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THE DEVELOPMENT OF A METHOD FOR MONITORING LOCAL AUTHORITY BLOCK CONTRACTS FOR RESIDENTIAL CARE FOR PEOPLE WITH LEARNING DISABILITIES

Volume 1 of 2

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ABSTRACT

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THE DEVELOPMENT OF A METHOD FOR MONITORING LOCAL AUTHORITY BLOCK CONTRACTS FOR RESIDENTIAL CARE FOR PEOPLE WITH LEARNING DISABILITIES

by Marilyn Barbara Miles

This research study began in 1993 and continued until 1996. The formal data collection period was between April 1993 and July 1994 which was during the first period after the implementation of those sections of the NHS and Community Care Act 1990 which relate to the contracting of social care by local authority social services departments. The research methodology adopted was one of action research within a case study.

The study is set in the context of the changes in community care initiated by this Act in the UK and in the particular circumstances of Berkshire Social Services which was re-structured in 1991 in anticipation of these changes.

The development of a method for monitoring block contracts for residential care for people with learning disabilities is described. Although the contracts were in place before April 1993 (the time varied from a few weeks to 11 months), little thought had been given during the development of the contracts to monitoring and review issues e.g. procedures. The method described evolved during the course of the study as the author responded to events and results from the task of monitoring.

Keyworkers to residents in the residential homes are one stakeholder group in the contracts. Their perspective was explored in greater detail through a postal questionnaire carried out in November 1994. Results show areas where providers could improve to meet the standards of the contract specification and improve the quality monitoring and the quality of life of the residents. Specific areas were in induction and training of staff, individual and care planning, meeting health needs, and promoting choice/autonomy. The survey also shows the limitations of the contract documentation in terms of measuring and improving quality outcomes for residents. Recommendations from the survey for future contract monitoring in Berkshire are discussed as is the way that the author's subsequent practice was affected. This formed the second part of the study. Good practice guidelines in monitoring are postulated and the wider implications from the study as a whole are also explored.

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Preface

This research project aims to show how a local authority social services department, which was already committed to the "contract culture" and had established a number of block contracts (where all the places in one home were purchased) for residential care for people with learning disabilities, tried to establish a model of good practice (to include methods, guidelines and procedures) for monitoring these contracts. It looks at how the method was established, what the method was and how it was implemented across the county. It was hoped that experience gained from this project would inform future contract monitoring for this client group e.g. where the county was purchasing one residential place in one home (spot purchases) and also have an influence on the documentation of future contracts and agreements both block and spot.

The thesis is in two volumes of which this is the first volume and contains the text and list of references. The second volume contains the appendices.

The choice of the research topic by the author was formalised in July 1993 after a change in her job within Berkshire Social Services from Individual Programme Co-ordinator (a post held from September 1989) to Placement and Monitoring Officer (Learning Disability) a post held from February 1993 to June 1994. During the final two years of the study the author moved from a secondment to the post of Joint Commissioning Development Officer (July 1994 to November 1995) to her current post of Joint Commissioning Contracts Officer (December 1995 to date).

The author wishes to retain individual and commercial confidentiality and avoid the identification of individuals or organisations. The names of care and housing providers as well as residential homes have therefore been changed. The names are fictional and any connection with existing organisations of the same name is accidental. However, the local authority where the study took place (Berkshire) is identified.

Acknowledgements

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They include the staff and their managers in the homes who participated in the survey of keyworkers and the staff in the Berkshire County Council Local Government Library who processed many inter-library loans for books and journal articles.

The Central Council for Education and Training in Social Work (CCETSW) made a grant to meet the cost of fees for 3 years of part-time registration and Berkshire Social Services Department gave study leave, travel expenses and management support to carry out the research. David Taylor, Assistant Director (Purchasing and Care Management - Adults and Disability) kindly acted as agency link between the university and the SSD.

Particular thanks are due to Professor Bryan Glastonbury (academic supervisor) and other colleagues in the department of Social Work Studies, University of Southampton for continued support and feedback. Finally thanks go to John Miles, without whose encouragement this thesis would not have been completed.

Abbreviations used

ACC	Association of County Councils
AMA	Association of Metropolitan Authorities
BCC	Berkshire County Council
BILD	British Institute for Learning Disability
BSS	Berkshire Social Services
CCT	Compulsory Competitive Tendering
CHC	Community Health Council
CMHT	Community Mental Handicap Team
CMIT	Community Mental Illness Team
CSM	Care Services Manager
CTPLD	Community Team for People with Learning Disabilities
DHSS	Department of Health and Social Security
DOH	Department of Health
EHO	Environmental Health Officer
GP	General Practitioner
GPFH	GP fund holder
INLOGOV	Institute for Local Government Studies
IPP	Individual Programme Planning
LAC	Local Authority Circular
LGTB	Local Government Training Board
NCVO	National Council for Voluntary Organisations
NDT	National Development Team
QUANGO	Quasi-autonomous non-governmental organisation
Part III	Part III of the 1948 National Assistance Act
PSSRU	Personal Social Services Research Unit
S28A	Section 28A of 1977 National Health Service Act
SCM	Senior Care Manager
SSD	Social Services Department
SSI	Social Services Inspectorate
STG	Special Transitional Grant
TUPE	Transfer Undertakings Protection of Employment
VAT	Value Added Tax
WBHA	West Berkshire Health Authority
1984 Act	Registered Homes Act 1984
1990 Act	National Health Service and Community Care Act 1990

Chapter 1.

Introduction - the wider context.

This study on the development and experience of the contract monitoring of residential care for people with learning disabilities was carried out between 1993 and 1996. It is based on the professional work of the author who, for part of the study period, was employed by Berkshire Social Services (BSS) as Placement and Monitoring Officer (Learning Disability). The thesis sets this contract monitoring within an historical context (outlined in this chapter) and a contemporary context (covered in chapter 2). It embraces both a national scenario as well as a local (Berkshire) picture. There is not a separate review of literature, this being referred to as and when appropriate in relation to explanation or clarification about what was happening during the time-span of the study.

Historical background

1.1 How people with learning disabilities are defined.

The words used to describe people with learning disabilities and the services provided for them has changed over the last century to reflect society's view of this group of individuals and the value, both moral and economic, ascribed to them. Words such as idiot, imbecile and feeble-minded gave way to grades of subnormality e.g. subnormal (SNL), severe subnormality (SSNL) and educationally subnormal (ESN). A less derogatory view emerged when the words "mental handicap" became commonplace. There was still grading - mild mental handicap, moderate mental handicap, severe mental handicap - and the word was used as a noun or as an adjective e.g. the mentally handicapped, a mental handicap hospital. An example of this is the government publication "Better Services for the Mentally Handicapped" (DHSS, 1971).

As the 1970s progressed, the idea of including the word "people" in descriptions became prevalent e.g. day centre for people with a mental handicap. With the impetus from the self advocacy movement, the people themselves who had been so labelled took exception to the word "mental" and the description was changed in many arenas to "people with learning disabilities". Although this term has been adopted in official documents and by many providers of services for people with learning disabilities, there is still resistance in some areas especially parents. Many parents feel that the word

learning disabilities is confused with (specific) learning difficulties, a term used in educational circles to describe children with such diverse problems as dyslexia or emotional problems which affect their ability to learn. In particular, they feel the term learning disability minimises the many difficulties and problems that such a condition has on the individual and their carers.

Attempts have been made to promote more positive attitudes towards people with learning disabilities for example May et al (1994) who targeted second year medical students. Although attitudes were positive, the students still felt that people with learning disabilities were somehow qualitatively different from themselves and other non-disabled people; less able, more dependent and child-like.

Although it is problematic to give a clear cut definition of learning disability - as it includes the dimension of restricted intellectual functioning as well as limited social functioning - this term is used throughout the thesis. See also Sinson (1993, Chapter 2).

The author believes that the term learning disability confers a more positive value to the condition by emphasising the process (learning) rather than the condition (retardation). By stating the person first and the handicap second (people with learning disabilities) this also helps to promote positive images of people. See also Hastings and Remington (1993).

1.2 Services for people with learning disabilities

Services for people with learning disabilities moved from one of containment or exclusion to one of training, then education. Now it is one of enabling people with learning disabilities to experience a valued social role in society and emphasises citizenship, respect of their individuality and empowerment (e.g. Department of Health, 1994a). The Jay Report (1979) laid the foundation for these current models of care when the view was propounded that people with learning disabilities had similar rights to the rest of the community with the expectation for them to participate in the least restrictive environment with appropriate support.

The 1913 Mental Deficiency Act established a network of "colonies" which provided institutional care for large numbers of people with learning disabilities. These were often geographically and socially isolated and the people were committed there by a magistrate or a doctor. Many of these colonies were incorporated into the new National Health Service (NHS) which was created in 1948 and became hospitals. This medical

model where people with learning disabilities were ill and/or disabled and needed care from doctors and nurses has been perpetuated to the present day.

After the end of the Second World War in 1945, welfare services to help and support people in need were developed by local authorities under the framework laid down by the 1948 National Assistance Act. Welfare services could be provided for those LA residents who were "blind, deaf or dumb, and other persons who are substantially permanently disabled by illness, injury or congenital deformity or such other disabilities as may be prescribed by the Minister" (Section 29). There was also a duty on the local authority to provide accommodation for all persons who by reason of age, infirmity or any other circumstance were in need of attention not otherwise available to them (Part III, section 21).

There had been recognition from the early part of the century that some people with learning disabilities could be trained in simple tasks and in personal living skills. However, the right for all children and young people between the age of 5 and 19 to have compulsory education by the local education authority (LEA) was not achieved until 1972. Prior to that there had been education and training - often provided in junior training centres by the LA or in hospital schools by long stay hospitals with few trained teachers. At the same time, the child could be excluded from "school" or centre on the grounds of behaviour or multiple disabilities. Alternative services were rarely offered.

The 1971 government report "Better Services for the Mentally handicapped" (DHSS, 1971) advocated the closure of many hospital beds, the non-admission of children to long stay hospitals, co-ordination of disparate services (e.g. health, social and educational) and the provision of suitable hostels and day services. However, it took many years before this became a reality. Wagner (1988b) pointed out that there was "no wholesale move from hospital care to community care". Despite the closure of some long-stay hospitals, to date many have not closed. In 1993 there were still 16,000 people resident under the learning disability speciality in NHS hospitals and units in England and Wales (Cronshaw 1996). Even those that have or plan to close have sometimes re-created small institutional settings within communities to replace the one large one on the periphery of the community (Collins, 1992).

Following the 1948 National Assistance Act local authorities developed dedicated residential hostels for people with learning disabilities and many service users living at home received regular day services and occasional respite care. Even within these fixed resources, more imaginative uses of resources were possible e.g. hostels were divided

up into smaller units, each of which created a home-like environment; day centres moved away from production line contract packing and basic occupation to work experience and social and community training within the local community. By way of example some of the residential homes covered by this study (see Chapter 5) were part of the movement to de-institutionalise a large 24 bed hostel into 4 smaller homes.

1.3 Values and philosophy of care

As has already been mentioned, the Jay Report (1979) laid the foundations of the philosophy of care for people with learning disabilities. A vision of community care was spelt out in the Kings Fund report (1980) "An Ordinary Life". The goal was to see people with learning disabilities in the mainstream of life, living in ordinary houses in ordinary streets, with the same range of choices as any citizen, mixing as equals with others, mostly non-handicapped, members of their own community. This is most often described as a model of "normalisation" and as will be seen later this vision and goal are accepted by many involved with people with learning disabilities as well as service users themselves.

The principle of normalisation first appeared in North America in the late 1960s having been evolved from a concept first articulated in Scandinavia by Nirje (1969). In 1976 Nirje defined "the normalisation principle .....(as) making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life in society". It was developed into a theory by Wolfensberger who had based it on sociological concepts of deviance. It was to be used to guide the design and conduct of human services and used the following definition. "Normalisation implies, as much as possible, the use of culturally valued means in order to enable, establish and/or maintain valued social roles". (Wolfensberger and Tullman 1989) One of the difficulties is that normalisation has been interpreted in practice to mean that people with learning disabilities were to be "normalised" rather than the support services they receive or the environment in which they live.

Nirje (Perrin & Nirje 1989) has been somewhat dismissive of the application of the normalisation principle by Wolfensberger whom he felt encouraged people with learning disabilities to minimise their individual differences and the supports they needed, so they would merge more easily into the general society. An example was in an evaluation of services by Wolfensberger where a service user wearing a visible

hearing aid lowered the score of how well the service met the principles of normalisation.

1.4 O'Brien's Five Accomplishments

A well accepted framework which tries to reconcile the developmental needs of the individual with the desire for services and the environment in which they are delivered to be "normalised" is through O'Brien's "Five Accomplishments" (O'Brien 1987 a, b and O'Brien and Lyle 1987). The five accomplishments are

1. community presence,
2. community participation,
3. choice,
4. dignity
5. competence development.

These principles or values underpin many services for people with learning disabilities in Britain today and have implicitly become accepted to a greater or lesser degree by government, professionals, providers, politicians and neighbourhoods. An example of O'Brien's accomplishments from Berkshire is in the Appendix A to the Section 28A Agreement (Berkshire Social Services and Berkshire Health Authority 1995). Here it states that all services will focus on, or seek to achieve, the following outcomes:

> **"COMMUNITY PRESENCE:** People with learning disabilities should be present in the same place as other members of the community. This will involve living in the same areas, using the same community resources and facilities (e.g. shops, leisure facilities, primary care services, work places etc.) as other people, at the same time as other people. There is no need or role for segregated times and places for people with learning disabilities to go about their daily lives.
>
> **DEVELOPING RELATIONSHIPS (also known as COMMUNITY PARTICIPATION):** People with learning disabilities should be supported to develop positive relationships with other people with whom they share their community. This should **not** be limited to relationships with other people with learning disabilities and staff who are paid to support them. These relationships should cover all aspects of personal and emotional need, including sexual relationships.

CHOICE: People with learning disabilities should be enabled to exercise the maximum possible amount of choice over their own lives. It is important that this be **informed choice,** that people with learning disabilities' choices are not limited by a lack of experience from which they can take informed decisions about their own lives.

RIGHTS, STATUS AND DIGNITY: People with learning disabilities should be afforded the full rights, status and dignity that we would wish society to confer on ourselves. This might involve practical matters such as a tenancy, owning a house, having a job or being registered to vote, or it may be in the way that other people relate to them in their tone of address or listening to and respecting what they have to say. People with learning disabilities have a right to make representations and complaints.

SKILL AND COMPETENCE DEVELOPMENT: People with learning disabilities should be supported to develop a range of skills that will enable them to maximise their own potential to gain value from the other areas of the Five Accomplishments. Those skills may be in practical matters such as cooking, using transport, managing money, or may be in the area of personal skills such as communication, interacting with other people, expressing their opinions or assertiveness. Specific help and training will need to be given to some people with learning disabilities about how to exercise their right to make representations and express dissatisfaction."

There is considerable evidence (Sinson 1993, Emerson & Hatton 1994, Garvey and Stenfert-Kroese 1992) that meeting the aim of community participation is often the most difficult to achieve. Being *present* in the community as opposed to being isolated in an institution such as a long stay hospital did not mean that the person with learning disabilities would be any more valued by the rest of the community. Nor would they necessarily be experiencing a valued social role such as friend, worker, tenant etc.

O'Brien's intention was to use these five (service) accomplishments as a means of evaluating the extent to which services met the professed aims of normalisation. As will be seen in later chapters, O'Brien's accomplishments is used as a mechanism for contract monitoring and a means of securing the policy objective that services are provided on the basis of this philosophy of normalisation. A related example in a different sphere would be an employer wishing to monitor the experience of its

workforce in the areas of recruitment and promotion to see that the employer's policy objective of equal opportunities was being met.

The new community care

1.5. Changes in the last decade

Since the mid-1980's the policy of central government towards local government has been that the latter should become the "enabler not the provider". The introduction of compulsory competitive tendering (CCT), the Housing Act (1988) and the Education Reform Act (also 1988) share the common objective of diminishing the role of local authorities in direct service management and provision. (Wistow et al. 1992b)

In 1989 the government published its White Paper on community care (Department of Health 1989). The objective was "to enable people to live as normal a life as possible, with the right amount of care and support to achieve maximum possible independence, while giving people a greater individual say in how they live their lives and the services they need to help them do so". There were 6 key objectives: (Section 1.11).

- to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible
- to ensure that service providers make practical support for carers as high priority
- to make proper assessment of need and good case (care) management the cornerstone of high quality care
- to promote the development of a flourishing independent sector alongside good quality public services
- to clarify responsibilities of agencies and so make it easier to hold them to account for their performance
- to secure better value for taxpayers' money by introducing a new funding structure for social care

The SSDs were to become the lead authority in implementing the new community care within the following context.

1) **People were to be encouraged and enabled to live in their own home.** The 1990 Act provided a mechanism for funding community care through local authority SSDs with an emphasis on developing domiciliary, day and respite services to enable people to live in their own homes (often something they would prefer) instead of entering residential care which was perceived to be expensive.

2) **Services should be targeted on those with the greatest needs and the highest risks**

3) **Clear eligibility criteria for service should be established and published.** The LA could not withdraw services to existing users without first assessing their need (this became known as the Gloucester Judgement after a service user in Gloucestershire successfully sought a judicial review following a reduction in their service)

4) **The response of the LA should ensure choice to the service user**

5) **There should be stimulation of the independent sector (i.e. private, voluntary and not-for-profit) providers.** The changes in social and community care promoted a greater range of non-statutory provider agencies to give a mixed economy of care. This was done by central government insisting that 85% of the new funding given to SSDs (known as the Special Transitional Grant - STG) was to be used in the independent sector and only 15% could be used for in-house social services provision.

6) **Service users should be charged for services.** For those people who moved into residential and nursing homes or received services arranged by the SSD, under their new powers and responsibilities the client would be financially assessed and charged according to their means.

7) **The local authority was to work with other agencies especially health authorities.** The transfer of STG funds from central government was dependent on there being specific agreement between local health and social service authorities (known as the pre-condition or December agreements)

8) **There was to be no unilateral disengagement by either health or social services.**

In relation to point 2 and 3 local authorities have become more explicit since 1993 about eligibility and how they define "needs" and "risk". Note that in relation to point 6, prior to 1993 local authorities could not pay for residential care for people over retirement age (except within their own Part III facilities), only being able to provide limited care in the client's own homes. The LA had no involvement in nursing home placements so people either arranged their own care or it was provided free by the NHS e.g. in a geriatric ward. One of the principles of the 1948 NHS Act i.e. "free at the point of delivery" was maintained in the new 1990 legislation so that any service provided by the NHS could not have a charge levied. As more responsibilities were transferred from the NHS to LAs under the Community Care Act, the LA was obliged to charge for its services including nursing home care.

The 1989 White Paper (DOH 1989) was a response to the publication of the Griffiths Report (Griffiths 1988). This report had recommended that local authorities should have lead responsibility for assessing people's needs. It had long been recognised that those that qualified for means tested benefit of income support could be cared for in a residential home but the equivalent public money was not available to keep the same person at home with the help of domiciliary or respite care. Many people with learning disabilities come into this category.

The White Paper was followed by the NHS and Community Care Act 1990 (the 1990 Act) and within the context outlined above, there were 4 main thrusts in the new legislation (Gomm 1995) all of which were to make sure that services fit users' needs.

1) Cost containment, in terms of targeting services, increasing charges, introducing competition to reduce prices and ensure value for money
2) Prioritising community and domiciliary care over residential care (to more reflect service user need and choice)
3) Introduction of market principles by separating out the purchasers of services (LAs and health authorities) from those who provide them and encouraging a flourishing independent sector in the provider field
4) Devolving power to consumers and users of services by increasing choice to them

Under the 1990 Act it was expected that the new funding structure for people seeking public support for residential and nursing home care would start in April 1991 but in practice this was not transferred to local authorities until two years later in 1993.

1.6 The National Health Service

The 1990 Act ensured that within the National Health Service (NHS) the separation into purchasing and providing was mandatory, thereby creating an internal market. The (purchasing) health authority was to

- ensure health needs of a given population were met
- have effective health promotion and disease prevention policies
- ensure provision of health care was comprehensive
- set targets and monitor performance of providers to kept them on the mark (Levitt and Wall 1994).

The providing side of the NHS was to be self-governing NHS Trusts - providing hospital and/or community (e.g. district nurses and professions allied to medicine) services. Trusts could have contracts with any health purchaser (including health

insurance companies) but mostly their income would come from the local health authority as they are treating people who live locally.

The 1990 Act says that NHS contracts are not legally binding in the sense that social care contracts are (see Chapter 4) though the use of the word has been retained. The aim of the NHS contract is to agree with the provider an overall cost for a given volume of work with identified quality and other standards (Levitt and Wall 1994). A further reform within the NHS was the shift of purchasing responsibility to the primary care team in particular the General Practitioner (GP) who became GP fund holders (GPFHs). They can purchase specified services from hospitals and other health providers and can enter into fixed price contracts for particular specialisms.

Although the aim of the community care reforms was to separate out the purchasing and providing function of the NHS and SSD, in the latter the split was not mandatory. Each local authority needed to decide for itself how best to meet its new responsibilities. The different ways that a range of LAs responded to these changes is described in Lewis et al (1996), where one of the authorities studied was Berkshire.

1.7 Preparation for care management

In many of the discussions and publications by central government much emphasis was put on "case management" and the role of the "case manager" in assessing clients' needs and arranging a package of care to meet those needs. Although the name quickly evolved to care management and care manager, the underlying concept was the same.

The Department of Health (Department of Health 1991a) defines care management as the "process of tailoring services to individual needs" and then refers to specific care tasks. The guide describes 7 core tasks in the cyclical process of care management.

1) Publishing information
2) Determine level of eligibility
3) Assessing need
4) Care planning
5) Implementing care plans
6) Monitoring care plans
7) Reviewing care plans

Renshaw (1987) described how case (care) management had become increasingly important in the 1980s. She broadly defined case (care) management as "careful

assessment of need, comprehensive care planning, co-ordination of services and follow-up". This would involve not only meeting need in individualised ways and not fitting users into services that were available, but also promoting a service development role - promoting service which improved efficiency and reduced gaps and overlaps in services.

Much of the government guidance on care management and assessment was based on the work done by Personal Social Services Research Unit (PSSRU) at the University of Kent. One example is the different dimensions of efficiency and effectiveness to be considered when monitoring service (Department of Health 1991a). Challis (1994) reviewed 10 different case (care) management projects - 7 in the UK and 3 in the US - when looking at common problems of implementation of care management.

1.8 Summary

This chapter has briefly described the development of services for people with learning disabilities and also the major shift in government policy concerning personal health and social services. The role of the local authority SSDs in implementing this shift of policy through care management is emphasised. The next chapter shows how one local authority SSD (Berkshire) responded to this shift and how it impacted on local services for people with learning disabilities.

Chapter 2

Introduction - the local context

This chapter sets the research study in a local context and describes how Berkshire SSD responded to the new community care policy by re-structuring in 1991. Its influence on services for people with learning disabilities is also discussed.

2.1 Historical background to general welfare services

The previous chapter described the role of LAs in developing residential and day services for people with learning disabilities under the National Assistance Act 1948. The welfare services responded to people according to the category of problems people displayed e.g. children, elderly people, people with mental health problems. Authorities would have a children's department and a health and welfare department. The latter covered people with learning disabilities as well as those who were elderly, had physical disabilities or mental health problems. The education department probably had an education welfare section. As time progressed, it was recognised that many people did not necessarily fit into simple categories and that it was wasteful and unhelpful to have several professionals from different departments all working with a particular individual or family. (Seebohm, F. 1968)

2.2 The creation of social services departments

In 1971 the social services departments (SSDs) in England and Wales were created to try and address these difficulties. These local authority departments were to take on the statutory and discretionary responsibilities for services previously provided by children's departments and health & welfare departments. There were established at the second tier level of government - county or city council. Prior to 1971 children's departments had often been provided at the county level but health and welfare departments were at the borough or district council level. This added to the confusion for the client and the lack of co-ordination in services.

