residents and many “traditional” activities are more geared to females, would like to be able tin invest in other activities and outside activities.
* Whilst we provide onsite activities, we struggle to provide activities outside of the home i.e. trips to shops, shows, swimming etc etc as we don’t have the budget, staffing to spare to go out or transport.  This means many adults don’t get to leave the home.

**Are homes adopting dementia friendly principles around the care home?**

* Confident / staff trained.
* Issue is getting support from the dementia team, major issue. Only if adult physically violent daily will team visit within a week.
* Police not supporting home if staff or residents at risk. Only if adult at risk
* Diss team /111 option 2 not helpful
* Aggression difficult to manage.
* SETSAF delay in being investigated.

**What should be included in the basic rates?**

* Support with toiletries would be good, as most adult do not have their own supplied yet families will then try and say the “basics provided by the home” are not suitable.

**What are your thoughts on third party top ups?**

* 3rd party tops ups – problems with invoicing.
* Rather see LA fund in full. LA recover any costs incurred.
* Social worker encouraging private funders to go on framework to reduce their costs, so their money lasts longer.

**Choice and Control**

* Care planning and likes and dislikes – bread and butter everyone should be doing.
* Problems with ISP’s being sent without being updated, as well as missing basic information. – needs to be open and honest at time of placement

**WORKSTREAM 2: RANKING, REFERRALS AND KPI’S/MI’S**

**Survey feedback on ranking – what works well / what could be improved?**

* Referrals are increasing in complexity.
* There needs to be a link/key social worker – who knows the adult and knows the care home – help with the decision making on which home is able to meet need.
* 9pm-4pm for referrals
* Better process for exceptional needs payment is needed as well as 1-2-1 support – there needs to be a clear process in place.
* Focus on quality.
* Essex needs to own contracts more, would like PAMMs rating used to show quality, won’t damage relations if findings from PAMMs audit are fair. PAMMs more holistic view of the care home and know the care home.
* Homes don’t know where they are on the framework.

**73% of survey responders wanted to see the matrix of rates to continue – do you agree?**

* There should be one price at cost of care.
* There should be one rate for Essex, with higher rate for higher level of complexity.
* Current system promotes a “race to the bottom” which isn’t suitable when the service is around healthcare.
* There was concern over one price possibly being less than the top band of the pricing matrix due to affordability.
* They felt the one price approach could potentially cause parts of market to fail.
* They felt dementia homes should be considered different to a typical care home with different fees.

**How should we rank, what should be considered? CQC, PAMMS, price, social value delivered and climate commitments, KPIs?**

* CQC and PAMMs preference for ranking – using both to show quality of home.
* Combination of KPI, PAMMs and CQC to assess quality?
* PAMMs – there needs to be more transparency on how PAMMs rating is worked out, not clear how this is done or how the algorithm works – need to know this to have trust in the rating and process. PAMMs rating can be based on an opinion, needs to be more consistent/professional – sometimes focus on paperwork other times talking to people – need to spend more time with care home residents.
* Slow CQC inspection timelines mean that the current system of ranking can be unfair if you receive an RI rating.
* Open to CQC being replaced by PAMMS, they didn’t think this change would lead to poorer relationships with QIT, as long as there are open conversations.
* They felt a low rating meant feeling forced to taking a hit on their fees to promote placements.
* Larger organisations can take hits on fees easier than smaller providers which could be unfair due to the current system.
* The table felt we could use the new CQC percentage scores to possible have a ‘buffer zone’ where providers at the top of RI could still be considered as good.
* KPI’s should be considered to ensure larger providers don’t have an inherent advantage.
* All measures should be proportional.
* The KPI ranking tool should be accessible and not ask providers to report on information already held by the council elsewhere.
* Providers would like to see how they rank compared to their peers.
* Providers would like ranked lists to be refreshed more than annually.
* They felt our KPIS’s were more data driven than considering actual quality of care for adults.
* Providers would like a more dynamic pricing system. They would like to have the option of changing price points at least twice annually. West London Alliance has a system they would like us to replicate. Kent allows bi-annual price refreshes.
* CQC have 34 statements they measure against; we could use these statements as a basis for our KPI questions.
* They are confident there are mor QIT members in Essex than CQC inspectors There has been an instance of a home not being inspected for 7 years.
* Don’t foresee an issue with relationship with QIT if everything is fair. They felt ECC can look at things more holistically than CQC who will only consider what happened on the day of inspection. They would feel comfortable with PAMMs becoming effectively becoming the regulator for ECC.
* Concern that not all providers would get on board with PAMMS for ranking as CQC are the actual regulator.
* They felt every two years was a fair timeline for PAMMS inspections. Also happy with every 6 months for inadequate. Every year for RI and every 3 years for good/outstanding