At the time of local government re-organisation in 1974, social services departments in England and Wales also incorporated those social work services previously provided in hospitals. Until that time, these had been provided by individual hospital management committees which ceased to exist and were replaced by area health authorities in 1974. Probation services have never come under the social services' umbrella.

2.3 Berkshire in the mid-eighties

After the 1974 local government re-organisation Berkshire Social Services began operating 6 separate geographical divisions serving similar size populations. There was also for several years a seventh division covering the social workers based in both the acute and the long stay hospitals. The geographical divisions ranged from the rural Newbury division which covered nearly half the county's area to the densely populated towns of Reading and Slough with a significant ethnic population. Each division managed its social work teams together with the local provision of homes, day centres and home care services.

The structure of teams varied slightly from division to division but generally there was a children and families team, an intake team and an elderly team (which also gave service to people who were blind or had a physical handicap). The home help service was part of the elderly team and the professional staff of the divisions included social workers, occupational therapists and home help organisers.

Services for people with learning disabilities were localised in each division and in time there were 6 Community Teams for People with Learning Disabilities (CTPLDs), 6 residential hostels and 6 adult day/training centres - one for each division in the county. Residential and respite services for children with learning disabilities were less evenly distributed with a respite centre in both east and west Berkshire but all the long term residential provision for children was located in the west of the county.
This arrangement where services were localised and managed within six fairly autonomous divisions continued until the department re-structured in September 1991. It was hoped that this major re-structuring would enable Berkshire Social Services to meet more effectively its new obligations under the National Health Service & Community Care Act 1990 (the 1990 Act).

2.4 Berkshire's response to the 1989 White Paper

By the early 1990s Berkshire County Council was ready to externalise many of its services to the independent sector. The Highways and Planning Department was externalised in 1993 (the contract going to consulting engineers Babtie & Co.) with a small client side remaining within the county council. The property department was contracted out to Jones, Lang, Wooton. However, the social services committee in 1991 were committed to changes being introduced only if it would be of benefit to clients.

After publishing a summary of the White Paper (Berkshire Social Services, 1990a), Berkshire set about preparing for its implementation. A number of internal discussion documents were published during 1990 and a number of demonstration projects were set up in an attempt to test out various models of assessment and care management. This culminated in a staff consultation document on sub-structures (BSS, 1990b) which gave the tasks that were to be carried out within the re-structured department. At the time this was published the term "case management" was still in use but the term "care management" will be used in the description and discussion for greater clarity.

The December 1990 paper (BSS, 1990b) showed there would be 3 main streams within the SSD -

1. purchasing and care management
2. service provision
3. quality assurance and strategy

By the time this paper was published, the senior assistant directors had been appointed to lead the three teams and the paper gave several options about how the 3 teams could work and relate to each other. The intention was that every member of staff, except the Director of Social Services, would be allocated to one of 3 streams described below.

1. The **purchasing** stream would include over 350 social workers, 60 occupational therapists and half the 50 home care organisers. Together with administrative, clerical and financial support staff, this gave about 650 full time equivalent (FTE) staff.

2. On the **providing** side there were to be 67 residential units (and 31 group homes for people with learning disabilities and mental illness), 63 day service units as well as home care operations, and family and adult placement services. The number of staff employed in the providing stream was in excess of 3,500 and the annual budget was over £38 million.

3. The third stream was to cover **strategy and quality assurance** and included the inspection unit, the planning section and capital projects. It would be a much smaller team than the purchasing or providing stream. The quality assurance section would be inspecting private, voluntary and in-house residential homes using the same criteria. This inclusion of inspection of in-house provision was another aspect of the 1990 Act. Berkshire also proposed that the inspectors would

inspect care management within the purchasing stream though this was not required by the new legislation.

The December 1990 (BSS 1990b) paper also looked at the respective tasks of each stream which were:-

1. The "care management and purchasing stream" would be utilising existing skills as well as other opportunities and responsibilities. In terms of "client champions" the tasks would be assessment, counselling/treatment, advice/treatment, arranging services (packages of care; single service), rationing and budgetary awareness/control, representation/ advocacy, monitoring/review. In terms of "service champions" the tasks were service development and promotion, service specification/contracting, quality control, targeting/noting shortfall in resources.

2. The "providing stream" had already faced significant change in the previous years which would be developed after re-structuring. These changes included in the late 1980s, in the wake of an SSI inspection report, the department moving away from a home help to a home care service - a huge shift from cleaning and shopping service to targeted personal care to meet the needs of frail and vulnerable people living at home. In addition day nursery provision for working parents had been transformed into a therapeutic service for abused children and their families; day services for people with learning disabilities had moved from light industrial work to a full range of social skill and work experience programmes; residential care services for elderly people were incorporating more respite care, outreach work with frail elderly people and high dependency day care 7 days a week. Prior to 1991 the SSD, in line with other county council departments, had moved to cost centre or devolved management. The hope was that after re-structuring managers within the providing stream could have further autonomy through arms length management but this would be short of "contracting-out".

3. The "strategy and quality assurance stream" also included capital projects though it was recognised that the latter did not fit neatly into any of the proposed 3 streams. The role of the strategy team would be to: define the culture of the organisation and setting values and principles for services; set objectives and priorities; define broad partnership arrangements with health and housing; set out the market rules for purchasers and providers and review the implementation of

policy and strategy. The inspection duties of the quality assurance team is defined by legislation but it also encompassed quality assurance/ quality improvement remit for the whole department. In addition it would be implementing the complaints procedure newly required by the 1990 Act.

Prior to the implementation of the purchaser/provider split Berkshire Social Services established 6 case (care) management projects which ran from July 1990 to September 1991. The original intention was that these projects would inform the resulting re-organisation but in many instances the lessons learnt were put to one side or disregarded. In December 1991 the final evaluation report of the 6 case (care) management projects was published (BSS, 1991c). This summarised the major lessons and experiences of the projects but these had not all been included in the final re-structuring which had taken place three months previously.

As might be imagined the purchaser/provider split caused considerable upheaval. Twelve hundred staff were transferred to new posts and took up their new responsibilities over a single week-end in September 1991. (Lewis et al, 1996).

2.5 Final re-structuring

The original and final structure of the re-organised Berkshire SSD is shown in Fig. 1 and 2 at the end of this chapter.

Purchasing stream

By mid April 1991 the 2 Assistant Directors (Purchasing) were appointed. They would have line management responsibility for 16 locality teams (9 in the West and 7 in the East). Each locality would have 2 teams - one for children and families and one for adults and disability. The teams would be staffed by ***care managers*** (previously qualified social workers and occupational therapists) and ***assistant care managers***. There would also be a ***community development and carer support worker*** for each locality as well as a support services manager who was responsible for the clerical and finance assistants. For each of these new posts job descriptions were agreed.

One of the biggest changes was to remove the social work/occupational therapy distinction and create a new grade of care manager. Care managers reported to one of the 2 ***senior care managers (SCM)*** in each locality who would arrange professional consultation with a discipline specialist if this was not the specialism of the SCM. After pressure from the two professional groups, it was agreed that the posts would be called

Care manger/Social Worker and Care Manager/Occupational Therapist, though the job descriptions are identical (BSS, 1991d).

The six multi-disciplinary Community Teams for People with Learning Disabilities (CTPLDs) and the six Community Teams for Mental Illness (CMITs) were to remain intact but the social workers (care managers) would be part of the purchasing stream. For CTPLDs their line management would be through lead locality managers (covering an area bigger than one locality) and then to the assistant directors (purchasing).

Each assistant director (purchasing) also had a group of staff giving professional support to the locality and community teams. This included the development consultants (child care, physical disability, learning disability/mental health and elderly), the child protection co-ordinators, the children's reviewing officers and the training/practice learning co-ordinators.

Providing stream

The providing stream also divided into East and West with the ***group managers*** being responsible for services according to client group. There were therefore 2 group managers for children and families, 2 for elderly and physical handicap, 2 for mental health and learning disability and 2 for domiciliary services. The latter 2 were each responsible for 3 home care services as the home care teams had kept to the old divisional boundaries. Each group of providing managers in East and West had support staff (personnel, training/staff development and finance). (BSS, 1991a).

Strategy and quality assurance stream

The third stream included the planning officers, the inspection unit, those involved with capital projects and the information section.

By September 1991 staff employed in Berkshire Social Services were in one of the 3 streams - providing, purchasing or strategy/quality assurance. Procedures and guidelines for care management were issued (BSS, 1991b) and an extensive training programme for the new care managers was undertaken. These were revised in 1993 (BSS, 1993d).

During most of the time of this case study (April 1993 to October 1996) there was little change within the structure of the three streams, though there were some changes in personnel. Changes took place towards the end of the study period because of the implications of the Secretary of State's decision in July 1996 to change the County

Council and the 6 District Councils into 6 Unitary Authorities. This will occur in April 1998 and further re-grouping within the purchasing and providing streams occurred in September and October 1996 respectively.

2.6 Impact on services for people with learning disabilities in Berkshire post 1991

For most service users and carers of people with learning disabilities, the 1991 re-structuring had little impact in the early years. Service users still attended the same day centre or used the local hostel for long term or short term care. Their local social worker (though called a care manager/social worker) or community nurse still worked from the same office of the Community Mental Handicap Team. It was not until 1993 that all teams were officially renamed Community Teams for People with Learning Disabilities (CTPLDs).

Nevertheless, there had been changes external to the CTPLDs. Within the NHS, the community nurses and other health personnel had been employed by either East Berkshire Health Authority or West Berkshire Health Authority. The establishment of NHS Trusts did not happen all at once. In the east the NHS Trust was established in 1992 to manage the hospital provision of 250 beds over 3 hospitals and provide some of the community services (mainly community nurses). Other health professionals (e.g. occupational therapists, speech therapists) came from a separate (community) Trust. In the west, the Trust providing services for people with learning disabilities was not established until 1993. Because by that time there was no large scale hospital (in-patient) provision this NHS Trust was not a "single function" Trust as in the east. The Trust based in the west covered generic community services, community hospitals as well as specialist health services for people with learning disabilities. These specialists were attached to the west CTPLDs thereby giving a multi-disciplinary focus to the work of the team that was less prevalent in the teams on the east.

On the other hand there had been much more formal joint planning of services within the east with 3 local planning forums with representatives from health, social services, education, the voluntary sector and district councils. There had also been a few jointly funded (by health and social services) residential schemes including one using Housing Corporation money for the buildings.

Those professionals working in the NHS Trusts are "providers" and those who are care managers/social workers are "purchasers". Consequently, the CTPLDs are one of the few areas within the county where purchasers and providers are in daily contact and

working closely together to provide a co-ordinated and integrated services for clients and their families. In many instances they are doing essentially the same job. However, because sometimes purchasing and providing are perceived as being on either side of a divide, there are inevitable tensions within the community teams particularly in the interpretation of the role of the care manager.

Budgets for BCC in-house providers (that is Berkshire Social Services) remained within the providing stream. Overall responsibility for other purchasing decisions for people with learning disabilities (e.g. residential care with private or voluntary organisations) remained at a high, third tier level - Assistant Director (Purchasing). Budgets for this client group were not devolved down to Senior Care Managers (a fifth tier post) in the 16 localities as they were for people who were elderly, those with a physical handicap or children.

The purchase of some specialist health services for people with learning disabilities should have been transferred from the health authority to GP fundholders (GPFH) from April 1994. The Regional Health Authority delayed implementing this until 1997. Purchasing by GPFHs for this client group was blocked back to the health authority until that date and will continue for 1997/8. This meant that the existing pattern of service provided by health within the teams was relatively unchanged during the time of this study.

2.7 Summary

It can be seen from the preceding discussion that a centrally imposed government policy to change the nature and delivery of welfare services in England and Wales was under way at the time of the study. The re-structuring in 1991 within Berkshire SSD was radical compared to other LAs. The language of "purchasing" and "providing" became as commonplace within the Berkshire LA as it was within the NHS.

However, there is a major difference in the culture and accountability of the two organisations. The NHS has more central control (the hierarchy of management passes from area to region to the Department of Health). The officers of a health authority report to a board but who act collectively as a QUANGO. The LA social services department has local accountability through their social services committee which consists of democratically elected councillors. These councillors are members of the same political parties as the nationally elected politicians (members of parliament), although the majority party at the local level may not be the same party in power as at the parliamentary level. In the case of the 1990 Act national politicians had passed

legislation which would need to be implemented at a local level. Policy and guidance given at the national level would need to be interpreted locally at the officer and member level. Both officers and members would influence this interpretation.

Table 2.1 Organisational plan before restructuring

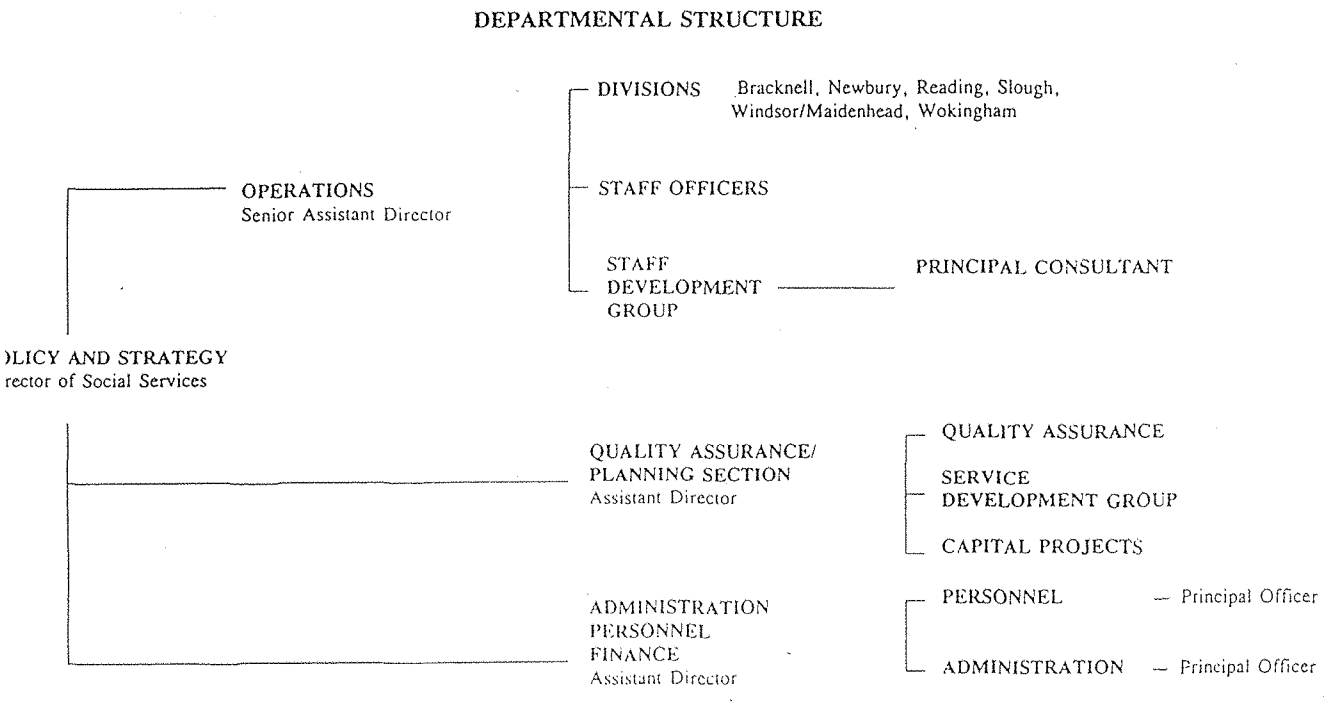
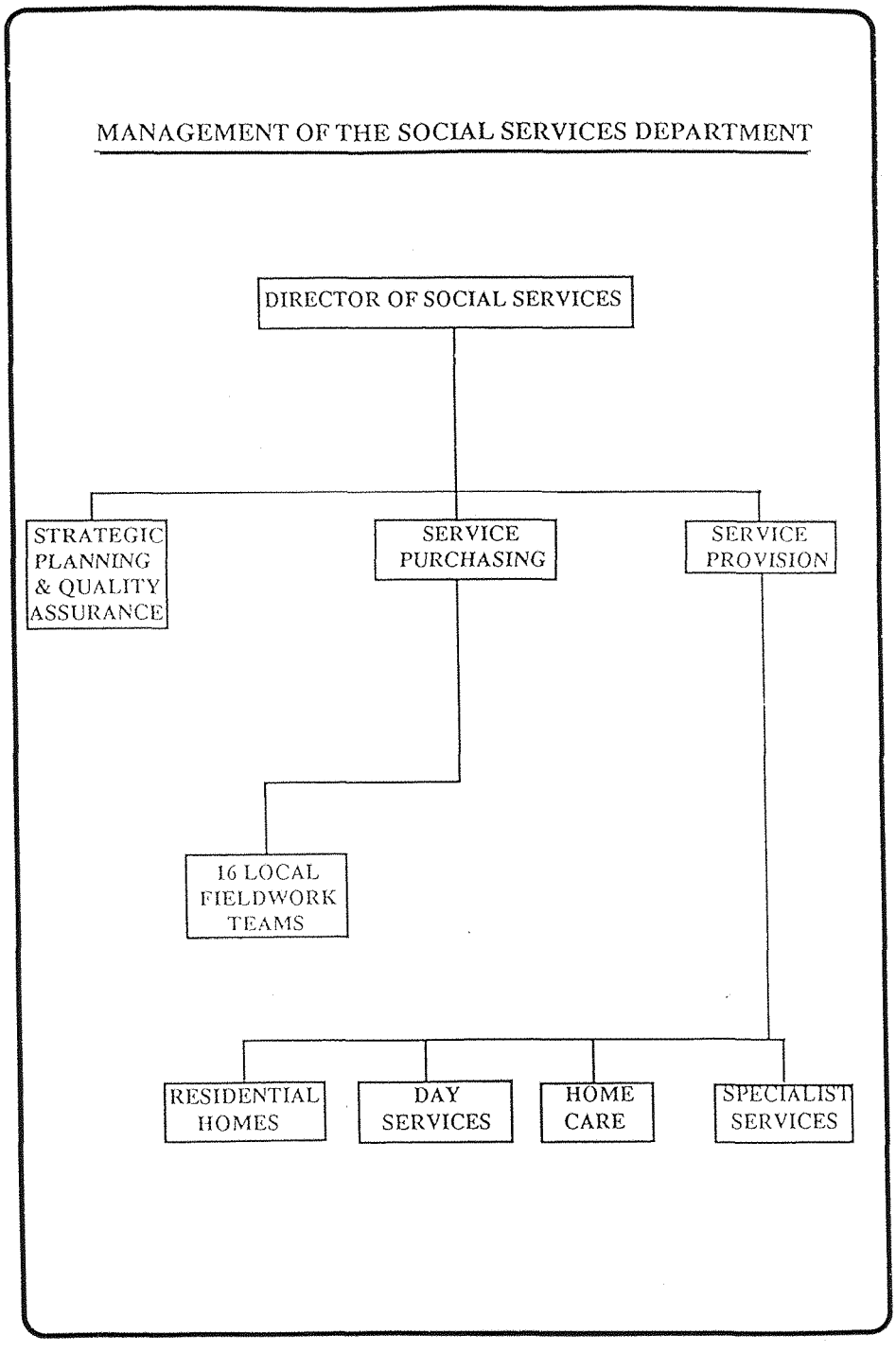


Table 2.2 Organisational chart after re-structuring showing 3 streams



Chapter 3.

Aims and methodology for this research study

3.1 Aims of the study.

The first two chapters looked at changes in the delivery of welfare services in the UK in the late 1980s and early 1990s and how Berkshire SSD responded to these changes. This chapter looks at the aims of the research study and the chosen methodology adopted.

The use of social care contracts (described in greater detail in chapter 4) was one of the ways chosen by the central government for carrying through the implementation of the community care reforms described in the previous chapters. Two of the major aspects of this central policy were

1. to keep people in need within their own home with support rather than move into residential care,
2. to improve the quality of life of all people receiving services and achieve value for money.

This study addresses this second aspect of the policy and is concerned with those services which are residential care. In addition it is looking at a narrow range of residential provision - block contracts for people with learning disabilities.

Contracting in the social care field is new both within the UK and within Berkshire. A mid-career social worker qualifying in 1970, as the author was, would not necessarily have "contract monitoring skills" as a tool in the same way as the tools for therapeutic intervention or advocacy for clients e.g. for their welfare benefits.

3.1.1 Underlying assumptions

The author did make a number of starting assumptions at both the personal and organisational level which informed the initial aims of the study. These starting assumptions were:-

1. The personal style of working which the author utilised was one of collaboration and support. She would feel more comfortable carrying out monitoring in that way than a more combative style that looked for breaches

in contract. In addition many of the staff with whom she would be collaborating were divisional colleagues prior to the re-structuring in 1991.

2. The purchaser/provider split was a fact of life within Berkshire SSD and the whole organisation worked to maintain and refine it to best meet the needs of the clients it served. This organisational ethos extended beyond the SSD to other council departments.
3. Contracting was a new dimension for residential care for people with learning disabilities. There was little body of theory or experience on which to base working practices. Contracts were in place and it was assumed some thought during the process of drafting had been given to how monitoring would be carried out. However, the author had no fixed views about how it should be carried out and was willing to change methods if required.
4. It would be possible to detect differences in the standards of care provided by the different suppliers through the monitoring process. This assumption raised 3 methodological questions
    a) How to measure standards of care? What were the criteria and what was the method of measurement?
    b) Would the chosen method of measuring be effective in detecting differences in the standards of care between the providers?
    c) Were these measured differences material to the contract and would they hold up in a contractual dispute e.g. arbitration or a court of law?

3.1.2 Aims at the beginning of the study

Bearing in mind these working assumptions, the author had the following aims at the beginning of the study.

1. To develop an method of monitoring block contracts for residential care for people with learning disabilities which would ensure there was contract compliance and an effective use of the department's resources to meet its obligations to these residents.
2. To see if any method of monitoring which was developed could be used for other situations e.g. the monitoring to individual contracts for residential care.

As will be seen in the later chapters, these initial aims were a little ambitious and as the study progressed the aims became more modest. This study show how monitoring as a task was implemented within a section of the SSD, how the importance of the monitoring task for block contracts varied depending on the overall objectives of the

SSD and how the role of the "purchaser" and the "provider" in contract monitoring varied over time.

3.1.3 Factors affecting the research design

Five year block contracts for residential care for people with learning disabilities began in 1992 in Berkshire SSD. There was a recognition within the department that these would need to be monitored and reviewed, hence the new job description of the author early in 1993. The author had been party to some of the commissioning of the new services that resulted in the block contracts (see Chapter 5, section 5.3 for more detail) and she was aware of 3 factors which would affect the research strategy:-

1) Contracting in social care was in its infancy in Britain and therefore in Berkshire Social Services.
2) There was no agreed method for monitoring social care contracts within the social services department in 1993.
3) The research would be taking place within an organisation, of which the author was a part and which would influence her objectivity in making a study of this subject. She was at once a key player and an observer.

This last factor highlights the fact that there was a process taking place which would inevitably affect the research strategy. The research method could not be explicitly laid out at the start of the study and then followed without deviation. It developed over time and was influenced not only by the data collected during 1993/94 but also what was happening within the organisation where the research was being carried out. Much of what occurred in the latter part of the study was an attempt by the author to validate the tentative conclusions drawn from the more formal part of the study.

These three factors (implementation of a new policy, no existing good practice guidelines and the author being someone who would shape and observe the process) indicated that a qualitative approach would be more appropriate than a solely quantitative method.

To appreciate the strengths and limitations of this chosen approach it is necessary to reflect on the different traditions.

3.2 Quantitative and qualitative research

Quantitative research is often associated with "pure" science and areas of science which concentrate on the physical and biological world rather than the world of the

individual behaviour. It uses the hypothetico-deductive methodology and such a science would rely on empirical methods of observation which would be objective. This method is characterised by the attempt to discover general laws or principles that affect the events being observed. There will be some theory construction and hypothesis testing. The theory tries to explain the phenomena which are being observed and hypotheses are generated which predict what will happen in certain prescribed situations. These hypotheses are then tested (usually) in an experimental situation and the proof or otherwise of the hypotheses add to or detract from the validity of the theory.

Data collected using a quantitative research design is expected to be amenable to statistical analysis (e.g. results of a survey questionnaire or laboratory experiments) and such surveys would be aiming to analyse the influence of the key variables that have been identified.

Qualitative research is not averse to quantification as such but has the perspective of the individual as the main emphasis (Bryman 1989). A core feature of qualitative research methods is that satisfactory explanations of social activities require a substantial appreciation of the perspectives, culture and "world views" of the actors involved (Allan 1991). This feature affects both the theoretical basis of what is being investigated as well as the mode of collecting and analysing data.

In qualitative research people's understanding of the nature of their social environment contrasts sharply with the quantitative approach where such facets of the environment are treated as "objects" in the scientific sense (Bryman 1989). Qualitative data collection methods tend to concentrate on techniques such as participant observation, semi-structured or unstructured interviews and/or collection of documents.

Guba and Lincoln (1989) reject totally the "scientific" approach to explanation and methodology in the realm of human behaviour. Their (fourth generation) evaluation is described as a responsive constructivist evaluation. It is responsive in the sense that this is the mode of focus by which questions are asked and information gathered. The claims, concerns and issues of the various stakeholders are taken into account and worked with in order to design and conduct any evaluation.

The constructivist method adopted by Guba and Lincoln is in direct contrast to the paradigm or belief system contained in the scientific (positivist) view. It has three basic assumptions to the methodology.

1. Realities are a social construction of the mind and there are as many constructions as there are individuals (though many constructions are shared).
2. The interaction between the observer and the observed creates what emerges from that inquiry.
3. There is a rejection of the controlling or experimental view of science in favour of one where the interaction between the observer and observed creates a constructed reality and this is as informed and sophisticated as could be at the given point in time.

Bryman (1989) makes the distinction between research designs and research methods (or techniques of data collection). His five research designs are

1. experimental design,
2. survey research,
3. qualitative research,
4. case study research and
5. action research.

The two research designs adopted by the author were action research and case study research which are described below.

3.3 Action research

Action research is also known as formative evaluation. Harre and Lamb (1993) give the following definition.

> "When used as a process action research involves systematically collecting research about a system relative to some objective goal of that system: feeding these data back into the system: taking action by altering selected variables within the system based on both the data and the hypothesis: evaluating the results of action by collecting more data ... These actions typically entail manipulating some variable in the system that is under the control of the action researcher. Later a second static picture is taken of the system to examine the effects of the action taken".

Action research is an approach to applied social research where the action researcher and a client collaborate in the development of a diagnosis and solution for a problem, whereby the ensuing findings will contribute to the stock of knowledge in a particular

empirical domain (Bryman 1989). He describes action research as a special kind of single case study.

It is therefore a systematic attempt to feed back research findings to practitioners and any changes occurring as a result of these finding are also researched. Bryman (1989 pp 181-2) described a study by Pasmore and Friedlander in 1982 looking at injuries to assembly line workers in the computer industry. Sinson (1993) looked at how attitudes to people with learning disabilities varied from urban to rural areas and how these might be changed.

Action research is also used by Bryman to describe the participative model, particularly with those within the organisation being investigated, who actively collaborate with the researcher to diagnose the problem and implement the findings. The Pasmore and Friedlander study was an example of this and Bryman felt it showed a number of characteristics of action research.

1. Concern with problem solving but contributes to understanding of the problem in its wider context
2. Style of research favours a participative and collaborative style
3. At the implementation stage, the findings are implemented thereby giving a framework for the application of the finding
4. Reveals a concern for the understanding of the whole system.

Stoecker (1991) also points out the importance of the researchers and the participants in any case study. The researcher not only affects the theoretical choices about which questions are going to be addressed, but also affects the empirical methods of data collection. The "subjects" of the case study also help to substantiate the validity of the work both by commenting on the accuracy and eliciting further information. Yin (1989) uses this as one method for improving the construct validity of a case study. Guba and Lincoln (1989) take this further by recognising the role of the researcher and participants (or stakeholders whom they feel are important to identify as particular groups) by building it into the methodology from beginning to end. In the quantitative or scientific method the researcher is expected to remain as separate as possible from the arrangement of the data.

3.4 The case study method

The case study in the study of psychology relates primarily to the individual or person. It is idiographic (i.e. personal) as opposed to nomethetic (i.e. law like) which refers to the study of groups. The nomethetic approach is trying to find general laws which can

lead to generalisations about people. It can be used to predict with some accuracy future group results but it cannot help predict individual behaviour as the uniqueness of each response is to a large degree "swallowed up" in the group score (Gross 1987).

The case study method in other social sciences generally has a wider interpretation that the one described by Gross (1987), though Yin (1970) described a case study to investigate one person who suffered from a rare clinical syndrome where people can not recognise faces by visual clues alone following a brain injury.

Sociologists and social anthropologists used case studies widely in the first half of this century but they appeared to fall into decline after 1950 except in the field of education (Mitchell 1983). Mitchell argued that case studies are most useful when there is an attempt to use the data from the study to aid theoretical explanations and developments. His working definition is that a case study is a "detailed examination of an event (or a series of events) which the analyst believes exhibits (or exhibit) the operation of some identified theoretical principle" (1983: page 192). This does not preclude descriptive case studies but these may not easily lead to direct general theoretical interpretation (Eckstein 1975). Eckstein lists how various types of case study can lead to different levels of theoretical explanation.

Yin (1989) points out that the choice of research strategy depends on 3 conditions

1) The type of the research question
2) The control an investigator has over actual behavioural events
3) The focus on contemporary as opposed to historical phenomena

The case study tends to concentrate on the "how" or "why" questions. It tends to be an investigation in the here and now and the investigator has little control over what is actually happening. An historian also tries to answer the questions "how" and "why" but because the events are past they cannot have the benefit of two techniques available in the case study - direct observation and systematic interviewing (Yin 1989).

There is also an emphasis on the wholeness of the case study. Rose (1991) quotes previous researchers of the 1950s (Goode and Hatt) who said that the case study approach is "a way of organising data so as to preserve the unitary character of the social object being studied".

The technical definition which Yin (1989) uses is the one that describes this research project.

A case study is an empirical enquiry that:-

- investigates a contemporary phenomenon within its real life context when
- the boundaries between the phenomena and their context are not clearly evident and in which
- multiple sources of evidence are used

The reasons for choosing these two methods of action research and case study were because of the three factors described at the introduction to this chapter. Relying on these methods would ensure that the author would be as systematic as possible in the observation of data and in the reflection on the process and action. The next section of this chapter looks at the criticisms of the case study method, how they can be minimised and what efforts were made by the author to improve the validity and reliability of this study.

3.5 Criticisms of the case study method

The case study method has two main criticisms levelled at it, primarily because it is concentrating on the uniqueness of the individual and their situation. One concern is its validity and one the other its ability to be representative - both of which are closely linked.

Validity and generalisation.

Validity is the ability to measure what it is supposed to measure. Both Stoecker (1991) and Mitchell (1983) discuss this in some detail.

In quantitative methods the researcher aims to select a statistically reliable sample of the whole population which are considered to be typical of the whole. Conversely, generalisability has come to mean the ability to extrapolate with statistical confidence to the population from which the sample was drawn (Rose 1991). This is what Mitchell refers to as statistical inference. Great care is taken to ensure that the sample being investigated is chosen in such a way that there is "no bias" in the sample compared to the parent population (i.e. the sample is representative of the whole from which it is drawn). Mitchell makes the distinction between such statistical inference and logical or scientific inference, the first being inappropriate to a case study whilst the second can be applied.

Logical or scientific inference is used when trying to describe the relationship between the characteristics which are observed empirically and what might be an explanation of

such a relationship. Mitchell used the example of age and probability of being married as an example. By reflecting the age distribution of the population and selecting the sample randomly, a relationship (or correlation) was observed between age and probability of being married. From statistical inference it would be possible to say that a similar correlation existed in the whole population. However, to link the characteristics together (e.g. in terms of the normal life cycle) requires the process of logical inference as it is "not based upon the representatives of the sample and therefore upon its typicality, but rather upon its plausibility or upon the logicality of the nexus between the two characteristics". It would also need to be validated by other types of observation and in the values of the people concerned.

Stoecker (1991) points out the limitations of the quantitative methods and shows how the case study aims to fill the gap.

1. Probability sampling and statistically significant tests do not necessarily give a valid explanation nor a valid generalisation. (See also Mitchell's criticisms.) A variety of explanations could be used to cover a particular statistical association or correlation. The case study, which has a time dimension and studies process, can greatly help at explaining factors contributing to the causal explanation.
2. Scientific method does not control for scientific bias. Large scale, very formal structured interviews introduce bias by not allowing for the fact that the same questions can have different significance and meaning to different respondents. This is a similar argument used in a wider context by Guba and Lincoln (1989). This feature is shown in the analysis of results of the questionnaire described in Chapter 10.
3. The survey research method is not useful for applied research.

Stoecker (1991) reserves the term case study for those research projects which attempt to explain holistically the dynamics of a certain historical period of a particular social unit. He feels it is not a "method", more a frame determining the boundaries of information gathering.

Yin (1989) argues that scientific facts are rarely based on single experiments but on many experiments replicating the phenomena under different conditions. He concludes that case studies can be generalised to theoretical propositions and also do not represent a "sample". The investigators' goal is to expand and generalise theories (analytic generalisations) and not enumerate frequencies which is statistical generalisation. The

former depends on the adequacy of the underlying theory and related knowledge and needs to be qualified by relevant contextual conditions (see also Mitchell 1983).

Given that the case study approach cannot depend wholly on quantitative methods and statistical inference, it is clearly necessary to find ways to maximise the validity and reliability of the case study.

3.6 Maximising validity and reliability in a case study

Yin (1989) feels it is important to maximise four aspects of the quality of the case study

A. Construct validity
B. Internal validity (if concentrating on a causal case study)
C. External validity
D. Reliability

A. Construct Validity

This is establishing correct operational measures for the concepts being studied. For example in a psychological test, if persons scoring high and low on the test differ in ways predicted by the theory then the test can be described as having high construct validity. The tactics used in a case study to improve construct validity are:-

- using multiple sources of evidence
- establishing a chain of evidence
- having key informants review draft of case study report

B. Internal validity

Internal validity is where a causal relationship is established, thereby certain conditions are shown to lead to another condition as distinct from spurious relationships. (i.e. x leads to y and is not caused by z.) It does not apply to descriptive case studies.

Yin (1989) describes 2 of the ways of showing internal validity

- Pattern matching. Such a logic compares an empirically based pattern with a predicted one and if they coincide this strengthens the internal validity
- Explanation building. Analysing the data by building an explanation e.g. causal links or series analysis

Neither can be applied to this study as it is a descriptive case study.

C. External validity

This is establishing the domain to which a study's design can be generalised particularly in the realm of analytical generalisation. Here the investigator is striving to generalise a particular set of results to some broader theory.

The types of theory which could be investigated are:-

- Theories about individuals
- Theories about organisations e.g. bureaucracies, organisational structure
- Social theories e.g. urban development, function of the market place.

In this study the author has not attempted any of these - informed explanations based on past experience and the author's professional knowledge base were all that were possible.

D. Reliability

Reliability is the ability to show that the operations of a study - such as data collection - can be repeated, with the same results. The main aim is to minimise errors and biases and to improve this Yin (1989) favours the following methods to improve reliability.

- Using a case study protocol before the study begins e.g. rules about how data is to be collected or which questions are to be answered, and
- Developing a case study database so that the case study documentation is kept distinct from the case study conclusions

3.7 Improving validity and reliability in this case study

One of the possibilities of case studies and the strategy adopted here is the combination of quantitative and qualitative research (Bryman 1988). By employing the two in tandem helps check the validity of findings using different approaches to data collection. This is also referred to as triangulation - use of multiple methods - (Denzin 1970 and Bromley 1986).

Construct validity

One of the main methods to improve construct validity in this study was by using multiple sources of evidence. The following sources of evidence were used:-

a) A contemporaneous diary kept by the author from June 1993 to July 1994

b) Data obtained on monitoring visits e.g. reviews held, documentation in the residential home, records of staff turnover

c) Reports of meeting held e.g. with care managers and senior staff of a particular home
d) Memos, letters and other correspondence
e) The text of the contracts themselves
f) Results of a postal questionnaire to keyworkers.

These multiple sources of data help to establish a chain of evidence and corroborate and augment evidence from other sources. One example was the line of investigation in the questionnaire to keyworkers. These were based on assumptions generated from the analysis of the contracts and of the monitoring visits which needed to be tested. For example, the author felt that keyworkers were not very clear about what "care planning" meant, how it should be done and how it related to other methods of reviewing and planning with a service user for their future. Questions in the survey were written specifically to see how far this occurred across all the contracts.

There were many other groups of informants that could have been asked to participate, particularly in semi-structured interviews. At least 11 different groups were identified (see Chapter 8) but time constraints limited these alternatives to the group of keyworkers.

Reliability

The case study protocol ensured that as far as possible data that was being collected was in the same format for each home or contract. For example staff turnover was recorded as a chart with the name of the staff member and the number of hours they were contracted to work in the left hand column and the months across the top row. The month that a staff member started work or left was recorded by a cross. For each month the total number of staff was added up and recorded as full time equivalents (FTE) and this was compared with what was expected from the staff establishment. It was also possible to compute from this numbers of staff changing, length of stay of staff, average length and stay and variation from the mean. This could then be compared with other studies that have been published within the field on the topic of staff turnover.

A protocol for the administration of the questionnaire to keyworkers was written before it was distributed and adhered to by the author. (See Chapter 8).

3.8 The phases of the study

This case study and action research project had a number of phases which are described below

First part

April 1993 to July 1994	Author had formal responsibility for monitoring block contracts for residential care for people with learning disabilities with an emphasis on those in the west of the county. Contract documentation was analysed and a method proposed for monitoring. This was put into effect in April 1994 but was not continued beyond July 1994
November 1994 to summer 1995	Questionnaire to keyworkers sent out, analysis of results and conclusions written up

Second part

July 1995	New care specification for residential care for people with learning disabilities finalised
October 1995	Joint commissioning for people with learning disabilities agreed between Berkshire Social Services and Berkshire Health Authority
July 1996	Recommendations of research study circulated to senior managers in BSS and to Berkshire inspectors

3.9 Action research within this case study

In this case study of describing how a method of contract monitoring was established, the author was the main person investigating the problem. The "contract culture" was only just beginning to affect practice in social services nationally as well as locally in Berkshire. This meant there were no guidelines or "signposts" to which the author could work. The specification for residential care in block contracts had changed several times in the immediate period before the study began. There was not a method for monitoring the contract against the specification and the author was developing it as the study progressed. Although participation and collaboration were encouraged from the various care providers by the department generally and the author specifically, when this was not forthcoming the author then imposed the method and continued to observe and react to that imposition made.

The results of the questionnaire, which were not available until some time after the end of the period of formal data collection, were used in the second part of the study when different methods of contract monitoring were incorporated in the revised block contracts.

The original aims of the study were modified to reflect the reality of the task which was one of several within the author's job description and her changes in post. The first aim (developing a method for contract monitoring) remained intact but the second (to develop a method which would have wider use) was not achieved within the period of the research study. Nevertheless, pointers to where the conclusions of the research project have wider implications are discussed in the final two chapters.

3.10 Summary and guide for the rest of the thesis

The first two chapters have set the scene regarding community care arrangements, both in the wider context and the local context, and this chapter has described the overall methodology of the study. In the following two chapters (chapter 4 and 5) social care contracting in its wider context is discussed as well as a description of the more local arrangements within the study area.

Chapter 6 and 7 reviews the literature on contract monitoring and service evaluation and describes the development of a model of contract monitoring. Chapter 7 makes specific reference to the study area via a content analysis of the contract documentation. It also describes the development of a method of monitoring and its implementation, making use of data derived from observation, informal discussion and diary recordings.

The next three chapters (chapters 8, 9 and 10) describe the setting up of a survey of keyworkers, which explores their perception of the monitoring of contracts and the degree to which they were meeting the contract specification. Chapters 9 and 10 give detailed findings arising from the questionnaire which marks the end of the first phase of the study.

The penultimate chapter (chapter 11) outlines the second phase of the study and discusses changes introduced as a consequence of the first phase, including specific recommendations made in the local context. The final summary chapter (Chapter 12) discusses the wider relevance of this research study in the development of a model of good practice for contract monitoring.

Chapter 4.

Contracting for social care in local authorities

4.1 Introduction

This chapter gives further information about contracting in social care which emerged in the 1990s around initiatives of the new community care. It also gives detailed information about how the contracts for residential care which form part of this study were developed as well as giving characteristics of their type and content. Much of the early literature about contracting in social care and the thrust of the new community care policy came in the form of DOH/SSI guidance. This covered both care management and the purchase (contracting) for care. Contracts are the mechanism by which the providers of services (and there are a wide range of providers) and purchasers of services (health authorities, social services, GPFHs, private insurance companies) agree upon the range, type, level, means, cost and quality of care and treatment. (Gleave and Peck, 1992a).

4.2 Assessment of need

Assessing need is part of the care management process and was given the following description "to understand an individual's needs; to relate them to agency polices and priorities, and to agree the objectives for any intervention" (DOH 1991b). The guidance indicated that assessment was always expected to be a separate exercise from the consideration of the service response. "Need" itself was defined as the ability of the individual or collection of individuals to benefit from care (DOH, 1993) which is quite different from the taxonomy developed by Bradshaw (1972). This distinguishes between:

- "normative need", which is the need defined by a relevant professional or expert against currently accepted norms or criteria
- "felt need", which is what the relevant population believe they want
- "expressed need", which is felt need expressed or made explicit - this is often referred to as "demand" and is usually less than felt need
- "comparative need", which is evident when people are not receiving help or service that is made available to other people who are in identical circumstances

In 1994 Salter described the community care policy as having vast ambitions, fragmented resources and a precarious future (Salter, 1994). The Parliamentary Health Committee (Health Committee, 1993) pointed out the paradox of trying to implement a policy within the two parameters of cash limits (previously it had been open-ended because of the rules about income support) and assessment of need (previously services had not been dependent on the level or degree of need). Agencies implementing the community care policy - primarily the NHS, LA social services and the Department of Social Security - needed to manage supply and demand in four arenas. The control of demand was through the identification of demand and access to provision of services whilst the control of supply was through finance and resource allocation.

The ethos of care management involves identifying need, client and carer choice, providing services to meet need rather than fitting people into existing services and working within available resources. Salter noted that it lends itself as much to generating as controlling the demand for community care. (Salter, 1994).

4.3 The practice in Berkshire in relation to people with learning disabilities

The health authority in the west of the county, whilst closing the two long stay hospitals, maintained their commitment to the three multi-disciplinary Community Teams for People with Learning Disabilities (CTPLDs). There was concern that assessments of people with learning disabilities carried out by members of the teams were limited and were not always accepted by other disciplines within the team. This led to further, repetitive assessments. Some assessments concentrated on skills rather than needs. The client's view was often neglected and it was difficult to disentangle the needs of the carer from the needs of the primary client (the person with learning disabilities).

A small working party, which included the author, developed the Common Assessment Form and guidelines for completing the form for use by professional staff in conjunction with service users and carers (BSS and WBHA 1991). The assessment, once done, would be accepted by a professional from a different discipline i.e. it was "common" to the team. As far as possible it looked at what the person's needs were in all areas of their life and the support they needed (physical, emotional and financial) to participate in those areas. On the basis of the Common Assessment Form (CAF), services would be identified to meet those needs. The person completing the form, which often included input from other professionals (e.g. other members of the team, district nurse), was often the person responsible for co-ordinating the various services

being provided. Within a particular service e.g. a day centre, there would also be a staff member (usually known as a keyworker) who would co-ordinate those elements of the day service which were to be provided e.g. travel training, sport and leisure opportunities, social and domestic skills. In July 1991 it was agreed that this common assessment process would be used be all people transferring to adult services at age 19.

The imposition of the purchaser/provider split in BSS in September 1991 meant that the CAF was not implemented with equal vigour across all 6 CTPLDs in the county. On the other hand Berkshire understood that the meaning of care management and purchasing was more complex than an administrative tick-box exercise. They allowed a large amount of professional discretion in how care managers went about the business of assessment. The CAF has continued to be used, with some modifications, to the present day and is one of the accepted forms of assessments within the department's care management guidelines.

In many respects this way of working anticipated the forthcoming care management approach enshrined in the 1990 Act. The new community care policy and legislation attempted to put individual decisions and actions by field workers within a strategic framework and to be more explicit about the criteria for access to assessment and services than had been in the past.

4.4 Markets in social care

Flynn (1990) describes the developments in social policy since 1979. Apart from attempts to control public expenditure, there was also the desire to reduce the autonomy and independence of local authorities. The government could not rely on local authorities to pursue a market-oriented approach to public services if they were left to their own discretion. The changes affected health, education and personal social services.

The government hoped within its reforms (community care and others) to separate out the purchasing functions (needs assessment and service specification) from the providing functions (delivery of service) and create a "market" between the purchaser and the provider. These markets were compared with other commercial markets as the latter showed responsiveness to need/demand and competitive prices

They also hoped that by specifying services and encouraging purchasers to put services out to tender, this would be a way of stimulating the non-statutory sector and also improve the efficiency and effectiveness of statutory providers. An example of this was

the requirement under the 1990 Act for the inspection service of social services departments (which carry out the regulation of the Registered Homes Act 1984) to be "arm's length" of the local authority. From 1991 they were to inspect their own in-house provision to the same criteria as private and voluntary homes.

Compulsory Competitive Tendering (CCT) had been implemented in the area of building and road maintenance since 1980 (1981 in Scotland) and for some local authority services (e.g. waste disposal, school meals) more recently. Although the number of such services was increasing, the government decided against CCT for social care services preferring to give local authorities the opportunity to make greater use of service specification, agency agreements and contracts in an evolutionary way (Wistow et al 1992b). One of the outcomes of CCT was the need for ~~have~~ contracts as the local authority was purchasing a service for which they paid the provider. Whereas it would be possible to objectively define some services (e.g. emptying a dustbin into a dust cart such that no rubbish spilt on the pavement) it was much more difficult in the field of social care which involve personal care to individuals. Walsh (1991) argues that the contract based management which has arisen from these government reforms makes it necessary to assess the quality of public services. The problem is not simply one of complexity, but of coping with the fact that public services involve value choices and is therefore inherently a political issue.

Moreover, there has been considerable scepticism about the benefits of competition because "social care is different". Knapp et al. (1994) looked in greater detail at markets in social care and the role of local authorities in developing their enabling role. Public services do not act in the same way as commercial enterprises. They have different purposes from businesses and a different relationship to their users (Flynn, 1990). The markets tend to have been constructed through a set of administrative rules rather than technology and knowledge. Entry and exit costs may be high and in some instances impossible to surmount. Flynn (1990) uses the example of the privatised water companies where there are considerable barriers to entry and the chances of a competitor establishing an alternative distribution network are remote. In addition the user (or person receiving the service) is not the purchaser and so the direct relationship between the provider and consumer so common in commercial markets is lost. This has led to the development of the concept of the **quasi-market** which to be successful needs to have multiple purchasers and multiple providers (Deakin, 1996).

4.5 The emergence of contracting in social care

Gutch (1992b) described the "growing feeling that open-ended grants were an unsatisfactory way of ensuring accountability for public money being given to voluntary organisations" This was £0.5 billion in the UK in 1987/88. On the other hand voluntary organisations had been wary about the introduction of contracts which might lead the voluntary organisation to "lose their independence, blunt their campaigning edge and find themselves working to other people's agendas". (Gutch, 1992b) A negative side of grant aid is that it is re-negotiated each year and could easily be cut if there were financial pressures on the LA.

As will be seen later when the various types of contract for residential care in this research study are described, some of the services were a result of "contracting out" i.e. the LA had provided the service in the past (a total of 11 contracts) and in the other cases (4 in total) a new service was commissioned. In these four latter contracts the LA did not expect to provide the service either directly or indirectly.