**WORKSTREAM 3: CLIMATE AND SOCIAL VALUE**

**Social Value**

* There are concerns around social value KPI: The CQC don’t currently measure providers social value. They felt infrastructure from ECC should be in place before we implement a SV KPI. They felt we could calculate a score for 2-3 years to help providers scale, and learn how to report, before it became an official part of the KPI process.
* Concept of Social Value is perceived as airy-fairy by care market. Their focus is around daily delivery rather than incoming skills. Insignificant and low priority.
* Trialled in schools as not a lot of young people were employed. Twelve apprentices were taken on, but they needed to be constantly managed which was not sustainable. If they were not managed, they used their phones instead.
* Students on placements and volunteers have been deployed.
* Should not be an agreement at contract stage as we have an initiative already. Would work better at the twelve-month stage. Too much pressure on staff if agreed at contract stage.
* Employed a girl who was doing her Health and Social Care Level 3 qualification. We have been told that from next year this changes and work placements will not be based in care homes and will be in NHS hospitals.
* One care provider employed a young person with learning disabilities.
* Another care provider helped a boy with disabilities to complete his Duke of Edinburgh award in 2018. They recruited him as a Community Engagement Officer during lockdown, and he is still employed in this role.
* Reporting functionality exists but care providers didn’t know they could claim for what they do.
* Suggestion of an annual return to Social Value surveys, rather than quarterly; making it easier to track.
* Waste of time and resources and extra paperwork to write up the Social Value activities we are already doing. Can someone be sent out to us to write it up on our behalf?
* We already provide Social Value by supporting vulnerable people in our area in an appropriate and caring way. We provide over and beyond expectations in our own time.
* Intrinsic support. Cost of care model does not contain a line for Social Value. It has a cost attached which is time and/or effort. With care fees being so tight, there are lots of things we’d love to do but cannot afford these as our focus is care and health provision.
* How can it be less labour-intensive? Don’t we get more information from CAMHS when they visit? Can this be incorporated?
* Social Value model will lead to lies as we already have pressures from CQC and CAMHS.
* Could become a tick box exercise unless evidence needs to be provided.
* Where are reports with examples sent to and who reads them?
* Social Value is politically driven but what is the benefit to care providers?
* Care providers will become more interested when we have received end results, local community input, etc
* There is an existing Ambassador programme which involves attending schools and sourcing apprenticeships, so this is not tangibly different to Social Value provision.
* Can you provide us extra funding if we provide the evidence?
* Providers wanted clarity over proxy value and proportionality in contract, e.g., 25p per £1 within contract value.
* Wanted to understand if it would affect their ranking if they do not provide Social Value within the contract.
* Concern about whether information needs to be provided up front. Reassurances given that this is not expected as a mandatory contractual requirement, maybe after one year.

**What is your organisations plan regarding the climate agenda?**

* Already part of CQC audit.
* One provider has started Net Zero conversations. They include as part of internal accounts, ESG and Carbon reporting and ask our staff for ideas. Looking to expand into recycling ventures, repairing and replacing outdated equipment. looking at producing a process-driven statement from our quality team and have encourage employees to work on KIND projects in their area.
* 80% of our energy and food waste is recycled. Do most of those things already. We have installed energy-efficient lighting units, looked at fuel costs and have negotiated a new contract. Food and vegetables are locally sourced and cooking oil is recycled. We are more socially aware now. Some of our staff are local and we work with shopworkers and Mums in our communities. Students do placements and provide music for our residents. School children visit so we are community exclusive. Local rotary groups and churches give talks and integrate. Has EPC rating as noted that was part of the KPI.
* Hard to cover outcomes in surveys: is a resident happy with a volunteer coming in, etc?
* Reputation is an important consideration.
* Will we be in direct competition? Care homes love awards like Prospect awards.
* Knock on effect on recruitment hopefully would be a benefit.
* Would like to part of a ‘Critical Friend’ forum.
* Core of what we do is community exclusion.
* Access to Green ventures is an important consideration.
* Clamour for redeveloped TOMs and reassurance given that we will gauge market impact. Contractors may not understand in current form. Important that everyone understands.
* Don’t understand distinction between community enterprises and voluntary organisations.
* Talk about encouraging FANS initiative to go across Essex including Loughton.