Gutch made a study of contracting in the United States to see if there were any lessons to be learnt in the UK from across the Atlantic (Gutch, 1992a). Even taking into account cultural differences, many of the potential advantages hoped for by the government in the UK from contracting had not been realised in the US after 20 years of practice. Most contracts in the Gutch study were renewed annually, overspending was not re-imbursed, underspending was clawed back, few "open-ended" grants for general activities were given, financial security was poor with the voluntary organisation often "subsidising" the contract. Consequently, the lobbying and campaigning role was being reduced and both state and provider were drowning in a sea of paperwork trying to supply monitoring data required by the purchaser. (Gutch, 1992a)

4.6 Purchasing arrangements

The formal document linking the two functions of purchaser and provider is the contract for care.

To have a contract there must be (Woolf, 1992)

- an offer of and an unconditional acceptance of that offer
- the intention to create a legally binding relationship
- The exchange of a consideration e.g. provision of service on receipt of money

In terms of the contracts being monitored in this case study, the contract would be a legally enforceable arrangement whereby an organisation is given a specification for a job which is to be done for an agreed amount of money.

Berkshire Social Services has a long-standing tradition of using the independent sector for residential care in addition to that provided by the statutory authorities which are health and social services. The independent sector covers:

1) Private	managed by owners/directors. Profits are distributed to the owners or shareholders. e.g. Peter Brown (sole trader) and Community Homes Ltd (limited liability company)
2) Voluntary	managed by a voluntary management committee. Surplus funds are ploughed back e.g. Care Unlimited (national voluntary organisation)
3) Not for profit	managed by directors. Surplus funds are ploughed back. e.g. Basildon Trust and the Thames and Loddon Consortia.

4.7 Department of Health types of contract

The DOH Guidance (e.g. DOH, 1991d) makes a distinction between the service specification - what the public body wants delivered - and the contract which is the legal document which sets out the expectation of the parties to the agreement.

The DOH has 3 types of NHS contract (DOH, 1991d) which are further explained with reference to Øvretveit (1995), page 142.

1) **Block** contracts are like a *budget for a defined service*. The contract is purchasing access to facilities rather than services for a defined number of clients. They specify the quantity and the quality of the inputs rather than the outputs. It would be an agreement to pay a sum for a period (e.g. one year) in exchange for patient access to the service, but the number of patients (the volume) and costs per patient are not specified. There are few incentives for efficiency or for raising quality.

2) **Price by case** contracts where the price is quoted for each types of case or unit of provision or service purchased as required. An example would be a set amount

for a defined service to one person (or a test) e.g. a single consultant episode, outpatient episode.

3) **Cost and volume** contracts which specify a volume of service and a total cost. A quantity of service is purchased for an agreed sum and additional service provided on a price by case basis. Some cost and volume contracts are like a more sophisticated block contract with an agreed specification for the total number of patients to be treated by e.g. a hospital for a defined amount of money. Others give more indication of the services and specialities within a provider organisation. Some have different payments according to the severity of the illness and/or intensity of service e.g. high, medium and low cost categories.

4.8 Managing the social care contract

To be legal the contract needs to include both the care specification and the terms and conditions of contract. Managing the contract is a process starting from the provider tendering for services, to negotiating and letting the contract, and then monitoring and reviewing it. A number of commentators have identified types of contract management.

Walsh (1994d) identified two fundamental types of contract management.

1) **punishment** based where the purchaser looks for contract failure and carries out sanctions when it is discovered.

2) **relational** where a good relationship of trust is established between purchaser and provider. Shortcomings are dealt with by mutual agreement and negotiation.

Common and Flynn (1992) took a number of contracts of social care between LAs and providers (private, voluntary and not for profit) and analysed how they had progressed and developed over time. The various factors which affected the style in which the contracts were managed were

- the knowledge and skills of the officers carrying out the purchasing function and supervising the contract
- which parts of the specification were used as a basis for monitoring the services
- the degree of trust between the purchaser and provider

From these they identified 3 models or styles of contract management

- contract manager
- purchasing manager
- partnership support

1) The contract manager was an experienced "purchaser" but knew little about social care, though in some instances took advice from others (e.g. professional social workers or elected members) who were in touch with the provider.
2) The purchasing manager was a specialist in the type of care being purchased and worked closely with the providers but did not wish to "manage" the service, relying on the contract documentation for guidance only. They may serve on advisory committees or give management guidance.
3) Partnership support has "hands-off" monitoring and advice by professionals both for the purchaser and the provider. This was prevalent in specialist services where the provider organisation was likely to have the skills and expertise to cater for a particular client group.

The author felt that over the course of the study her model of contract management varied from 2 (e.g. giving management advice) to 3 (e.g. seeking advice from members of the local CTPLD) depending on what she felt was needed by the home at any given point in time.

Although Gleave and Peck (1992 a and b) looked at the implementation of contracts for health, particularly in relation to mental health services, their "images" of the contracting process gave 3 further systems/models of contract management. Mental health services are different from other health purchasing (which is mostly for acute services), and is more akin to services for people with learning disabilities. They describe 4 major characteristics of mental health which differentiated them from acute services.

1) Services provided are long term. This means health care and social care are difficult to distinguish. Although not mentioned by Gleave and Peck one could also include housing provision in this category which is also long term.
2) There are a large number of provider agencies from all three sectors (private, voluntary and statutory). By the same token there are several funding sources (e.g. NHS, LA, social security).
3) Services are nearly always provided through a multi-disciplinary team where the medical doctor is rarely the one with overall responsibility. The team will often select a keyworker who co-ordinates care through the "care planning" programme or care management approach.
4) In recent years services for people with mental health problems are in a period of transition from institution to community. This is less so with services for people with learning disabilities because many have lived all their lives at home

with relatives. However, many community facilities (e.g. large hostels and segregated day centres) could be said to be institutionalised in manner or regime.

The images described were based on the work of Morgan (1986) and reflected the views and attitudes held by those participating in the contractual process which influenced their behaviour and the future development of the process.

The 3 "images" were *status quo* or business as usual,
competitive and
collaborative.

Those people in the *status quo* group either actively opposed the changes in the NHS directed from the centre or superficially adopted the change but failed to make any real changes either consciously or unconsciously.

Those in the *competitive* bidding group felt that competition in the health and social care market would stimulate providers to develop higher quality services at lower cost. People in this group were often working in metropolitan areas and feared take-overs by another mental health unit or a diversion of resources to LA and voluntary providers.

The main aspiration of the people in the *collaborative* commissioning group was for the purchaser and the provider to work together creatively whilst recognising their different perspectives. This group also embraced other aspects of the community care reforms such as service user involvement and co-operation and better communication between health and social services. An example of the collaborative image is where the purchaser and provider work over a long period of time to build up a high quality reliable supplier (e.g. Marks and Spencer, Nissan and their suppliers). Collaborative commissioning is the model favoured by central government (Gleave and Peck 1992a) because it is based on the assessment of need, respects providers' knowledge, acknowledges the responsibilities of the purchaser and retains the element of service development. Lewis et al (1996) show how difficult it is in practice to work within the market environment and discusses whether the voluntary split into purchaser/providers in SSDs has brought any changes (apart from an increase in bureaucracy).

Gleave and Peck (1992b) concluded that the NHS reforms contained in the 1989 White Paper (DOH, 1989) had a fundamental impact on the attitudes of some managers and clinicians. The image of the contracting process held by major local players influenced the way that reforms impacted locally. This concept is discussed further in relation to

this study in Chapter 9 (e.g. poor response from providers when asked how they carried out internal monitoring).

Chapter 5

Social care contracting in Berkshire SSD

The previous chapter described contracting within the community care reforms of the 1990s. Although chapter 3 gives some information of the situation pertaining in Berkshire, this chapter takes a more detailed look at contracting within Berkshire Social Services. It also describes why the block contracts for residential care for people with learning disabilities of this case study emerged and how they differed from one another.

5.1 Contracting arrangements in Berkshire SSD

At the time of the study there were 4 different types of agreement in Berkshire SSD for residential care for people with learning disabilities. These did not wholly tally with the DOH definitions as described in Chapter 4. The four categories have continued beyond the time of the research study.

1) **Block contract**. Here the department agrees to purchase a specific number of beds within a residential home - often all of them - for a period of 5 years. The type of service is determined by a general care specification for the particular client group with an indication for the standard of care expected. It does not specify the range of complexity or variety of need with which the provider would be expected to deal within the contract. There is a price for the contract, formulae for agreeing increases arising from inflation and the names of the first residents form one of the appendices. The purchaser has the right to nominate new residents for the first 6 months of a vacancy and after that the provider can "sell" to another purchaser. However, if a new purchaser was not forthcoming, Berkshire was still financially responsible for the full cost of the vacancy.

This case study is concerned primarily with this form of block contract for residential care for people with learning disabilities

In all block contracts of the study except one, BSS initially purchased all the available beds in homes which varied in size from 4 to 18 beds. In one home, it was agreed to reduce the number of respite care beds purchased after 6 months and the provider eventually sold the place to another purchaser for use by a long term resident. In anotheer block contract a premium was paid over and above the basis contractual price which reduced as each vacancy was filled by a spot purchase.

2) **Spot purchases**. This is the term used to describe what was known as agency or out-county placements. Part III of the National Assistance Act of 1948 ensures that local authorities can provide residential accommodation and care for those people unable to look after themselves in their own home. These Part III homes are for people who are elderly, have learning disabilities or physical handicaps. If the local authority is unable to provide residential accommodation within its own resources for these groups of clients it can purchase care from another provider. Although sometimes this is with another local authority, primarily it is within the independent sector. These "out-county" placements are not necessarily outside the geographical boundaries of the authority but they are outside of the local services of the authority. If the fees of a particular home were above the maximum of the board and lodgings rate paid by the Department of Social Security (DSS), then the local authority is able to "top-up" the fees and receive the DSS income as the residents' contribution. For residents living in a registered home for people with learning disabilities the DSS income was £215 per week in 1992/3. As has been described in Chapter 1 (section 1.5) the "top-up" could not be paid prior to April 1993 for people who were elderly.

Spot purchases equate directly with the price by case contracts of the DOH and the provider carries the risk of any vacancy. Voids are allowed for in the price and the unit cost for a spot purchase is therefore likely to be higher than for a block contract providing a comparable service. In one of the block contracts in this case study only 3 of the possible 5 beds were purchased.

3) **Service agreements.** These are similar to the DOH definition of a block contract. In order to simulate an internal market, service agreements were developed after re-structuring for all services provided by Berkshire Social Services - day centres, residential homes, family centres, home care services, foster homes etc. For the first year it was agreed that the purchasing stream would block book 100% of the places with the providing stream to give time for providers to develop a more individualised range of services in later years. With service agreements no money changed hands as the budgets for the individual units remained with providers. Some attempts (although sort-lived) were made in Berkshire to establish trading accounts for new services e.g. Windsor Day Centre for people with learning disabilities which opened in 1992.

The service agreements for people with learning disabilities were first signed in July 1993. Discussion has continued about re-shaping the services and moving towards a

cost and volume type contract but to date (December 1996) there has been little change in the method of funding the service agreement.

4) **Grant aid or block grant funding**. This has been the traditional way for SSDs to fund the activities of voluntary organisations. In terms of residential care for people with learning disabilities, Berkshire SSD made block grants to cover the deficit funding of 4 residential homes run by a national organisation (Care Unlimited). All were opened before contracts such as those that form this study were in common use. In another instance (a local society for people with learning disabilities) Berkshire SSD supplied staff in kind to work in the home and the agency provided a "training for independence" house and associated group homes. The local society was therefore the registered proprietor in terms of the 1984 Registration Act.

5.2 Berkshire model of contract management.

One of the recommendations from the BSS case management projects (see Chapter 2, section 2.4) was that the purchasing stream needed to develop expertise in specification and contracting arrangements. A task group chaired by the Head of Information was established and their "timetable was to bring forward for consultation proposals about how ... to set specifications for services and how ... to contract for these services" (BSS, 1992a).

The care specification element of the contract

Although at the time of the case study the care specification for spot purchases for people with learning disabilities was different for that for block contracts (the former having been adapted from the care specification for residential care for elderly people), it became common for all 4 types of agreement in October 1995 (BSS, 1995b). The philosophy of care in the original specification was based on that in "Home Life" (Centre for Policy on Ageing, 1984) and did not relate specifically to O'Brien's five accomplishments. An example of the care specification used in the block contracts is included as Appendix 1.

Terms and conditions of contract

The terms and conditions of contract for spot purchases was an example by Berkshire SSD to work collaboratively with independent providers - though effectively it was primarily with those homes that provided services for elderly people. The providers were fairly suspicious and reluctant to conform to anything which meant they were expected to provide a service above the minimum standards of the Registered Homes

Act 1984. The terms and conditions of the contract for spot purchases with the independent sector reached the 16th draft before it was finally agreed in May 1993 (BSS, 1993a). New terms and conditions for contracting for residential care for people with learning disabilities were agreed in July 1994 and a second set of terms and conditions to cover all client groups in residential care were agreed in October 1995 (BSS, 1995b). These were revised again in May 1996.

The terms and conditions for the block contracts which were included in the placement contract were different from those for spot purchases. For example they reflected the differences the purchaser had in nomination rights, payment methods which were quarterly in advance instead of monthly and two weeks in arrears. A copy of one of the placement agreements is in Appendix 2.

Contract management within Berkshire

One of the briefing papers for consultation on the 94/95 Community Care Plan (BSS, 1993c) outlined Berkshire's view of contract management which was one of collaboration. It referred to budgetary control and enabling contract managers to maintain and improve quality standards through dialogue and monitoring. It added that the scope of contract management was wide, covering all relationships with internal, private and voluntary providers and included grant aiding. It favoured devolved, decentralised contract management which aimed to develop local agreement to meet locally assessed needs.

This partnership based approach and the establishment of trust between purchaser and provider was endorsed again as the BSS's preferred model of contract management (BSS, 1995c). This purchasing stream guidance (op cit.) pointed out that the role of the contract manger is considerably more complex than that of a standard commercial contract manager in that there are separate roles of care management, inspection and regulation. Care management and purchasing decisions which are the responsibility of the purchasing stream and its staff will be influenced by information from the inspection and regulation functions. The guidance distinguishes between contract management (the evaluation of the arrangement between the social services department and a supplier which does not relate to individuals) and contract ownership (the concept of identifying an individual officer with the overall responsibility for a specified contract).

The contract owner would most likely be based in a locality (purchasing) team. Because services for people with learning disabilities often cover a geographical area

greater than one of the localities, contracts were often held at locality manager level or one level below (Care Manger Co-ordinator).

5.3 Factors influencing the development of the block contracts within the case study

a) The necessity for costings.

Because much of the 1990 Act was aiming to create internal as well as external "markets", it was important for each section of an operation to be costed. Without that, it would be impossible to put a price on a contract nor would the purchaser be able to compare costs or to know if a particular service was cost effective.

With this in mind Berkshire Social Services moved towards cost centre management in anticipation of devolved budgets and their accountability. Cost centre management was introduced in 1989 within social services as part of a wider exercise within the county. Efforts were made to quantify what each service "cost", whether it was a day centre or a community team (CTPLD). Although it was recognised that many cost centres were too small and this was rectified in September 1991, it was still difficult in 1994 to estimate the 'unit cost' for a service. Not only is it difficult to estimate the on-costs which the central organisation provides (both the county council and the social services) but also the accounting procedures do not allow staff to assign costs to people with different needs. For example, the cost of care for a person with learning disabilities attending a day centre and spending most of their time out of the centre at adult education and/or work experience is likely to be different from the cost for a person in the main centre whose activities are always in the company of staff. It will be different again from a person in the special needs unit where the staff ratio is 1:3 as opposed to 1:10 in the main centre. Unit costs did not reflect this variety, or if they did it was at a crude level - e.g. giving the unit costs of the main centre and the special needs unit.

b) Others reasons for the emergence of block contracts

The block contracts for residential care for people with learning disabilities commenced in early 1992 and continued until March 1993. There were a number of reasons, some unique to Berkshire, which encouraged the move to block contracts for residential care for people with learning disabilities.

1) The department wished to move some residents from one sort of provision to another. In one instance it was because there were concerns about the quality of

care in a high cost private provider. In the other, a social services hostel was to be re-provided into smaller units.

2) No provider would come into the market unless there was guaranteed revenue for some years to come. Voluntary organisations who relied on capital raised charitably or housing associations who raised capital through the Housing Corporation always needed revenue guarantees to match the capital. Changes in Housing Corporation rules encouraged (and expected) some of the capital to be raised privately. Housing associations and private providers would be approaching banks and financial institutions for capital loans for capital to buy property and establish homes. They needed the security of revenue in a contract.

3) The inspectors, who had been at "arm's length" since 1991, were reporting that existing local authority accommodation did not meet registration standards under the Registered Homes Act 1984. The solution would be either to carry out extensive re-furbishment and reduce the bed numbers or remove the residents to alternative, smaller and more appropriate homes.

4) The department wanted a mechanism for controlling prices - especially the fees of residential homes which had increased over the rate of inflation for many years.

5) The general thrust of government policy was for local authorities to move away from direct provision to "enabling". Central government was also committed to developing the independent sector (i.e. private, charitable and not-for-profit organisations).

6) Berkshire County Council promoted the externalising of services. See reference to the Highways and Planning Department in Chapter 2, section 2.4.

7) As more of the provision was moving away from "in-house" there was a need to have mechanisms for setting and monitoring standards of care over and above the minimum standard set and monitored by the inspectors under the Residential Homes Act 1984.

There were 4 major factors which influenced the way the 15 block contracts of the case study were developed and therefore written. Each of these factors is discussed in greater detail below after looking at the types of contract and types of provider.

Major factors

1. The desire to "contract out" the service in a Part III hostel
2. The re-provisioning of a Part III hostel into smaller units
3. The need to move a substantial number of residents from a particular provider

4. The re-shaping of some existing local authority services into those run by the independent sector

5.4 Types of contract and of provider in the case study

Each of 15 residential homes has a separate block contract and although the contracts had many similarities, there were 3 main types of contract which are distinguished by the employment position of the residential care staff.

Type 1 The care provider was the registered proprietor under the 1994 Registered Homes Act and employed the staff direct. The proprietor signed the purchasing agreement. There were 4 homes in this group.

Type 2 The care provider (proprietor) did not employ the staff directly but had a separate care contract with the provider (sub-contractor) who supplied the staff. In this case it was the providing stream of BSS. There was a cash transaction associated with the care contract and money changed hands. There were 9 homes in this group.

Type 3 The care provider (proprietor) did not employ the staff directly but had a separate care contract with the provider (sub-contractor) who supplied the staff in kind. In this case it was the providing stream of BSS. No money changes hands in relation to the care contract. There were 2 homes in this category.

Two care providers were involved with the Type 2 and Type 3 contracts but only one provider was the sub-contractor. As far as they were concerned the same management accountability rested with the sub-contractor irrespective of whether the staff were supplied in kind or for a money transaction. There were therefore 2 types of provider.

Provider A employed their own staff

Provider B staff were provided under contract (for a price or in kind) from the providing stream of BSS

In the author's study the 4 contracts in the Type A category are different providers. They were therefore known as Provider A1, A2, A3 and A4. The 2 providers in the Type 2 and Type 3 contracts are referred to as Provider B1 and B2.

5.5 "Contracting out" the service in a Part III hostel.

The first contract was the "contracting out" of one of the LA run hostels, Warley Green and was signed in March 1992 and is a Type 3 contract.

The property was a social services hostel built in the mid 1970s and known to be below the registration standards of the Registered Homes Act 1984. Part of the rationale behind the agreement was the hope that the consortium and housing association would have access to funds for upgrading not open to a statutory authority.

The master agreement among BCC, the housing association (Silver Housing Association) and the consortium enabled the property to be leased by Silver, managed by Loddon Consortium and they in turn would have a care contract with BSS who would provide the staff "in kind".

The Social Services Committee needed to consider the proposals for the changes at Warley Green. This was done on 2 March 1990 and 25 July 1991 and at the latter meeting entry into the agreement was authorised.

At the time of transfer to Silver Housing Association, the hostel was registered for 24 beds (23 single rooms and 1 double). There were also two 3 bed-roomed houses on the site which had been staff houses. The first visit by the inspectors in September 1992 (an unannounced visit) stated clearly that care practices would need to improve and the buildings would have to be adapted so that the numbers in the main hostel were reduced to sixteen.

By the end of March 1993 the 2 three bedroomed houses were occupied by people with learning disabilities and a further 4 residents had moved to another registered home managed by the consortium. This reduced the number of beds in the main hostel to sixteen (15 long stay and 1 respite bed), though there were a number of vacancies

5.6 Re-provisioning a Part III hostel

These four block contracts arose from the re-provisioning of a social services Part III hostel (Part III of the 1948 National Assistance Act) in the west of the county. All were Type 2 contracts. Consultation on the proposals was done at the local voluntary sector in the winter of 1989/90 but had not become a reality until October 1992.

The hostel re-provisioning resulted in four new contracts (Hawker Lodge, Sheridan Way, Rose Cottage and Main Road). Two of the properties (Rose Cottage and Main

Road) were not available until six months after the signing of the contract. As the hostel was to close in March 1993 the 12 residents were housed temporarily in four adjoining terrace houses which came under the 1991 small homes amendment part of the 1984 Registered Homes Act.

The re-provision scheme enabled the Abell Housing Association to buy the hostel for £1 and the local district council to use it for homeless families. This housing association was already working with Loddon Consortium to build a 6 bedroomed bungalow for people with physical and learning disabilities using Housing Corporation money (Hawker Lodge).

Abell Housing also had access to land and capital through their relationship with the local district council to build two further 6 bedroomed houses in the area (Rose Cottage and Main Road). A fourth house (Sheridan Way) was to be converted from 2 council houses in Thatcham which in the past had been a children's home but had been empty for some time. The housing association would take on a lease from the district council and Loddon Consortium would manage the property.

Loddon Consortium in turn would have a care contract with BSS for all four homes so existing BSS hostel staff would be re-deployed. Any extra or new staff would be employed by BSS and become part of the care contract. Apart from the desire of BSS to remain a "good" employer to existing staff, there was also the need to satisfy the District Auditor (see next chapter) in relation to the nature of the care contract in the Type 3 contracts. There was always the expectation that eventually the care contract would not continue as the staff would transfer their employment under TUPE to Provider B1 and Provider B2. This did happen in 1996.

Such a radical shift in council provision would need the agreement of the social services committee. It would need to be justified on the grounds of cost, balancing the cost of upgrading the existing hostel and the inevitable loss of four bed spaces against the new capital and revenue costs. The paper that was presented to the committee in November 1992 indicated that it would cost an extra £120,000 per annum in revenue. This was the cost of funding four "agency" placements which would be necessary to accommodate the 4 people who would be not be accommodated if the hostel was upgraded. The deadline for the move was 31 March 1993 so that the residents from the Part III homes would achieve "preserved status" with the DSS. The 1990 Act meant that new admissions to residential homes on or after 1 April 1993 would not be able to claim the previous level of DSS income support - see Chapter 1 (section 1.5).

5.7 Move of residents from one provider to another

In March 1992 a local independent provider increased its fees for residential care for people with learning disabilities by 30% setting them at more than £1,000 per week per resident (net of DSS benefits). BSS (purchasers) decided to reassess the needs of all the 21 children and adults placed with this provider with a view to moving them to alternative provision. In all, 18 people were moved over a period of 12 months, the majority to three new homes commissioned by the social services department with the needs of those particular individuals in mind. These three providers - 1 voluntary, 1 sole trader and 1 private company - entered into 5 year purchasing contracts with BSS to provide inclusive residential and day care for a fixed number of people at an agreed price. These Type 1 contracts were the second set of block purchasing contracts that BSS entered into where the provider employed the staff directly. The contracts were negotiated by the two Assistant Directors (Purchasing) - East and West. These are the contracts of Mendip Way, Allenby and Pencolm and were the same apart from the contract price, the name of the provider and the names of the first residents.

5.8 Re-shaping existing services

Within the county it was decided to develop and re-shape existing provision and this resulted in six new contracts. One was a Type 1 contract (the provider employed the staff) and 5 were Type 2 contracts (staff employed by BSS under a care contract and in one of these the staff were supplied in kind - Type 3). A brief description of these contracts follows:

a) The Valley House agreement was signed on 29 June 1992 where 2 houses were upgraded to become a registered residential home for 7 people. This was the first Type 1 contract to be signed though it was over 8 months before the residents moved into the new home. The agreement was negotiated primarily by a group manager from the providing stream who was responsible for the residents in one of the houses at the time the negotiation started (1989). There was minimal input from the purchasing stream. One of the houses had been used as an unstaffed group home and the other was empty. In the more distant past both had been houses for staff working at the nearby Part III (local authority) hostel for people with learning disabilities. This was the hostel that was being re-provided in the above section 5.5.

The main difference between this contract and the other Type 1 contracts was that it was a three way agreement. BCC contracted with a housing association (Golden Housing Association) which was entitled to sub-contract the care and management of the

property to its managing agent (a national voluntary agent - Care Unlimited). The third party was the housing association which was the owner of one of the properties. The three way contract is titled an "agreement to provide revenue funding for premises at Valley House, ...". One of the houses was owned by Ford Housing Association - one of the signatories of the agreement. This association arose from the local district council housing department and they leased their property to Golden Housing Association. The other house was owned by Berkshire County Council and leased to Golden Housing Association. Because one of the properties was owned by the county it was necessary to obtain Secretary of State's approval to enter into this lease with Golden Housing Association. This was granted on 17 and 21 February 1992. Berkshire Social Services Committee had already ratified entry into these agreements on 16 October 1991. The residents finally moved in to their new home in February 1993. The long lead-in time no doubt was a reflection of the complexity of the contractual relationships that needed to be clarified amongst the parties.

b) The Blossom Cottage contract (a Type 3 contract) was signed in March 1992 and was on similar lines to the Warley Green contract described earlier. Berkshire County Council owned the property and leased it to Abell Housing Association who had a management agreement with Thames Consortium (a Provider B type). The home was registered for 5 people and was situated in a quiet residential area. All the residents attended the local SS day centre.

c) The other 4 contracts to re-shape existing services are all Type 2 contracts. There is a care contract between BSS and the care provider and all were signed in March 1993.

- Langley House. A house was offered by the local district housing department to Golden housing association and accommodated 5 residents from the local Part III hostel in the east of the county which was in the process of being re-provided. This re-provision has been over a longer period than the one described earlier as it was not expected to be fully completed by the 31 March 1993 deadline. This hostel finally closed in 1996.
- Brookside. This home was registered to accommodate 8 people of varying levels of dependency but a vacancy was retained for many months. Some of the residents were living there before the contract commenced and some new people were moved in.
- 1 and 2 Green Close. These 2 homes (each for 4 residents) were originally staff houses on the site of the BSS respite hostel for children with learning

disabilities. One had been a long standing group home and remained unregistered despite the contract stating the contrary. The other house had more dependent residents and both homes shared the staff cover. For the group home there was also the provision of home care time from the locality team paid for by the residents' benefit.

- 3 Green Road. This was the upstairs portion of the children's respite hostel and adaptations were made to register it separately for adults and ensure it was physically self-contained. It was registered for 5 people and carried a vacancy for some months after the start of the contract.

5.9 Analysis of the content of the contracts

Initially, the author felt that analysing the detail of the written content of the contracts was important and would help to meet the first aim of the study (to establish a method of monitoring). By knowing what the providers were contracted to perform would enable her to measure whether what they were doing was what was expected.

Each type of contract was slightly different though the main elements were there - a care specification and terms and conditions of contract.

a) Simplest contract

The most straightforward contracts were the Type 1 contracts which related to the movement of residents from one provider to another (A1, A2 and A3) and were all agreed between October 1992 and February 1993. They consisted of 2 parts - a care specification and a set of terms and conditions. Both parts were incorporated into the placement agreement. The care provider was the proprietor, owned the properties and employed the staff so there was no sub-contracting within the agreement.

b) Variation of the simplest contract

This was the contract A4 (Valley House) described earlier in section 5.8 (a). The reason for the contract being with BCC and the 2 housing associations rather than directly with the care provider and registered proprietor was to accommodate the wishes of the housing association which owned one of the property. The differences compared to other types in the contractual arrangements did not cause problems during the early part of the study but did later. The problems were in relation to new admissions of residents and the responsibility for housing management by the sub-agent who was the registered proprietor. This is by far the longest contract as there are several appendices and schedules relating to the improvement of the buildings, the leases as well as the care specification and terms and conditions of contract.

c) Contracts with care contracts

The next group spanned a longer period, March 1992 to March 1993 and in all cases the provider exercised its option to sub-contract the care provided by residential staff to another provider (Type 2 and Type 3 contracts). They therefore did not employ the staff directly. However, the care contracts were different for the 2 types of contract as in one (Type 2) the care contract involved a money transaction and in the other (Type 3) the staff were supplied in kind.

5.10 Differences in the care contract for staffing

These are shown in tabular form overleaf.

The differences are mainly in the clauses relating to funding which show that the Sheridan Way care contract there is money involved (clause 4.6 specifying cost, 4.7 review of prices, 4.8 issue of invoices) In the Warley Green care contract (Type 2) the discussion of funding (Clause 5.1) is non-specific and in practice relates to non-staff costs.

When the Type 2 contracts (Warley Green and Blossom Cottage) were signed there was concern by the District Auditor that the local authority was not really contracting out its services despite the lengthy contracts i.e. there was a risk it was *ultra vires*. The residents who lived at the old Part III hostel (Warley Green) at the time of its transfer in March 1992 were not entitled to receive in DSS benefits more than their existing Part III rate. Those admitted between March 1992 and April 1993 when the rules changed were entitled to the full DSS income support for a registered home in the independent sector.

Legal advice was conflicting about the *ultra vires* issue. It was hoped that by having a money transfer between the providing arm of BSS and the consortia (Provider B1 and B2) and emphasising the intention to eventually transfer the staff to the new provider, this would satisfy the District Auditor.

The placement agreement was between BCC and the relevant consortium and the price of the contract enabled the provider to met the staff costs liable in the care contract and the other non-staff care costs which included rent or lease costs. There was uncertainly about whether the consortia would be liable to Value Added Tax (VAT) on the care contract. The cost of the placement contract between consortia and BCC took this into account. The care contract had a clause about VAT should this not be payable by the

consortium. In time Customs and Excise decided that VAT was not payable and this sum was re-paid to BSS.

Table 5.1 Differences between the care contracts of Sheridan Way, Newbury (Type 2) and Warley Green (Type 3 contract)

Sheridan Way (care contract for a price) March 1993	Warley Green (care contract - supplied in kind). March 1992
1. Definitions	
Recognition of purchaser/provider split	No reference to placement contract
2. Notices	
To be served to Senior. Asst. Director (Providing)	To be served to Director of Social Services
	3. Alteration to contract
No reference to alterations	indicated how could be altered
3. Licences	**4. Licences**
3.1. Legal status of resident is licensee 3.2 Consortium responsible for admission & removal 3.3 Consortium to consult contractor about admissions	Only reference to resident as licensee
4. Funding	**5. Funding**
Contractor to employ agreed establishment of staff in Schedule 1 4.6. Specify cost of contract 4.7. Review of prices 4.8. Issue of invoices	5.1. Reference to existing as well as new residents. Contractor to employ agreed number of staff (annex A). Gives means of how contractor recovers cost of staff (in effect in kind) and who is responsible for different parts of the budget. No reference to price
Other clauses similar apart from numbering. Check Clause 10 & 16	

The later care contracts were for a longer period (5 years compared to 3 years) and were specific about how the consortium could complain about the performance of one of the contractor's staff and what the contractor was expected to do (clause 10.5 and 10.10).

Although the contractor in both arrangements could sub-let the care contract, they had the option to assign the care contract (with permission) only in the later contract. This forms an extra clause in Type 2 contracts.

When staff left posts which were part of the care contracts with the consortium, there was a difference between who employed the replacement staff depending on whether the contract was with Provider B1 or Provider B2. These differences (which were reflected in the overall contractual arrangements) were primarily due to the view of the group manager within BSS (providing) about "contracting out" services and the purchaser/ provider split. In the east, the manager was content to allow Provider B2 to employ replacement staff in the 6 contracts and they were then seconded back to the BSS (providing stream). In the west (with 5 contracts), the group manager resisted this and all new staff were employed by BSS even though it was known that eventually all the staff would be transferred to Provider B1. This policy continued until the point of transfer in 1996. At that time 90+ staff transferred to Provider B1 and only 19 needed to be transferred to Provider B2.

Effect of these differences on the monitoring process

Although there were differences in the care contracts, this had little effect on the author's practice. Most of the contact was between the author and the front-line staff (i.e. the home manager and keyworkers). Whether the staff were employed direct, supplied in kind or were part of a care contract for money made no difference in the development of the monitoring process. The author made some effort to contact middle and higher management within Provider B1 and B2 but this was mainly in an attempt to ascertain how they monitored their care contract so as not to duplicate the author's monitoring of the main contract. As will be seen in the subsequent chapters the two Provider B proprietors varied in the importance they placed in working collaboratively with the author.

5.11 Variations in care specifications

The main variations in the care specification are contained in Table 4.2 shown at the end of this section. There are 4 main variations of the care specification and the table shows how they differ clause by clause.

A. Type 3 contract. The provider has a sub-contract for staff but they are supplied in kind and no money changes hands. Signed March 1992.
B. Type 1 contract. The provider employs the staff. This was one of the early contracts (July 1992) but the home was not operational until February 1993.
C. Type 1 (variation). The provider still employs the staff but was more like a Type 2 (D) contract than the Type 1 (B above) contracts. Homes opened between October 1992 and February 1993.
D. Type 2 contract. The provider has a sub-contract for staff and "purchases" the staff for money. All signed in March 1993.

As the care contracts had evolved over time, so had the care specifications but the changes appeared to be greater. The first specification (March 1992) to be used (example A in the chart) formed schedule 6 of the Warley Green contract (a "contracted out" hostel). The second one (example B in the chart) was in July 1992 was Valley House (the upgrading of some old staff houses) and the specification formed Appendix 3 of the contract documentation. The final two sets of specifications (C and D) were very similar to each other and were the ones for the commissioning of the new services and the re-provision of a Part III hostel.

The differences reflect the following 2 factors

1. The 3 properties in the "commissioning new services" group (C in the Table 5.2) were all owned by the care provider i.e. the housing and the care provider were one and the same
2. In the final variation (D in Table 5.2) there was more emphasis on the wishes and rights of the residents. In clause 7.2 residents' rights not to be included in the weekly leisure activities is to be respected. There is also an extra clause (clause 15) where the joint responsibility of the keyworker and the care manager to promote advocacy is stated.

The author did not discuss with the staff who drafted the various contracts to discover why they evolved as they did. The most likely explanation is that the were modified in the light of experience. An example would be the establishment of a panel for monitoring in the Warley Green and Valley House contracts (see Chapter 6 for more details). When the author began monitoring and tried to find out about the existence of the panels, she was told that in the case of Warley Green they had not proved successful and so no longer met. In the case of Valley House it had never even been convened. Another factor could be the desire to shift power (albeit limited) into the hands of the service user (e.g. licence to occupy, respect of choice, specific mention of advocacy).

This would accurately reflect the ethos of the new community care reforms and also the growing awareness amongst people with learning disabilities of their rights which is encouraged by staff working with them, both purchasers and providers. The majority of the residents in the Type 2 and 3 contracts (11 out of the 15 in the study) do not have allocated care managers (purchasers) and this leaves a greater onus on the keyworker who is a provider and possibly greater conflict of interest issues than for a purchaser. Only those residents where the care provider and housing provider were the same (Provider A1, A2 and A3) had allocated care managers.

Table 5.2 How the care specifications varied

A. Type 3 contract - care contract, staff supplied in kind	**B. Variation of Type 1 - later than Type 1**	**C. Type 1 contract - Provider employs staff**	**D. Type 2 contract - Provider has care contract with another provider**
e.g. Warley Green (March 1992) Schedule 6	*e.g.. Valley House (June 1992)* Appendix 3	*e.g. Pencolm (January 1993)* Schedule 2	*e.g. Sheridan Way (March 1993)* Schedule 2
1. Principles	**1. Principles**	**1. Principles**	**1. Principles**
	1.1 Gives aim of home		
1.1 Normalisation and 5 accomplishments	1.2 Normalisation and 5 accomplishments	1.1 Normalisation and 5 accomplishments	1.1 Normalisation and 5 accomplishments
A. Type 3 contract - care contract, staff supplied in kind	**B. Variation of Type 1 - later than Type 1**	**C. Type 1 contract - Provider employs staff**	**D. Type 2 contract - Provider has care contract with another provider**
2. Accommodation	**2. Accommodation**	**2. Accommodation**	**2. Accommodation**
2.5 Internal decoration by provider on 5 year rolling programme	2.5 Internal decoration by Association on 4 year rolling programme	2.6 Decorate inside and out to reasonable standard of appearance	2.5 Internal decoration by provider on 5 year rolling programme
3. Staffing	**3. Staffing**	**3. Staffing**	**3. Staffing**
2.9 Repairs within 2 days	2.9 Repairs within 2 days	2.10 Repairs within 2 days	2.9 Repairs within 3 days
3.1. Ensure safety, health and support of residents in accordance with principles in section 1. Staffing set in annex A.	3.1. Ensure safety, health and support of residents in accordance with principles in section 1. Staffing levels set in Annex A.	3.1. Ensure safety, health and support of residents in accordance with principles in section 1	3.1. Ensure safety, health and support of residents in accordance with principles in section 1. Staffing levels set in Annex 2
3.3 Role of keyworker list types of health needs	3.3 Role of keyworker list types of health needs	3.3 Role of keyworker. Health needs includes reference to Professional Support to Medicine Act 1960	3.3 Role of keyworker. Health needs includes reference to Professional Support to Medicine Act 1960

A. Type 3 contract - care contract, staff supplied in kind	B. Variation of Type 1 - later than Type 1	C. Type 1 contract - Provider employs staff	D. Type 2 contract - Provider has care contract with another provider
4. Finance	**4. Finance**	**4. Finance**	**4. Finance**
4.1. Resident to pay "licence fee" for accommodation and access to health care + transport to day care	4.1. Resident to pay "licence fee" for accommodation and access to health care	no reference to licence fee	4.1. Resident to pay "licence fee" for accommodation and access to health care
4.3 Inform resident of insurance policies and encourage if not cover own possessions	4.3 Inform resident of insurance policies and encourage if not cover own possessions	4.2. Care provider to insure property and structure. Encourage residents to take out insurance for own possessions	4.3 Inform resident of insurance policies and encourage if not cover own possessions
5. Placements	**5. Placements**		**5. Placements**
5.1 If have hospital treatment, keep bed open for 8 weeks & discuss with others before declare vacant. Reference to panel	5.1 If have hospital treatment, keep bed open for 8 weeks & discuss with others before declare vacant. Reference to panel	No reference in specification - all in schedule 3	5.1 If have hospital treatment, keep bed open for 8 weeks & discuss with others before declare vacant. NO reference to panel
5.2. Reasons to terminate licence. Reference to panel	5.2. Reasons to terminate licence. Reference to panel		5.2. Reasons to terminate licence. Reference to panel
no admission procedure but covered in schedule 5	no admission procedure but covered in Appendix 1		5.3. Admission procedure
6. Care Planning	**6. Care Planning**	**5. Care Planning**	**6. Care Planning**
6.4 IPP or review - other people as appropriate	6.4 IPP or review - other people as appropriate.	5.4 IPP or review - other people as appropriate	6.4 IPP or review - other people as appropriate including care manager
7. Leisure, social and religious activities	**7. Leisure, social and religious activities**	**6. Leisure, social and religious activities**	**7. Leisure, social and religious activities**
7.2 Consult residents about weekly joint activities	7.2 Consult residents about weekly joint activities	6.2 Consult residents about weekly joint activities	7.2 Consult residents about weekly joint activities. Residents' rights respected if decline or refuse
8. Use of community services	**8. Use of community services**	**7. Use of community services**	**8. Use of community services**
9. Food and clothing	**9. Food and clothing**	**8. Food and clothing**	**9. Food and clothing**
10. Privacy	**10. Privacy**	**9. Privacy**	**10. Privacy**
11. Policies	**11. Policies**	**10. Policies**	**11. Policies**

A. Type 3 contract - care contract, staff supplied in kind	B. Variation of Type 1 - later than Type 1	C. Type 1 contract - Provider employs staff	D. Type 2 contract - Provider has care contract with another provider
12. Record keeping	**12. Record keeping**	**11. Record keeping**	**12. Record keeping**
13. Health and safety	**13. Health and safety**	**12. Health and safety**	**13. Health and safety**
13.7 Follow and use council procedure in administration of drugs - copy in Appendix B	13.7 Follow and use council procedure in administration of drugs - copy in Appendix C.	12.7 Follow and use council procedure in administration of drugs but not included in specification	13.7 Follow and use council procedure in administration of drugs - copy in Appendix B
14. Monitoring	**14. Monitoring**	**13. Monitoring**	**14. Monitoring**
14.3 Consult residents but not include limitations of residents	14.3 Consult residents but not include limitations of residents	13.3 Consult residents but not include limitations of residents	14.3 When consulting residents, staff to facilitate - recognising limitation of some residents
14.5 Consult families of respite users every 2 years	No reference to respite users	No reference to respite users	14.5 Consult families of respite users every 2 years
14.6 Access to property by appropriate person proposed by panel. They or care manager can ask for comments from resident or relative	14.6 Access to property by appropriate person proposed by panel. They or care manager can ask for comments from resident or relative		14.6 Access to property by appropriate person proposed by Council. They or care manager can ask for comments from resident or relative
14.8 Association monitors provision & reports results to panel every year. Use methods proposed by panel.	14.8 Association monitors provision & reports results to panel every year. Use methods proposed by panel.	no reference to care provider monitoring	14.8 Care provider monitors provision & reports results to Council every year. Use methods in placement contract (clause 7).
	Incorporates specification of property in Annex B		Incorporates specification of property in Annex A & can add other properties
			15. Advocacy
no reference to advocacy	no reference to advocacy	no reference to advocacy	15. Advocacy to be promoted - joint responsibility of keyworker and care manager

Effect of variations in care specifications on the monitoring process

At the time of the analysis of the content of the care specification, it appeared to the author that these differences might affect the delivery of the care by the provider. As

will be seen in later chapters this was not the case - partly because providers did not rely heavily on the Berkshire care specification for their practice and management within the home. With the exception of one home (Provider A1) which was a sole proprietor, all the homes were part of wider organisations. It is accepted that all these organisations worked to the principles and values which are enshrined in the care specification. This is shown by their various brochures and booklets. However, the policies and procedures of these wider organisations were likely to over-ride any variations in the care specifications described above e.g. whether advocacy is promoted and by whom.

The main value of the analysis of the contents of the various care specifications was in relation to operationalising it when developing the monitoring method. This is described more fully in Chapter 7.

Chapter 6.

Contract monitoring and service evaluation

Earlier chapters have described the development of social care contracting in England and Wales, and how the block contracts which are part of this study emerged from the specific conditions in Berkshire prior to the start of the case study.

This chapter looks more closely at monitoring and reviewing contracts and also examines in detail how these concepts were expressed in the Berkshire block contracts. It also describes how the monitoring method was developed following the content analysis. References from the relevant literature will be interspersed with explanation and description of the situation pertaining to Berkshire.

6.1 Introduction

Chapter 1 outlined the changes in community care which have led to a greater reliance on independent sector providers, the search for value for money and the need to involve consumers and service users. As an "enabler" the local authority social services department would become further removed from the management and direct provision of services and would need to develop mechanisms for finding out what was happening within a services for which it would have no direct control or knowledge.

6.2. Definitions

Table 6.1 at the end of this chapter shows various definitions that commentators and researchers have used to describe monitoring, review, quality control, quality assurance and evaluation. The earlier literature (Grant, 1978 and Windle and Sharfstein, 1978) appears to confuse monitoring with review and evaluation whereas later writers are much clearer. The author found the following definitions helpful and the ones that most clearly described the work carried out during the research study.

Monitoring (Connor 1993)

> Regular checking of progress against a plan through the routine systematic collection of information. It is essentially value free.

Review (Adirondack and Macfarlane 1990)

> Looking back at activity and putting monitoring data into a usable form

Evaluation (Adirondack and Macfarlane 1990)

> An assessment of whether the organisation met the objectives, was the work worth doing, did it meet the criteria for acceptable quality.

As Connor (1993b) says evaluation makes an assessment or comparison and assigns a value or merit to it.

6.3 The purpose of monitoring

Generally the purpose of monitoring is an attempt to:

- match the service provided to the specification
- check that the quality and quantity is sufficient
- meet perceived needs
- check value for money especially as purchasers are expected to meet assessed needs "within available resources" (NCVO, 1989)

Monitoring is a means to an end and not an end in itself. It needs to serve the same end goal or policy objective e.g. avoiding an over or under-spend or ensuring there is a variety of providers supplying a value for money service to meet the assessed needs of individuals.

It can serve different purposes some of which are determined by the person/organisation who is carrying out the monitoring. A voluntary organisation providing a service would view the need for monitoring and evaluation to satisfy their desire to

1) provide the best service to users and
2) demonstrate the achievements of their service (Connor 1993b)

For the purchaser it is a means to secure contract compliance and to use the information to take corrective action if the service is not to standard. The government lays stress on the value of monitoring and review in their community care reforms. Both are mentioned as part of cycles of action (e.g. care management -Department of Health, 1991a - and joint commissioning - Department of Health, 1995b)

Local authority social services departments since the 1948 National Assistance Act have been in the position of carrying out the tasks of the "purchaser" when they made agency placements. They assessed its suitability for a particular client, reviewed the placement usually annually and changed the placement if, for any reason, it was not felt to be suitable for the individual. Agency placements (which could not be used for elderly people) were a small part of the social services budget and any monitoring or review was done by the individual social worker on a rather ad hoc basis. In that sense they were evaluating the service quality in the particular home.

The provider of service has always had "front-line" responsibility for the quality and standards of care they provide (e.g. to the inspector under the Registered Homes Act 1984, to its management committee or shareholders). The new community care reforms have given a new dynamic to the process of accountability. Many of the informal relationships are now part of formal procedures. There is a new accountability to purchasers to secure minimum quality standards (which are set out in the contract) and value for money. In addition the purchaser is acting on behalf of the service user or consumer and is attempting to be accountable to them. The variety of service which is being purchased is now much greater than the agency placements prior to 1993. These include residential and nursing homes for elderly people, domiciliary and day care for many groups living at home. With the exception of nursing home care, all these were provided and accessed by the LA within their in-house provision prior to the 1990 Act. The quality was known and subsequently the SSD was able to compare other providers against the yardstick of their own provision.

In relation to people with learning disabilities Perry and Felce (1995) stress the importance of monitoring as a result of the fragmentation and diversification of the provider base. This author feels that it can only be used effectively as a tool to meet end goals if purchaser and provider work collaboratively.

Much of the recent literature reviewed in this study lays stress on the "quality" of the service and the need to "monitor" such quality. McGowan (1996) when looking at services for people with learning disabilities discharged from long-stay hospital favoured making the distinction between quality of care and quality of life according to O'Brien's 5 accomplishments.

6.4 Economy, efficiency and effectiveness

In the 1960s much of the emphasis in evaluating and justifying the use of public money was in purely economic terms - the application of cost/benefit analysis. It assumed that it was possible to assign a monetary value to tangible (and intangible) costs and benefits. Since then there had been concern that the concept of "cost/benefit" had limited value. One of the important forces behind the move towards a mixed economy of care was the emphasis on the 3 Es - economy, efficiency and effectiveness. (Cave 1990).

Percy-Smith and Sanderson (1992) describe **economy** as the cost of acquiring resources; **efficiency** as the relationship between resources and outputs; and **effectiveness** as the achievement of a defined purpose at minimum overall cost in

resources. They also describe effectiveness as being "about ensuring maximum 'added value' where value is defined in terms of the purpose of the organisation". The Local Government Training Board (LGTB, 1987) used similar definitions. Economy was obtaining resources of the needed quality at the lowest cost, efficiency was getting the maximum service output for a given input and effectiveness was making sure the biggest impact was achieved for given inputs and outputs. However, it is possible to be efficient but not effective (by pursuing unwanted objectives at least cost) so it is of paramount importance to specify and agree the objectives by which effectiveness is to be assessed. (Wright, Haycox and Leedham 1994). Flynn (1990) points out that equity or targeting of services is more important in the public than the private sector as the latter can write off sections of the market that may be unprofitable. He feels there should be fourth "E" - equity.

6.5 Inputs, process, outputs and outcomes.

Inputs, process and outputs are often terms used in service specifications which bear a relationship to economy, efficiency and effectiveness. Walsh (1994b) describes inputs as the labour, capital and materials needed to carry out the service, process as the method by which the work is carried out and output as the actual product that is produced. In all three elements it is possible to focus on both quantitative and qualitative aspects. The Department of Health/Social Services Inspectorate guidance document "Purchase of Service" (DOH, 1991d) gave the following definitions:

inputs - expectation of the resources required to provide the service

process - details of the tasks to be done and the way in which the task should be completed

outputs - measurable units of service delivered to service users

In relation to residential care for people with learning disabilities examples would be as follows

Inputs - the number of staff, their qualifications and experience; the size of the home; the quality and quantity of the fixtures and fittings; the policies and procedures in place.

Process - could cover aspects such as how staff are utilised during their working hours; the quantity and quality of the interactions between staff and residents; how service users are involved e.g. in care planning and residents' meetings

Outputs - are often difficult to specify precisely in social care but would include the number of people living in the home and the vacancy rate; the number of residents meetings; the number of residents' activities carried out by the residents outside the home; the number of new skills learnt; how residents felt about the

service they received; the number of accidents sustained and other health and safety measures; the mental alertness of the residents.

To fully assess effectiveness, it would be necessary to look at outcomes - i.e. whether the clients gained in dignity, choice, comfort, security or other benefits from the use of the service (Walsh, 1994 b, d and e). A slightly different slant in that it looks at the contribution of the service rather than the effect on the individual is in the purchase of service document (DOH, 1991d). Here outcomes are defined as the contribution the service makes to the users' well-being.

In the context of people with learning disabilities outcomes in residential care would cover:

Outcomes - Measuring outcomes would mean looking to see how far the service provided to the resident measured up to the philosophy of the service and the overall aims and objectives of the home. e.g. how many friendships or relationships were established with non- handicapped people, how many activities were in non-segregated settings, to what extent were the new skills learnt promoting independence, to what extent were residents treated with dignity and respect and whether their views were listened to and acted upon.

Wright, Haycox and Leedham (1994) define 3 types of outcome.

1. **Final outcomes** (user outcomes) which reflect the ultimate goals of welfare provision and this reflect user welfare. They are outcomes valued in their own right and are more in line with Walsh (1994d and e) and DOH (1991d)
2. **Intermediate outcomes** (service or organisational outcomes) which are closely related to services, being the actual services received, throughput, quality and standards of care. They tend to measure the quality of the inputs or the process (e.g. proportion of qualified staff, suitability of the buildings, staff attitudes to users, user/carer satisfaction with respite care facilities)
3. **External outcomes** - externalities which include external benefits (which one can enjoy free or at a low price) and external costs (which one suffers without adequate compensation). These would be the costs and benefits to carers and society at large. e.g. adequate respite care and day care could ensure that people with learning disabilities remain longer with their families with less stress on the carer, people in society feel happier if people with a handicap are well looked after.

However, all four may focus on quality or quantity. Davis (1996) based the following matrix on the work of Steve Rogers at INLOGOV.

	Quality	**Quantity**
Inputs	staff skills	staff numbers
Outputs	effectiveness of care provided - doing things right	efficiency of service - doing the right thing
Process	relationship between carer and user	care activity
outcomes	enhancements of the dignity of user	% of users expressing satisfaction

Inputs and outputs are much more tangible and more likely to be measured by quantitative methods. Process and outcomes are less tangible and more likely to be measured by qualitative methods or those that rely on the judgement of the observer. Outcome measures e.g. client satisfaction may also give an indication about process.

6.6 Performance Indicators

One widely accepted method of monitoring is through the setting of performance indicators (PI) and checking the progress towards meeting these PIs. This gained greater currency during the 1980s and were central to the Thatcher Administration's strategy of reforming the management of government (Carter 1991). The apparent advantage of PIs were that they emphasised outputs rather than inputs.

In the 1980s PIs were couched in terms of the "3 E's" (economy, efficiency and effectiveness) which are described in section 6.4. Carter (1991) predicted that in the 1990s there would be "greater demand for indicators of consumer satisfaction and quality". The current Major Administration favours PIs in the form of citizen's charters whereby organisations (particularly statutory ones) would set and publish standards which a consumer could expect. This has been particularly prevalent in the NHS where the patient's charter and the statistics gathered to show the extent to which the charter is met, is used in NHS contract monitoring. It also determines the performance related pay of personnel and has led to the publishing of "league tables" of different NHS Trusts. Many PIs in the health service measure throughput and process rather than outcomes. The length of time someone waits between referral from a GP and being seen by a district nurse may bear little relationship to whether their medical condition improved or reflect the difficulty a community nurse may have to persuade a person

with learning disabilities who is frightened of needles to have an injection of insulin to treat their diabetes.

Some outcome measures are about the process of service delivery e.g. how well and often a resident is treated with dignity and respect in the course of interactions with staff. If trying to ensure a quality outcome and the "quality" is not something identifiable in its own right but is the by-product of activities being carried out, then the "quality" is the result of competence in the routine activities of the organisation. (Carter 1991).

Carter and his colleagues looked at 13 different government departments, public agencies and included a number of private businesses. They found that where PIs were effective in an organisation it depended on 3 factors - volume, timeliness and data design. In terms of volume, under 30 in number seemed the best and timeliness was important otherwise information was recorded too late so no action could be taken to rectify things. Lastly, they needed to be custom built and designed with specific objectives in mind as well as a clear vision about how they would be used.

6.7 Other ways of achieving service quality

In Berkshire and other social services departments performance indicators are gathered or collated by the provider and shared with the purchaser and could be considered a formal means of monitoring. Examples could be management information such as staff turnover, staff sickness record, reviews of complaints/compliments received. Informal means (e.g. unstructured visits where discussion is encouraged) would also be considered an acceptable means of monitoring if done by trained staff.

Some service providers have developed internal quality assurance schemes and there has been a growth of schemes providing accreditation of services by some independent body or association of providers (Department of Health and Welsh Office, 1995). In Chapter 9 there is discussion about the use of internal quality assurance mechanisms. None of the homes in the block contracts which form part of this study were part of an external accreditation process. Berkshire SSD has run its own accredited provider scheme since early 1993 and only one of the providers of block contracts (Mendip Way) applied and was granted accredited provider status by BSS in 1993.

Connor's study (Connor 1993a) of 26 voluntary organisations in Scotland was mainly in the field of children's and families projects and day care centres for frail elderly

people. She identified 6 broad types of monitoring and evaluation work all of which were "in-house" or self-monitoring evaluation methods.

1) Establishing the scale and pattern of use made of the service
2) Identifying outcomes of the service for direct users, others such as carers or parents and other service providers.
3) Feedback from users through surveys, interviews and other methods
4) Feedback from staff and other agencies
5) Organisational issues such as how staff spent their time and feedback from volunteers
6) feasibility studies for potential new projects or the development of an existing service

McGowan (1996) described a process whereby health purchasers were involved in providing qualitative data on individual outcomes following the resettlement of long stay residents from hospital. Review groups (consisting of a health purchaser, a social service purchaser, a service user, a supporter of the user, a carer, a relative or a parent, a health provider representative and a provider of community residential services) were set up. Each group spent 5 days with service users to experience life from their point of view. She concluded that "working with providers and users to agree meaningful measures and implementing peer reviews would go some way towards starting to improve quality of life". Peer group reviews were built into the Kent Community Care Scheme (Challis 1984) and described in Renshaw (1987). The author has also seen peer group evaluation as part of the monitoring of services for people with learning disabilities in Oakland, California (personal visit in May 1994).

Although Whittaker et al (1991) looked at a method for one-off evaluation of services for people with learning disabilities by service users themselves, the lessons learnt from this process can be used in monitoring of services. The key elements for success in service user led evaluation are described in Whittaker (1994). They are

- Commitment from service managers (the original study was carried out before the community care reforms and in Berkshire this would imply both purchaser and provider management commitment)
- Commitment from grass roots staff
- Involvement of service users from the start
- Training of consultants (i.e. for service users doing the evaluation)
- Providing the right support
- Allowing plenty of preparation time

- Teamwork

When looking at people resettled from long stay hospital, McGowan (1996) who is a health purchaser stressed the importance of improving the co-ordination of "all involved in monitoring and inspection" and listed those involved - the Community Health Council (CHC), the social services inspection unit, the nursing home inspectors, health purchasers, care managers, advocates, relatives, providers and users. The list of those involved is very similar for care packages purchased solely by social services and one could argue that because many people with learning disabilities access both generic and specialist health services the CHC and health purchasers should also be involved in these circumstances.

6.8 The distinction between contract monitoring and inspection

The Registered Homes Act 1984 is a major piece of legislation which requires the registration and inspection of residential and nursing homes to protect residents and maintain standards by local statutory authorities.

A registered care home is ".. any establishment which provides or is intended to provide, whether for reward or not, residential accommodation with board and personal care for persons in need of personal care by reasons of old age, disablement, past or present dependence on alcohol or drugs, or past or present mental disorder" [S1(1) amended]. The Act also covers the registration and inspection of nursing homes, the latter having been covered by legislation since 1927. Nursing homes are registered and inspected by health authorities whilst residential homes are the responsibility of SSDs.

The 1990 Act required that inspection was to be at arms length within the social services department and also they were to inspect their in-house provision to the same criteria as private and voluntary providers. Local authority homes, however, do not fall within the scope of the 1984 Act (i.e. they do not have to be registered and the same sanctions cannot be applied through the legal process). Berkshire Social Services Committee have always wished their in-house provision to be comparable to that of independent providers.

Registration is a system to identify who is carrying on the activity and the applicant is entitled to registration unless shown to be unfit. It sets minimum standards which are expressed broadly but more specific in "guidance" (e.g. DOH, 1992a and BSS, 1994a). The 1984 Act and guidance concentrates on "inputs" as described earlier in this chapter

- section 6.5 - except for "the promotion of the welfare of the resident". This latter element is not operationalised in the regulations and relies on the interpretation of the individual inspector.

The contractual process is the legal agreement between the parties and can therefore state what quality standards are expected and concentrate on outcomes, outputs and processes and not just inputs.

The inspection unit of the SSD is a mechanism for monitoring the standard of care within a home and as such form part of the monitoring required by the Berkshire contract. The DOH policy guidance (Department of Health, 1990) suggested that inspection units could be a source of advice on contracted out services and contribute to the process established to check that these standards were achieved. However, the consultation paper LA(95)12 (DOH, 1995a) states that "contracting and inspection are 2 separate processes" and "inspectors should not normally be involved in contract monitoring in ways which may compromise their regulatory function". In Berkshire the inspection unit in the SSD treated very seriously their "arms length" position within the department and relationships between it and the purchasing stream were generally on a very formal level.

In Berkshire, the monitoring of block contracts by the author assumed that the inspection unit was there and tried not to cover ground they were already covering. Berkshire's guidance to providers states:-

> "Responsibility for ensuring service delivery of the right quality and for monitoring outcomes rests primarily with those providing the service, whether they provide it directly or purchase it". (BSS, 1992)

In the revised guidance to proprietors (BSS, 1994a) this aim of the inspection team was still maintained, though in this section there was further reference to the conduct of inspectors and the rights of proprietors and managers. It also gave more detail of the advisory committee.

6.9 The "quality mountain"

Anne Davis (Davis, 1996) has described how it is possible to control service quality through the contracting process to a much greater degree than the registration process. Contracting and registration have different legal processes but do have areas of communality. The person registered to run the home can make representation and

appeal against refusal, variation or cancellation through civil law (the Registered Homes Tribunal) where the burden of proof is the balance of probabilities. Where offences against the legislation are believed to have been committed, the prosecution uses the criminal law where the burden of proof is beyond all reasonable doubt. Disputes within the contracting process are always within the civil law.

Davis uses the analogy of a beach and a cliff to describe the relationship between quality standards, inspection and contracting. The principle of the beach at the bottom of the cliff shows that this is a "dangerous" area especially for vulnerable people. The registration standard would be a "safe minimum" and would rest at the high tide mark of the beach. Being below that would put the vulnerable person at risk. The top of the cliff represents high quality standards of care with a margin of error to ensure they remain some way above the legal minimum.

In addition to the beach and the cliff there is also a boulder which is being levered up the cliff to improve standards. Sometimes the boulder will be moved be external factors e.g. regulation/registration or contracting or sometimes it will roll itself e.g. once an internal quality assurance system is in place. The cliff face between the beach and the top is not a smooth slope. Some parts will have a steep assent to manoeuvre e.g. when introducing a QA or management system. Other parts will have bumps where the boulder rests when it is teetering. Both inspectors and contractors might give time to allow the provider to put things right - the inspector to make sure it met the registration standard, the contractor to ensure the default in the contract was rectified. Hopefully the contracting standard will be part the way up the cliff and above the registration standard. The contractor, by being more specific to general standards or a particular individual can "pull" the boulder up because of the incentive of the control of finance whereas the inspector is only able to "push" the boulder. The "service user" standard could be at different levels on the cliff but more likely towards the top of the cliff rather than the beach. What is important to them will depend on their previous experience. A long stay hospital resident recently discharged may value the quietness of a small residential home where nothing much happened, whereas someone moving from their parental home may favour a more active life style with more variety.

The block contracts which are part of this study were a reflection of the time they were written (see Chapter 5) and did not differentiate the different groups of residents they served. When the Type 2 contracts were re-negotiated in 1966 to reflect the TUPE transferred staff there were final differences in the contracts with Provider B1 and B2. For example the annual contract review clause was strengthened and the performance

indicators requested varied on the internal quality monitoring the different providers already had in place.

6.10 Monitoring styles

Much of the literature published in anticipation of the implementation of the 1990 Act (e.g. AMA 1991, NCVO 1989, Flynn & Common 1990, Steele, 1992, Gutch 1992a) made reference to the importance of monitoring and the relationships that have to develop in order to sustain monitoring. The Consumers Association (Steele, 1992) referred to the 3 parties in the contract - the proprietor (or provider), the funder (or purchaser) and the resident (or service user). One of the key recommendations by the Association of Metropolitan Authorities (AMA, 1991) is that "contract monitoring requires a multi-dimensional approach which involves purchasers, providers, service users and elected members". They also said that service users were essential in the monitoring of outcomes of service.

Some writers have made reference to the style of monitoring and what it was trying to achieve. Windle and Sharfstein (1978) quoted in Grant (1978) stated that the purpose of monitoring was to

1. ensure the agency or provider complies with the requirements of the sponsor or purchaser (compliance checking)
2. obtain information about the project for future support and design decisions (overall programme funding)
3. stimulate improvement within local projects (project stimulation)

One should bear in mind that this was a USA context where government had been contracting with the voluntary and private sector for some years. Many grants were for one year, though often renewed, and this "annualization" gives great emphasis to purpose 2 about future support. (See Gutch (1992a) in Chapter 4). Whatever its purpose, the monitoring of programmes represents organisational intervention and it is necessary to gain support from the provider for such intervention (Grant 1978).

Even in the 1970s (Windle and Sharfstein 1978), there was debate about whether the "monitor" should be a helper or the policeman. The Association of Metropolitan Authorities (AMA, 1990) favours the former by saying that service monitoring was not just a policing function but collaborative and enabling.

Windle and Sharfstein gave details about how the National Institute of Mental Health (NIMH) used three main approaches to monitor federally funded Community Mental

Health Centres (CMHCs). There was a comprehensive individual site review which was a mixture of compliance checking and technical support. The federal government dictated which services the CMHCs were required to provide and the NIMH developed a standardised monitoring package which included an annual off-site document review.

The second part was a biometric assessment which was a profile package of 140 indices with frequency distributions to allow comparisons with a given centre and all the centres in their state or the USA. Indices includes such items as proportions of professional and non-professional staff, weekly staff hours per 100 persons served, number of people from ethnic minorities served.

The third approach looked at repeat studies and how a project fared over time and whether they met required services e.g. 24 hour cover. Although the regional offices combined compliance enforcement with technical assistance the authors admitted that it was not clear how the two aspects interacted.

There were also useful pointers which indicate where monitoring had been unsuccessful. Barry (1978) in his study on monitoring state rehabilitation programs in the USA pointed out a number of dilemmas.

1) The need to be consistent about data collection - both in content and over time, especially if wanting to make comparisons from one site to another and to ensure it is measuring the activity it purports to describe. On the other hand over-rigidity did not help to reflect changing needs or circumstances.
2) Some reporting systems were too global or general e.g. levels of disability. People do not fit into neat categories nor are uni-dimensional (e.g. it does not take into account their environment, how easy it is to offer the service and the interaction between these variables). As complexity increases, it adds to the problems of reporting and ultimately monitoring.
3) Service providers varied in their willingness to co-operate with the reporting process especially if they felt it took them away from their "real" job (i.e. rehabilitation counselling) or they felt it was inspectorial or the rules for reporting kept changing.
4) The mechanics of reporting, both in collection and summarising, were enormous. Computer systems were in existence in some programs but errors in programming and input often meant a manual system was also kept (which was often more accurate and up to date).

5) Different parts of the state agency funding the program often requested different types of information. Some programs had more than one source of funding, each requiring different data. Gutch's (1992a) report indicated that this requirement had not improved over 15 years and some program providers estimated that up to one third of staff time was spent on preparing information for monitoring and evaluation.

The "All Wales Strategy" is an initiative started in 1981 by central and local government (Welsh Office, local authorities and health authorities) to improve the quality of services for people with learning disabilities throughout Wales. It included resettlement programmes for closing long stay hospitals and the introduction of community team (CTPLDs) in all areas of Wales. Blunden and Beyer (1987) indicated that even some years after the implementation of the All Wales Strategy, monitoring had some difficulties even when it was existing. They identified five problems of monitoring.

1. It was an information gathering exercise divorced from action on the ground
2. The criteria for collecting information had more to do with its availability (e.g. referrals to statutory authorities, time in therapy sessions, waiting lists data) than with client outcomes
3. The monitoring was often negative and bureaucratic and did not help front line staff to know what was good (or not good) in the service they provided
4. Services were blamed for service deficits (e.g. person not ready to move to the community) rather than looking at what supports the person would need to live in the community
5. It answered the question "how are we doing it" rather than "how effective (i.e. the impact on the lives of service users) are we".

The National Council of Voluntary Organisations (NCVO, 1989) felt that monitoring should be constructive evaluation and local authorities needed to develop systems which facilitate the monitoring of services. Having a policing role is counterproductive and the monitoring should aim to develop a collaborative and enabling process. Two way feedback between purchaser and provider allows support and guidance to be given to provider organisations if they need to address difficulties or develop services. It will also help to facilitate the relationship between identified client needs, development of the specification and monitoring of provider output.

Experience in the USA (Gutch 1992a) and this country (Walsh 1994d) indicated that the development of a trusting relationship between purchaser and provider is the only way

the contracting process is viable. Other observers of the USA situation (Gupta and Gatiss, 1993) conclude that there is a need for co-operation not competition. In the field of social care, many providers and some purchasers agreed that competition does not produce better services at lower cost.

Colin McKay (1991) suspected at a conference in May 1991 that local authorities would not have time to monitor contracts effectively even if they had written stringent quality standards into the specifications. He was also concerned that if there was poor service the local authority would find it difficult to identify an available better service. He felt that users would be better served if they had a genuine say in the negotiation of the contract (see also Gutch, 1992a and b) rather than being asked to sign something and being told it was for their own good.

6.11 Evaluation of service

As stated earlier in the section on definitions, evaluation includes making a judgement about an activity or comparing it against another

Barritt (1993), whilst recognising the need to monitor and evaluate, was not happy with any of the 6 ways of evaluation he described in his paper. They were

1) Simple description of things "as they are" and not related to any research methodology
2) Goal monitoring - measures which reflected the extent to which planned activities are carried out. Examples are PIs and his criticisms were similar to those of Carter (1991).
3) Causal analysis which tried to link cause with effect e.g. the welfare model which tries to analyse welfare in terms of inputs, processes and outputs.
4) Interpretative evaluation which looks at "how" rather the "why". It therefore concentrates on an in-depth understanding of interactive processes by such methods as interviews, focus groups, participant observation
5) Structural analysis which tries to explain things at the level of meta-theory (i.e. macro "grand theory" such as the production of welfare model) with a particular political, economic, social or environmental message.
6) Pluralistic evaluation which seeks to reflect the viewpoints of all stakeholder groups. Barritt feels that trying to fit the variety of viewpoints and notions of success within a policy making framework can be very difficult and could lead to paralysis or less sophisticated methods of evaluation.

Barritt's main critique of the contract culture was that it was imposed from the centre with an emphasis on externally set performance measurements. He felt that not all voluntary organisations could be reduced to "bureaucracy, technology and managerialism". There was a need to look at what was distinct and unique about each organisation and take into account the health of the organisation. Evaluation and monitoring needed to be part of the organisational culture so that it could develop its own potential.

The regulation imposed by the Registered Homes Act and the concern for the protection of vulnerable people could mean that Barritt's ideals would never be reached in the field of residential care for people with learning disabilities. The market also favours the more powerful organisations - and these tend to be those that are better informed, are larger and have short term marketable products e.g. residential homes for people with learning disabilities who have challenging behaviour. These are the people who are the most disruptive and where the pressure on the purchaser to find a quick solution is paramount.

There are some moves towards a more pluralistic evaluation where service users' views are accorded more value e.g. development of self advocacy groups, evaluation of services by people with learning disabilities (Whittaker et al 1991), Hope House in USA (Segull 1994), but generally the current state of contract monitoring has not progressed beyond the provider satisfying the purchaser that the standard has been achieved.

6.12 Summary

On the basis of the literature review and the experience of the case study, the author has concluded that for the contracting process to be of value in maintaining and improving quality standards and purchase an individualised service to each resident it is necessary for the contract to be monitored. This presupposes that the contract documentation is appropriate to the task required with an emphasis on outcomes and all stakeholders view monitoring as a priority. It is most effective if done collaboratively between the purchaser and the provider. More effort and work is needed by both purchaser and provider if the service user is to play a greater role in contract monitoring. These views are discussed further in the chapter 11 and 12.

Table 6.1 Variety of definitions for commonly used concepts and tasks in contracting

Source	Monitoring	Review	Evaluation	Quality control	Quality assurance
Dictionary. Chambers 1994	from monition - to notice; a reminding or admonishing,	a critical examination; a looking back, a retrospect	from evaluate - to determine or estimate the value of	the inspection, testing etc. of samples of a product .... to ensure maintenance of high standards	
Connor (1993)	regular checking of progress against a plan through routine systematic collection of information - essentially value free		Judging the merit of an activity or plan by measuring against specific criteria. Make an assessment or comparison		
Grant (1978)	adds time dimension, provides continuous means of evaluating effectiveness of programme and providing basis for improving them				
Woolf (1992)	Ongoing collection of information. Performance indicators one method of monitoring		relates judgements and assessment of quality. Often use information gathered through monitoring		Closely linked of outcomes. Way quality built into plans and provision of services, indicates required standards. PI, and evaluation form of QA
Association of Metropolitan Authorities (1990)	evaluate whether services provided actually meets community need within standard specified by the authority		judging value of something for a particular purpose. Making statement of something based on one's own well developed criteria or well understood criteria of another		

Table 6.1 (continued)

Source	Monitoring	Review	Evaluation	Quality control	Quality assurance
Flynn & Common (1990)	about how services delivered			process of monitoring standards by inspection, auditors or supervision	ensures concerns about quality are built into the way services delivered. Responsibility of local managers and workers
Adirondack and MacFarlane (1990)	process of collecting information which can be used to evaluate quality or performance	looking back at activity and putting monitoring data in usable form	assessment of whether organisation met objective, was work worth doing, did it meet the criteria for acceptable quality		
Association of Metropolitan Authorities (1990)	evaluate whether services provided actually meets community need within standard specified by the authority		judging value of something for a particular purpose. Making statement of something based on one's own well developed criteria or well understood criteria of another		
Walsh (1994a)				checking services after they are provided	developing organisational systems to ensure unacceptable work not done in the first place

Table 6.1 (continued)

Source	Monitoring	Review	Evaluation	Quality control	Quality assurance
Windle & Sharfstein (1977)	process of observation, review and analysis leading to & including appropriate action in the regulation of the performance of community Mental Health Centres with respect to program, fiscal management & community purpose. Primary purpose is compliance with original ward (i.e. doing what supposed to be doing) in the proper way		judging the quality of something for a particular purpose		
Brewer (1990)	process of checking conformance and noting discrepancies against agreed criteria	comprehensive studies of issues or services which takes account of history, existing practices, development needs and sets possible future strategies	used to make informed judgements about a service or policy e.g. considering future service options, judging likely costs or consequences of a policy	means of checking activity or performance on a day to day basis	a process for the systematic inspection and evaluation of the quality of services and demonstrates improvement of quality over time
DOH (1991d) Purchase of service - practice guidance				Part of QA. Checking that quality of service maintained through inspection, monitoring & regulation. Use of objective feedback inform	processes which aim to ensure that concern for quality is built into service

Chapter 7

Developing the monitoring method

The previous chapter looked at monitoring, review and evaluation as activities and then related them to social care contracts. This chapter looks at what monitoring methods were incorporated in the Berkshire block contracts and how the author developed a method of monitoring with the providers.

7.1 Documentation within the block contracts.

The review and monitoring of services were given separate clauses in two parts of the contract - the main section (effectively the terms and conditions) and in the care specification. A comparison of all the clauses in the specification is described in Chapter 5 (section 5.11) and the part relating to monitoring is reproduced below in Table 7.2. The monitoring clauses outside of the care specification were also analysed and compared using the same categories as in Chapter 5 and are summarised in Table 7.1. The categories of block contracts were:-

A. Type 3 contract. The provider has a sub-contract for staff but they are supplied in kind and no money changes hands. Signed March 1992.
B. Type 1 contract. The provider employs the staff. This was one of the early contracts (July 1992) but the home was not operational until February 1993.
C. Type 1 (variation). The provider still employs the staff but was more like a Type 2 (D) contract than the Type 1 (B above) contracts. Homes opened between October 1992 and February 1993.
D. Type 2 contract. The provider has a sub-contract for staff and "purchases" the staff for money. All signed in March 1993.

There were two main areas of difference

1. In the care specification the Type 1 contracts (column C in the tables over) make no reference to the care provider monitoring the service. The conclusions of this study are that greater emphasis needs to be placed on care provider internal monitoring. If the care provider worked only to the contractual terms this would be a serious omission to Type 1 contracts.
2. The second difference highlights the abandonment of the panel for monitoring and the attempt to be more specific about what would be monitored and how the service should be reviewed.

Table 7.1 *Comparison of clauses relating to monitoring procedures outside of the care specification.*

A. ***Type 3 contract - care contract, staff supplied in kind***	**B.** ***Variation of Type 1 - later than Type 1***	**C.** ***Type 1 contract - Provider employs staff***	**D.** ***Type 2 contract - Provider has care contract with another provider***
e.g. Warley Green	*e.g.. Valley House*	*e.g. Pencolm*	*e.g. Sheridan Way*
Schedule 5	**Appendix 2**	**Placement agreement - clause 7**	**Placement agreement - clause 7**
March 1992	*July 1992*	*January 1993*	*March 1993*
Panel monitors provision against the specification - methods in Appendix 1	Panel monitors provision against the specification and meets quarterly. Panel to set methods	7.1 (i) effectiveness, efficiency and quality against the specification	7.1 (i) effectiveness, efficiency and quality against the specification
		7.1 (ii) quality of life through IPPs	7.1 (ii) quality of life through IPPs
Every year	Panel meet every 3 months	7.2 6 months after date of contract and then every year	7.2 6 months after date of contract and then every year
Written report to residents and relatives		7.3 Written report	7.3 Written report
		7.4 Joint strategic review on 4th anniversary. Could lead to change in specification.	7.4 Joint strategic review on 4th anniversary. Could lead to changes in specification, contractual and funding arrangements
		7.5 Done by (i) care provider and home manager and (ii) two representatives of Council nominated by Director of Social Services	7.5 Done by (i) care provider and home manager and (ii) one representative of Council nominated by Director of Social Services
Panel set up in Schedule 5	Panel set up in Appendix 1 - selection of residents		
Consists of 3 from BSS (purchasers), 1 from central team of WBHC and 1 from voluntary sector	Consists of up to 7 people including 2 co-opted from Social Services		

Table 7.2 Comparison of the clauses relating to monitoring procedures in care specification.

A. *Type 3 contract - care contract, staff supplied in kind*	B. *Variation of Type 1 - later than Type 1*	C. *Type 1 contract - Provider employs staff*	D. *Type 2 contract - Provider has care contract with another provider*
14. Monitoring	**14. Monitoring**	**13. Monitoring**	**14. Monitoring**
14.3 Consult residents but not include limitations of residents	14.3 Consult residents but not include limitations of residents	13.3 Consult residents but not include limitations of residents	14.3 When consulting residents, staff to facilitate - recognising limitation of some residents
14.5 Consult families of respite users every 2 years	No reference to respite users	No reference to respite users	14.5 Consult families of respite users every 2 years
14.6 Access to property by appropriate person proposed by panel. They or care manager can ask for comments from resident or relative	14.6 Access to property by appropriate person proposed by panel. They or care manager can ask for comments from resident or relative		14.6 Access to property by appropriate person proposed by Council. They or care manager can ask for comments from resident or relative
14.8 Association monitors provision & reports results to panel every year. Use methods proposed by panel.	14.8 Association monitors provision & reports results to panel every year. Use methods proposed by panel.	no reference to care provider monitoring	14.8 Care provider monitors provision & reports results to Council every year. Use methods in placement contract (clause 7).

In the 2 later groups of contracts (column C and D) the intention was for the care provider and a nominated representative of the council to monitor and review the service (clause 7.5). The review should occur annually and (Clause 7.1)

> (i) evaluate the effectiveness, efficiency and quality of the services against the specification
> (ii) monitor the quality of life of the residents and the implementation of individual development plans.

There was also to be a strategic review on the 4th anniversary date of the contract and this would be the time to modify the specification, the quality of the staffing and the financing of the service.

It is interesting to note that in the first contract to be written (Warley Green) the monitoring arrangements between purchaser and provider are more vague. Within the

management agreement between the housing association (Silver) and the Loddon Consortium in the contract for Warley Green there were very specific requirements for management information (e.g. residents' charges, repairs) to pass between the two organisations but there seemed to be no obligation or requirement to pass this information on to the purchaser.

7.2 Development of the monitoring method

The development of the method of monitoring block contracts emerged from the experiences of the author. From July 1993 a diary or log was maintained of all aspects of work concerning the monitoring of block contracts. At that point there were 15 block contracts for residential care for people with learning disabilities which are described in detail in Chapter 5. In summary there were 9 block contracts in the west of the county and 6 in the east of the county. The care providers were 4 different voluntary agencies (three local and one national) and 2 private organisations (one local sole trader and one national company). The author had responsibility to monitor these contracts with a bias towards those in the west (job description of Placement and Monitoring Officer - March 1993) but did not take responsibility for the east contracts until later in the study.

For the first year of the study only the 9 contracts in the west were monitored. In late 1993 the purchasing stream re-aligned its central "purchasing, management and support" function two years after the purchaser/provider division. The east-west split was replaced with a county-wide children and adult/disability split. The person with nominal responsibility for monitoring contracts in the east ceased to have a brief for learning disability and mental health in the east and took on responsibility for mental health across the county. Once this change was finalised the author took responsibility in April 1994 for monitoring the 6 contracts in the east.

The phases of the development of the monitoring method were as follows

A) Initial visits
B) Examining the care specification to operationalise them
C) Sharing this with providers to gain feedback
D) Establishing format for quarterly visits

a) Initial visits

Informal visits were made to each of the homes by the author in an effort to establish a relationship with residents and staff. A list of visits made is shown in Appendix 3. There were wide variations in the number and frequency of visits and were more often than not a reflection of the concern the author had about the quality of care which was

being provided. This concern was echoed by the care managers of residents in the Pencolm contract when they asked the author to arrange and chair a meeting of all the care managers with the provider which was held in July 1993. By this time there was one vacancy in this contract as one resident had needed to move following a deterioration in her behaviour and an official complaint to the department by the parents of the resident about the way the woman had been moved from the previous provider. The remaining 5 residents all had allocated care managers from the local community team (CTPLD).

It was agreed that such meetings would be held six monthly and this format was repeated for a second contract (Allenby) where care managers from different CTPLDs were concerned about the delivery of care. The first meeting for this contract was held in October 1993 and continued subsequently in both contracts. However, by 1997 only the 6 monthly meetings for care managers at Pencolm are still being convened.

b) Examining the care specification

It was not until December 1993 (diary entry 9/12/93) that a concerted effort was made by the author to analyse and compare the content of the contracts. This was nearly 9 months after the study began. Although there were apparent differences in the care specification in the various types of contract they were the most standardised element of the contract documentation. The author decided to base the monitoring method on compliance to the care specification with a view to using it for the annual service review as mentioned in clause 7 of the main part of the contract. (See Table 7.2 above).

Each clause of the care specifications was "operationalised" whereby each part of the specification had a method about how the care in that clause could be monitored and or measured. This process was completed by early in 1994 and shared with each of the home managers and representatives of the proprietors in the west of the county and one CTPLD. An example of the operationalised specification is shown in Appendix 4. Diary entry 4/2/94 indicated that specifications and their operationalisation had been sent to all homes. Those who received it were asked to provide feedback about which part of the specifications they felt was regularly being monitored and by whom. The author felt that the following four groups could be monitoring in one capacity or another.

1. The provider (e.g. through the monthly visit of the proprietor required by the Registered Homes Act 1984)
2. The Inspectorate through their legally required twice yearly visits,
3. The care manager especially if the resident was an open/active case

4. The author in her role as Placement and Monitoring Officer

Part of the reason for developing the contract monitoring methods in this way, was the collaborative style which the author wished to continue to cultivate with the individual providers which reflected her professional social work background. As described in the section on initial visits, some difficulties had been experienced with at least two of the contracts and feedback had been given by the author to senior managers of the care providers concerned. The style of monitoring which covered the first six months of the study was therefore one of the "technical support" model described by Grant (1978) in Chapter 6.

c) Feedback from providers

Feedback from the providers to the circulation of the care specification was negligible. Although shared with care managers, they too seemed unwilling to be involved. At about this time (diary entry 16/4/94) the author took on the monitoring of the 6 contracts in the east which had not been monitored since they were signed in March 1993. All these contracts were with another voluntary organisation (Thames Consortium - Provider B2) and copies of an operationalised specification was circulated to the home managers affected. The author met with the home mangers at one of their regular meetings but only one gave feedback.

d) Establishing the format for quarterly visits

Because of this limited feedback the author decided (diary entry 23/4/94) to draw up a list of things to monitor on each quarterly visit that she intended to make so that over the year all aspects of the care would be covered. Opportunities to talk to staff, residents and relatives would also be built in to the schedule of visits. This format was adopted by the author, presented to the care providers and the first round of visits began in May 1994. A copy of the content of this schedule of visits is included in Appendix 5.

In addition to developing these three-monthly scheduled visits, the author had already identified (internal memo 31/3/94 - response to a draft paper on contract monitoring for all client groups) the following methods of monitoring that she was using:-

1) Site visits - frequency depending on the amount of technical support needed.
2) Six monthly meetings of care managers and providers in two homes. Most of the residents in the other homes did not have allocated care managers.
3) Attending annual service review done by the provider in one home which involved feedback from care managers, staff and relatives/users
4) Collecting basic information and statistics

e.g. use of short term care
turnover of staff
inspection reports
use of allocated budget

5) Circulation (and trying to fill) vacancies.

In this memo there was no emphasis on the annual contract review as the author felt that this would be covered by the reports of the quarterly visits.

7.3 Progress once the method was established

Within a month of this format being instituted, the author was unexpectedly seconded to another post within Social Services and it was hoped that the person who would be seconded to the Placement and Monitoring Officer post would continue with the method developed. All 15 contracts were visited by the author during May and June 1994 and reports written on the topics to be covered 4 times a year. After the visits, it was felt that much of this information could be prepared beforehand and a pro-forma was designed by the author for future visits. Comments were invited from providers and several responded. An example of the finalised pre-visit monitoring form is included in Appendix 5.

There was a gap of 4 months before the new incumbent was seconded which meant that one quarterly visit was omitted. However, the pre-visit monitoring from was sent out in September 1994 and some information was returned. The response rate to this form was very poor - 3 responses out of a possible 15 within 3 weeks of the request. The reason for this poor response could be because it was not to be followed by an immediate visit and so there was less incentive for the provider to co-operate. There were also no sanctions for not complying.

By the time the new post holder was appointed in November 1994, the job of Placement and Monitoring Officer had been changed to one of Accreditation and Monitoring Co-ordinator. The job description was changed and the post holder had line management responsibility for 4 accreditation and monitoring officers. Monitoring of the block contracts for residential care for people with learning disabilities was not a priority for this team and so monitoring lapsed. Care managers in the CTPLDs still continued to review individual placements in two of the Provider A homes as historically these residents had been in agency placements (spot purchases) prior to the moves into block contracts. Other care managers also had occasional involvement with the residents in the other block contracts.

A new block contract for 10 places was signed in October 1994 (a Type A contract following transfer of staff from BSS providing stream under TUPE). This regularised an existing arrangement but was not assigned to any care manager, CTPLD or accreditation and monitoring officer for monitoring purposes. Nor was anyone made the "contract owner". Up to December 1996 this contract had not been formally monitored by the purchasing stream despite there being a vacancy since December 1994 following the death of a resident.

Priorities within any department change over time and the accreditation and monitoring team found itself concerned more with the accreditation of services which were not regulated by statute but which the SSD wished to purchase. Examples were domiciliary care and enhanced residential care for elderly people. In both areas the requirements of the Special Transitional Grant (STG) meant that the majority of these new responsibilities handed to SSDs under the community care legislation needed to be used in the independent sector. The internal, inter-departmental mechanisms to ensure quality and administer eligibility criteria which had been available for these in-house services could not be used for "out county" or independent provision.

A further task of the accreditation and monitoring team was in response to the fact that residential homes for elderly people in the independent sector were unused to reviewing residents' needs and setting objectives for further work. As this was one of the requirements in the residential care specifications for this client group the accreditation and monitoring team developed a sampling method to observe resident review and thereby monitor the service provided.

7.4 The formal data collection phase of the study

The shift of responsibilities for monitoring the block contracts which were part of this study indicates the downgrading of the importance the SSD placed on regular monitoring of such contracts. Only immediate problems and crises in the contracts could be given priority. Examples were the negotiation over extra staffing for the Valley House contract and the breach of contract dispute over the Mendip Way contract. The author was only on the periphery of these event in her new posts and cannot say whether regular monitoring in the format proposed in April 1994 and described above would have helped or hindered these difficulties.

The author had already decided early in 1994 to survey, either through semi-structured interviews or written questionnaires, some of the major players or stakeholders in these

block contracts. One group, keyworkers, were chosen and the part they play in the delivery of care is explored in the next three chapters.

Chapter 8

The questionnaire to keyworkers

This chapter gives the background to the survey of keyworkers and outlines the protocol developed for the administration of the questionnaire to this group of staff.

8.1 Introduction

At an early stage of this study a number of different perspectives on the monitoring of the contracts were identified by the author. They were (not in any order of importance):-

1. Those who developed and negotiated the block contracts
2. The proprietors of the registered homes
3. The registered home managers
4. The care managers/social workers
5. The residents
6. The relatives of the residents
7. The keyworkers
8. The budget holders who effectively "managed" the contract
9. The inspectors
10. Stakeholders in the care contracts - e.g. care services managers in social services
11. Other purchasers in the few contracts where not all the registered places were covered by the block contract.

Some of these perspectives were to be obtained as part of the monitoring process through the quarterly visits e.g. discussions with care managers, keyworkers and relatives. Others were to be noted through written documentation e.g. inspectors' reports, looking at complaints book or records of resident's meetings during the quarterly visits.

Monitoring activity was done primarily by the author through a visit to the unit managers of the homes. Though the model outlined in May 1994 (see Appendix 5) envisaged that twice a year there would be a discussion with a sample of keyworkers about care planning and advocacy, this outline did not give any details about how this would be done - neither the sampling method nor the questions to be asked.

Keyworkers are mentioned specifically within the placement agreement and the care specification and this was why they were specifically included in the format of the quarterly visits. The author decided to design a questionnaire for this group of people who would have a perspective on contract monitoring. It was hoped that the questionnaire could be developed into a written format that could be used annually in future monitoring procedures. Initially, the questionnaire was to achieve a two-fold objective - a check on how far the contractual obligations had been met (and this would the part which could be continued in future years), and also to find out about the keyworker's view of monitoring. In essence the former was looking at the quality of life of the residents and the latter at quality monitoring.

A written postal questionnaire was chosen as the preferred method of eliciting the views of the keyworkers for the following reasons:

1. The numbers involved. More than 70 different care staff were allocated as keyworkers
2. Their shift pattern. It would be difficult to interview them personally over a short period of time
3. The aim of developing a written format which could be used to monitor these and other types of contracts in the future.

8.2 The questionnaire design

The keyworkers are mentioned several times within the care specification and the placement agreement. In some sections of the contract the keyworker is referred to specifically, in others the reference is to staffing in general. Full references to the keyworker and staff in the contract documentation are in Appendix 7.

After analysing the placement agreement and the care specification in Type 2 contracts for references to the keyworker, a series of questions were designed to elicit how keyworkers carried out their role as well as finding out their views of monitoring. The Type 2 care specification was chosen as the basis because it included reference to advocacy on behalf of the residents though it was recognised that the other contract types did not include this clause. Type 2 contracts also covered a greater number of keyworkers (42 in Type 2 compared to 30 in Type 1 and 3) though the number of places purchased was similar (47 in Type 2 compared to 40 in the other 2 types). Table 8.1 overleaf shows this in greater detail.

Table 8.1 *Number of keyworkers surveyed and places purchased in the 3 types of contract*

Contract Type	Contract number	Keyworkers	Places purchased
Type 1	1	5	5
	2	3	3
	3	6	6
	4	3	7
Total	**Type 1**	**17**	**21**
Type 2	5	6	5
	6	3	5
	7	5	6
	8	5	6
	9	7	8
	10	3	4
	11	3	4
	12	6	5
	13	4	5
Total	**Type 2**	**42**	**48**
Type 3	13	5	5
	14	8	16
Total	**Type 3**	**13**	**21**
Total	***Type 1 & 3***	***30***	***42***
Total	***Type 2***	***42***	***47***

The same questionnaire was used for all keyworkers. This was felt to be acceptable because the differences between Type 1, 2 and 3 contracts were small (see discussion in Chapter 5). Moreover, it was postulated that any differences in the care practised and standards were not related to the differences in the care specification. This was discussed in Chapter 5 (section 5.4) and relates to the existence of the care contract with BSS (providing stream) for all the Type 2 and Type 3 contracts (54 out of 71 keyworkers in homes that were essentially "social services" in ethos and management) and the influence of the larger organisation over care practices within the individual homes. Much of the analysis of the questionnaires in Chapter 9 and 10 combines the answers from Type 2 and Type 3 contracts so that all of keyworkers in homes run by Loddon Consortium (Provider B1) and those run by Thames Consortium (Provider B2) were treated as if they were the same provider group.

8.3 Development of the questionnaire

The questionnaire was developed through 3 drafts and the second two drafts were piloted. The first draft of the questionnaire concentrated on questions where the respondent was to circle a number and occasionally questions which needed a written answer. There were also a series of questions with a Lickert type scale. This was an attempt to see how well the keyworker's view or attitude to their role matched up with the questions they had just answered. These latter questions were abandoned for the following reasons.

a) the first part of the questionnaire was already long enough and would take 20 to 30 minutes to complete.

b) it did not add a great deal more information than had already sought.

c) the author thought it might be difficult for respondents to "change gear" and answer a different type of question to the ones already presented.

A second draft was tested on 2 residential care workers who were keyworkers in a Part III social services hostel for people with learning disabilities where there was a service agreement but no purchasing contract. They were chosen because they would not be part of the main sample. Management of the homes within social services were comparable irrespective of whether there is a service agreement or care contract. Therefore one would expect similar care practices and care standards. Questions relating to contract monitoring were less relevant to them but they made valuable suggestions to other parts of the questionnaire.

A third draft was then tested on a keyworker who would be part of the main sample but who had keyworker responsibility to several residents. As the questionnaire asked the respondent to think about only one of the residents to whom they are keyworker, it was felt this would not adversely affect her responses to the final questionnaire. Further refinement were made to the questions, especially in relation to the instructions and she was also asked to comment on the letter to keyworkers which would accompany the questionnaire. Final versions of the questionnaire, letters to the keyworker and home manager are included in Appendix 6.

In order to ensure a good response rate it was felt necessary to enlist the support of the home managers, not only to distribute the questionnaire but also to ensure the keyworker was given time and space to complete it. This was done in two ways. In the first instance the Assistant Director (Purchasing - Adult and Disability) wrote to all the proprietors asking if their staff could be involved with the author's research. A letter

was also sent to the Senior Assistant Director (Providing) as these staff were part of the care contract in Type 2 contracts and were employed by social services.

After these formal letters were sent out, personal telephone calls were made by the author to all the home managers enlisting their help. They were asked to distribute the envelopes to the keyworkers and ensure that the staff member was given 30 minutes work time to complete the questionnaire on their own. It was stressed that the keyworker could choose whether or not to complete the questionnaire but it was hoped that the conditions in which the keyworkers could participate, should they wish, were as favourable as possible. The telephone contact was also used as an opportunity to check the list of keyworkers for accuracy.

With most of the homes the author already had a relationship with the officer in charge through the monitoring visits. In two homes, the officer in charge had come into post since the last monitoring visit in June 1994. In another home the officer in charge said she would ask the staff meeting if they would be willing for the questionnaires be sent to the home in the first place. She wanted to know as much as possible about what would happen to the original data sheets, how the information would be used and how the results would be disseminated. This was so that she would be able to reassure the staff that their and the resident's confidentiality was maintained. 100% of the questionnaires were returned from this home. In all other homes the manager was willing to distribute the questionnaires without taking the issue to a staff meeting. Nine out of the 15 homes returned a 100% response rate.

Once the officer in charge agreed to receive the questionnaires, individualised letters were prepared to the keyworker. These were posted with a covering letter to the officer in charge.

The protocol for administering the questionnaire was written before the questionnaires were distributed and was designed to ensure that all respondents were approached equitably by the line manager and that as good a response rate as possible was ensured.

1. A list was prepared of all the keyworkers in the block contracts and their respective residents from the monitoring visits carried out in June 1994. This list was checked for accuracy just before the questionnaire was mailed. Some homes (e.g. Pencolm) showed considerable changes.

2. Each person who was a keyworker was asked to complete a questionnaire. Some residents had more than one keyworker and some homes had residential staff who were keyworker to more than one resident. In one home where this happened (Warley Green - contract 15) they also used associate keyworkers - these associates were not surveyed. In other homes where residents had more than one keyworker, it was assumed they were co-keyworkers and had equal responsibility. Each co-keyworker was therefore surveyed. The questionnaire did not enable the respondent to indicate which resident they were referring to when answering the questions though some tracing could be done through the date of the resident's last review. Trying to maintain some anonymity so that keyworkers would feel able to answer truthfully ensured that it was not possible to link every returned questionnaire to a keyworker and a particular resident.

3. Each keyworker was asked to answer independently of other staff in their home or their provider organisation. Various measures were taken to ensure that this happened.

a) Before the questionnaires were sent out, the home managers were contacted and their co-operation sought. As well as being asked to distribute the questionnaire they were also asked to ensure the individual was given time and space to complete the questionnaire independently. An offer was made to come and talk to a staff meeting if the home manager thought this would be helpful.

b) Each keyworker had an individual letter requesting them to complete the questionnaire. They were asked not to consult or discuss their answers with other staff and told that their manager would be ensuring they had time to do this exercise (about half an hour).

c) Each sealed envelope to the keyworker contained the covering letter, a copy of the questionnaire and a stamped addressed envelope addressed to the researcher and marked confidential. These envelopes were sent with a covering letter to the home manager during the period 17 to 30 November 1994. Although it was hoped to send out all the questionnaires together, holidays and sickness in the home managers meant that their agreement was delayed. Examples of these letters are shown in Appendix 6.

4. Each questionnaire was numbered and these numbers referred to a master list of names of keyworkers which was kept at the home of the researcher. Three weeks after the questionnaires were sent out, follow up letters and a new copy of the questionnaire were sent to all keyworkers who had not responded to the first request. Again, because of the difficulty of contacting keyworkers on duty, it was felt a letter would be a more effective and consistent approach than a telephone call. Bearing in mind the shift pattern, a further 14 days was allowed to lapse before assuming this reminder had been

unsuccessful. Any subsequent follow-up was determined at that point e.g. telephoning the home's manager or contacting the keyworker direct. A record was kept of the date the questionnaires were sent, the date the completed questionnaire was received and the date of any reminder.

5. Non respondents. Some home mangers had been less co-operative than others with the monitoring that had been done by the author between April 1993 and June 1994. Because their active engagement was essential to ensure distribution of the questionnaire and the opportunity for the keyworker to complete it, this could have affected the response rate. The validity of the questionnaire depended on the assumption that the population of non-respondents was no different to the population of respondents. If the response rate varied considerably from home to home this would call into question the validity of the responders' answers.

Other reasons for non-response could be:

a) the named keyworker had changed and the letter was not passed to the new keyworker. This was minimised by having an up-to-date list of allocated keyworkers.

b) the keyworker was interrupted when completing the questionnaire and was then unwilling or unable to return it.

c) the keyworker lost the questionnaire

The last two reasons were covered to some extent by sending a second questionnaire with the follow-up letter.

8.4 Overall statistics Numbers sent out and response rate

Seventy two questionnaires were distributed and Table 8.2 and the end of this section shows the overall response rate.

Thirty five out of 72 (49%) of keyworkers responded to the first mailing of the questionnaire. A further 33% responded to the follow-up letter (24 out of the 37 letters sent - a 65% response rate). In total 59 of the 72 keyworkers surveyed responded (81%). Response rate varied from 100% (9 contracts representative of all three categories of contract and type of provider) to 63% (6 contracts). This does not include the lowest response rate of was 14% at Brookside. No responses were received from this home until 15 February 1995 which was 11 weeks after the letters were sent out on 30 November 1994. After this sole questionnaire was received, the keyworker in question was telephoned personally to ask if any other questionnaires were left to

return. If this produced no further response, it was decided that the questionnaires relating to this contract would be discarded. The one questionnaire from Brookside was excluded thus giving a total of 58 out of 71 (82%) questionnaires to analyse. It is these 58 questionnaires which form the basis of the analysis in the next two chapters.

Allocation of keyworkers to residents

The numbers of keyworkers in contracts varied considerably (from 3 to 8 per home and this was not always to do with the number of places in the contract). It is not possible to do more than speculate why some homes gave a better response rate than others. The reasons may relate to organisational factors. In Brookside the manager went on long term sick in December 1994 and in Warley Green, it was the only large hostel. Both these homes had lower response rates. There had been concerns about the quality of care in this latter home from the inspectors following the early retirement of a long serving manager and a considerable gap before a successor was appointed.

Being a keyworker to more than one resident may have affected the response rate as 43 of the 49 keyworkers (88%) who were keyworker to only 1 resident returned their questionnaire. 75% (12 out of 16) or keyworkers with 2 residents replied and 57% (4 out of a possible 7) who were responsible for 3 residents replied. At the time of the questionnaire (November 1994) the maximum number of residents to one keyworker was three.

For a postal questionnaire the response rate was high, probably because the author had a relationship with the homes - in particular the home managers - and had known a number of keyworkers over the preceding five years through her work with Berkshire Social Services.

Table 8.2 *Response rate to the questionnaires from different contracts*

Contract	Type	no. sent	1st response	remind	2nd response	total response.	% response
1	type 1	5	4	1	0	4	80%
2	type 1	3	2	1	1	3	100%
3	type 1	6	5	1	0	5	83%
4	type 1	3	2	1	1	3	100%
5	type 2	6	1	5	4	5	83%
6	type 2	3	2	1	1	3	100%
7	type 2	5	2	3	3	5	100%
8	type 2	5	4	1	1	5	100%
9	type 2	7	0	7	1	1	14%
10	type 2	3	0	3	2	2	66%
11	type 2	3	0	3	3	3	100%
12	type 2	6	6	0	0	6	100%
13	type 2	4	2	2	2	4	100%
14	type 3	5	3	2	2	5	100%
15	type 3	8	2	6	3	5	63%
TOTAL		**72**	**35**	**37**	**24**	**59**	**82%**

8.5 Analysis of results

The answers to the 58 questionnaires were collated and analysed using Longman Logotron Pinpoint for Windows computer programme. The results of this analysis are described in the next two chapters. Rather than make a separate literature review, this is included in the text about the results in the relevant section.

Chapter 9 looks at elements of the service that are "inputs" - keyworker pay and length of employment, supervisions and training of staff. An attempt was made to look at some "process" elements - to what extent keyworkers were aware that they were

working for an organisation that was part of a contractual arrangement between purchaser and provider and who they felt monitored the quality of care.

Chapter 10 looks at the four main responsibilities of the keyworker (care planning, social relationships, health needs and choice/autonomy) and attempts to define some "outcome" measures which reflect the quality of life of the residents. It was hoped that these results would start to provide some answers to the methodological questions posed on Chapter 3 (section 3.1.1) about measuring standards of care. In addition it was hoped that the subjective differences in the care noted by the author (as defined by the amount of technical support offered) would be noticeable in the responses provided by the keyworkers

A full set of frequency count tables are contained in Appendix 8 and tables of results not shown in the text of Chapters 9 and 10 are contained in Appendix 9.

Chapter 9

Responses to the questionnaire - quality monitoring

In Chapter 5 it was noted that the placement contract between Berkshire Social Services and the proprietor or care provider contained the care specification and the terms and conditions of contract. The terms and conditions are those under which the BSS would be doing business with the provider. The care specification formed an appendix of the placement contract and attempted to be explicit about the type of service, the quality expected and how the service would be monitored and reviewed. Some of the placement contracts also contained a care contract. This was where the proprietor had a separate agreement with BSS (providing stream) to supply staff to work in the homes (a Type 2 contract).

Reference has also been made in Chapter 5 to the evolution of the block contracts over time and the variation that existed among them at the time of this study. In total there were 15 block contracts and one of the main difference was the employment of staff. In 4 contracts, staff were employed directly by the proprietor and in the remaining 11 the staffing was through social services. In two if these contracts, the staff were supplied in kind and in the other nine instances staff were part of a care contract between the proprietor and social services (providing) stream. These two separate proprietors covered these 11 contracts, one for the east of the county (6 homes) and one for the west of the county (5 homes).

For the purpose of the analysis of the keyworker questionnaires, the homes where the proprietor employed the staff directly were known as "A" providers and the ones with BSS provided staff were referred to as "B" providers. The "B" group was further sub-divided into the "B1" and "B2" to distinguish the two different proprietors. The table below shows the number of contracts associated with each provider group and the numbers of keyworkers surveyed. Numbers of keyworkers for each individual home/contract were small (varying from 2 to 6 - see frequency count table 2 in Appendix 8) which meant that the analysis of the keyworker answers between contracts would not be statistically reliable. For this reason, many of the results are comparisons of three main groups (A, B1 and B2). More detailed tables of results are provided in the Appendix 9.

Table 9.1. Summary of contracts and keyworkers in each provider group.
N = 58

Provider	Contracts	Keyworkers surveyed	Keyworkers responding
A	4	17	15
B1	5	27	22
B2	6	28	21
Total	**15**	**72**	**58**

This chapter looks at the results of the questionnaire in terms of how well the respondents understood their role as keyworker, characteristics of keyworkers (pay, length of employment) and the way proprietors ensured quality staff through induction, staff supervision and on-going training. The final section (9.4) describes how keyworkers felt the overall service was reviewed. This is compared with the responses from proprietors on the same topic. Their views were sought before the keyworker questionnaire was issued. The following chapter (chapter 10) looks in more detail at the responsibilities of keyworkers.

9.1 Understanding the role of keyworker

Knowledge of the specification and role of keyworker.

At the end of the questionnaire, keyworkers were asked if they had seen copies of the care specification and placement contract and, if applicable, the care contract. 33 keyworkers worked in homes where there was a care contract and 25 worked where the care was not sub-contracted. (See Table 1 in Appendix 9 for information about whether keyworkers had seen the care contracts)

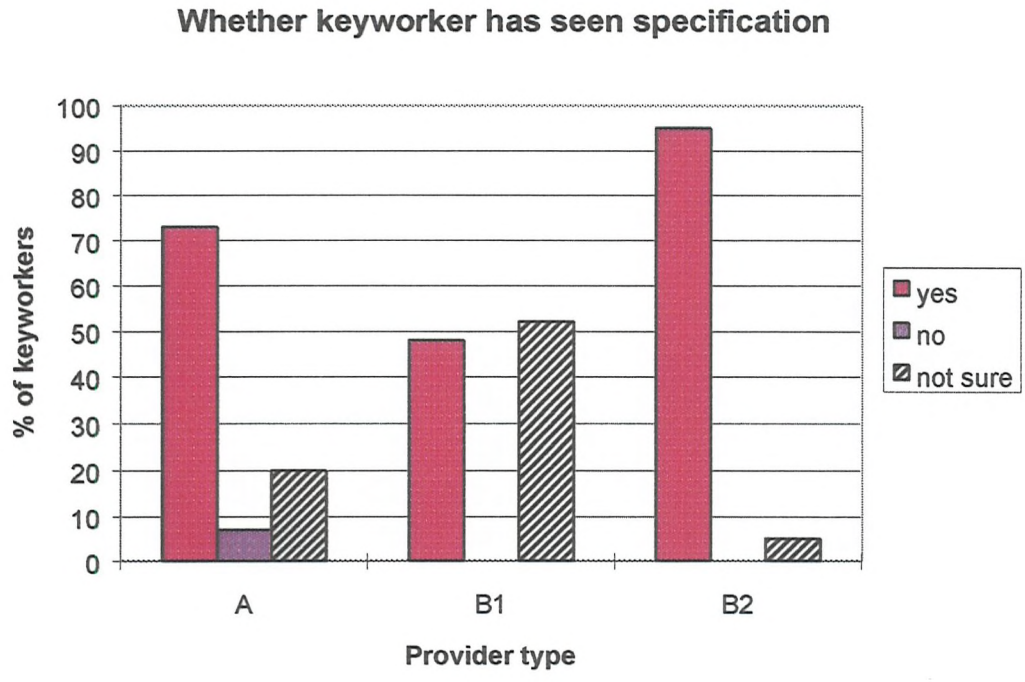
In the early monitoring visits during 1993, a number of the home managers had not seen the care specification (see diary entries from this period). An improvement was shown by the time of the survey where 40 of the 58 keyworkers (69%) said they had seen the care specification, only one said they had not and 16 (28%) said they were not sure (non response was 1). See Table 9.2 and Graph 9.2a

Table 9.2 *Whether keyworker had seen the care specification. By provider. N = 58*

Keyworker has seen care specification	Provider			
	A	B1	B2	Total
Not answered	0 0%	0 0%	1 5%	1 2%
Yes	11 73%	11 48%	18 90%	40 69%
No	1 7%	0 0%	0 0%	1 2%
Not sure	3 20%	12 52%	1 5%	16 28%
Total	15	23	20	58

Percentages by column.

Graph 9.2a. *Whether keyworkers had seen the care specification. N = 57 (excludes NR)*



Knowledge of keyworker role and how far met requirements

Keyworkers were also asked if they knew what the care specification said about the role of the keyworker and how confident they felt about meeting the requirements of the role. Although staff working in provider B1 and B2 were part of the same social services, those working in B2 were much more certain about whether they had seen the specification (90% compared to 48%) and also about what the care specification said

about the role of keyworker (100% compared to 43%) Many more felt they met all of the requirements of the role (74% compared 9%). The overall figures are shown in Table 9.3 and 9.4 and Graph 9.3 a and 9.3b. Full results are in Table 2 to 5 in Appendix 9.

Although 90% of B2 provider keyworkers felt they met all (74%) or some (16%) of their requirements within the care specification, this is not wholly justified. As will be shown later in the chapter in certain areas e.g. care planning and reviews there was greater inconsistency among homes in B2 than B1 provider homes; achievement of goals was less good (though it is accepted that no evaluation of the quality or appropriateness of the goal was attempted). The induction process seemed to be haphazard (more did not receive it in B2 compared to B1), though the keyworkers did seem to be aware that there was a provider system for monitoring the quality of care and they felt they were part of it.

Table 9.3 *Knowing what the role of the keyworker is by provider. (Excludes those who have not seen the care specification or did not answer). N = 56*

Know role of keyworker	Provider			
	A	B1	B2	Total
Not answered	1 7%	8 35%	0 0%	9 16%
Yes	10 71%	10 43%	19 100%	39 70%
No	0 0%	1 4%	0 0%	1 2%
Not sure	3 21%	4 17%	0 0%	7 12%
Total	14	23	19	56

Percentages by column.

B1 keyworkers had a much higher rate of non-response to these questions which would also indicate uncertainty. 35% did not answer the question about knowing the role of the keyworker and 57% did not answer about how far they felt they met the requirements of the role of keyworker.

Graph 9.3a Knowing what the role of the keyworker is by provider. N = 56

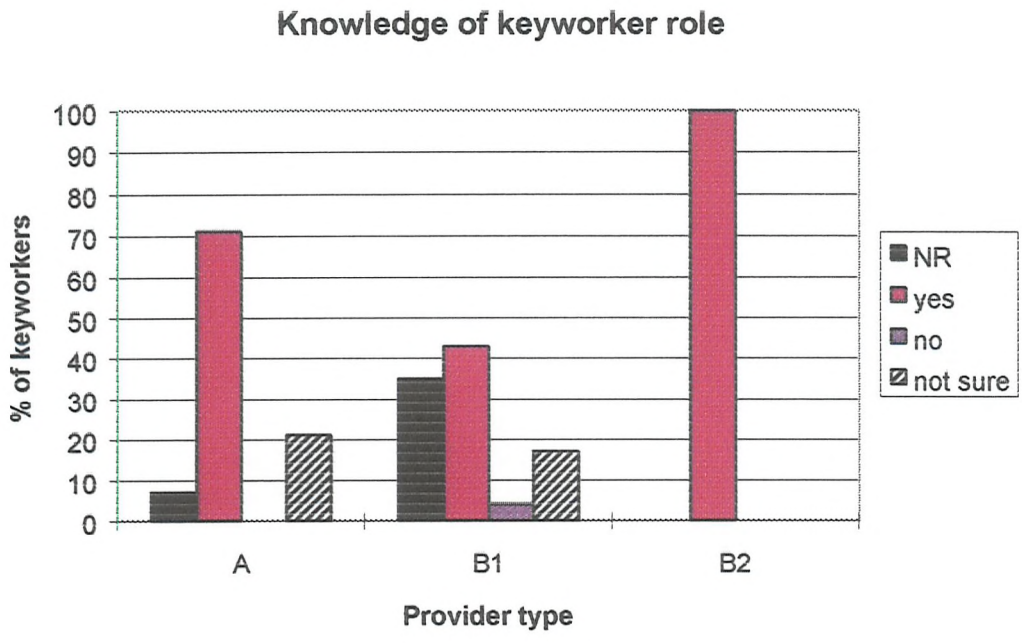
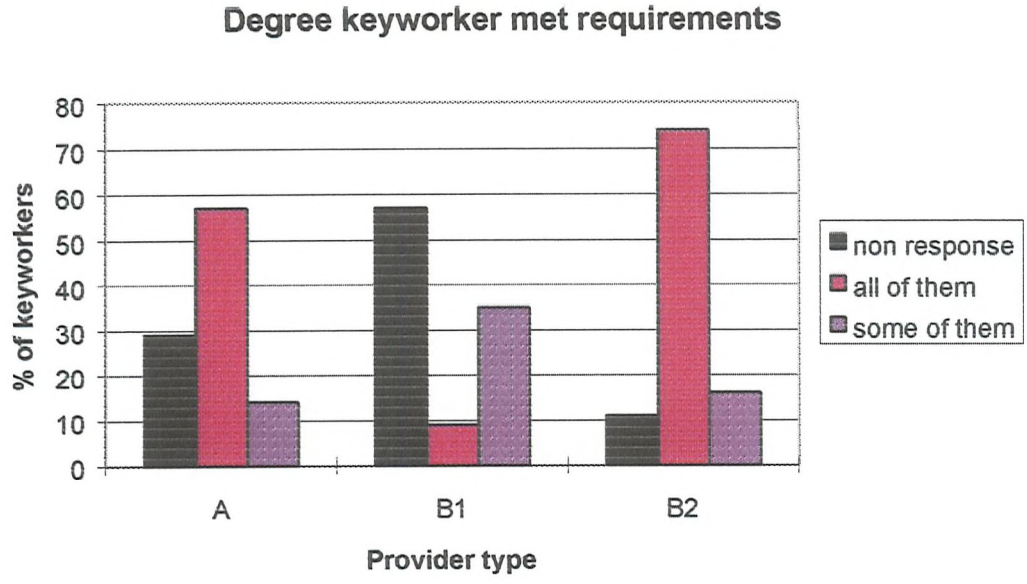


Table 9.4 How far the keyworker felt they met the requirements of the care specification (excludes those who had not seen it or did not answer). N = 56

How far meets specification	Provider			
	A	B1	B2	Total
Not answered	4 29%	13 57%	2 11%	19 34%
All of them	8 57%	2 9%	14 74%	24 43%
Some of them	2 14%	8 35%	3 16%	13 23%
Total	14	23	19	56

Percentages by column.

Graph 9.4a. How far the keyworker felt they met the requirements of the care specification. N = 56



The group who had seen the care specification and knew what it said about the role of the keyworker numbered 37. In provider A and B2 about $^{4}/_{5}$ felt they met all of the requirements whereas in Provider B1 only $^{1}/_{5}$ felt the same. There is tentative evidence later in the chapter, bearing in mind the small sample size of each contract, that the internal consistency within Provider B1 was much less than Provider B2 i.e. different views and practices were shown by keyworkers in the same home, or practice varied from home to homer within the same provider. Table 9.5 and Graph 9.5a shows the results of this sub-group of 37 in relation to how far they met the specification. Full results by contract are in Table 6 in Appendix 9.

Most of the non-respondents came from the group who either had not seen or were not sure if they had seen the specification and/or did not know or were not sure of the role of keyworker. If one looks at those who had seen the specification and knew what was expected of them, 23 out of 37 (62%) felt they met all of the requirements and 12 (32%) felt they met some of the requirements (non-response was 2)

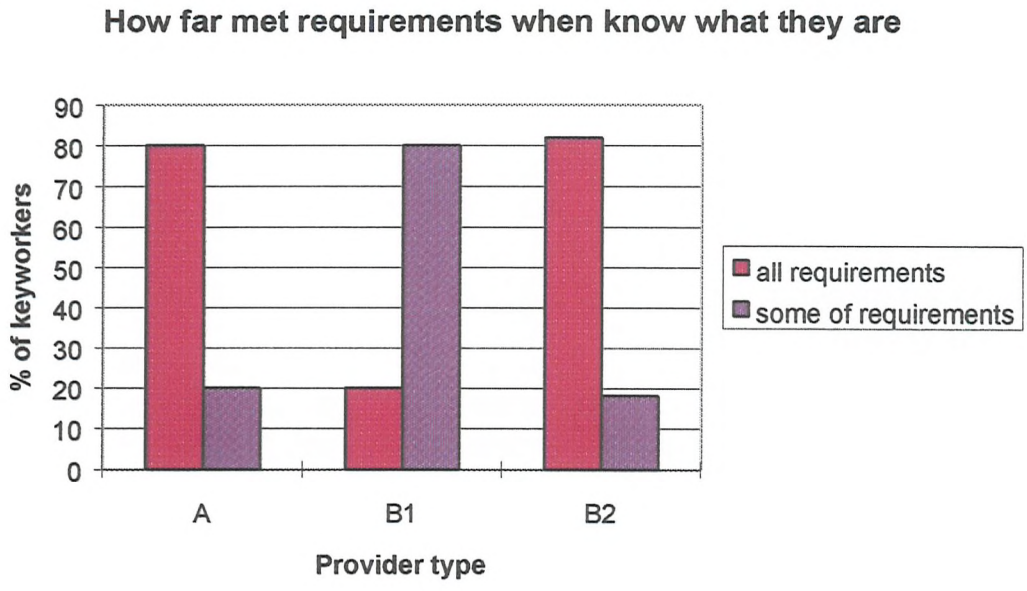
Table 9.5 *How far the keyworker felt they met the care specification, by provider type. Includes those who have seen what it says and know what is the role of the keyworker. N = 37*

(Excludes those who did not answer how far they met the specification).

How far meets specification	Provider			
	A	B1	B2	Total
All requirements	8 80%	2 20%	14 82%	24 65%
Some of requirements	2 20%	8 80%	3 18%	13 35%
Total	10	10	17	37

Percentages by column.

Graph 9.5a *How far the keyworker felt they met the care specification, knowing what it said. N = 37*



Without exploring further with individual home managers, one can only speculate about the reasons for this difference. The author was aware that Provider B2 had comprehensive proprietor's monthly visits which used checklists and there were regular home manager's meetings. The six homes were all in the same conurbation and one of the contracts (Brookside) was 10 miles further east. As only one questionnaire was returned from this home, the results are not included in any of the analysis. In the west, the homes were more dispersed - 4 in one town and one in a town 25 miles away. There were no differences in the types of contract for Provider B1 and Provider B2. The

majority were Type 2 contracts and each provider had one Type 3 contract (staff supplied in kind).

9.2 Keyworker pay and employment length.

One of the differences in the contracts was the rate of turnover of care staff which was charted through the on-site monitoring visits. With some (Type 2) contracts, staff had moved with the residents e.g. when the hostel was re-provided and this could have lead to lower staff turnover. In two (Type 1) contracts (Allenby and Pencolm) turnover was exceptionally high. In these houses there had been nearly 100% turnover in staff since the home had opened 18 months previously. The questionnaire asked questions about current salary, length of time worked at this home and length of time as keyworker to the current resident.

Hatton and Emerson (1993a) reported a crude annual turnover of 32% in a community unit in the midlands. Other studies reviewed in Emerson and Hatton (1994) showed that staff turnover rates for staff working with people with learning disabilities varied from 10% to 25% per year. There was some evidence that turnover may be higher in community based staffed housing services (which are comparable to most of the contracts in this study) than in larger community units (e.g. Warley Heath) and institutions such as long stay hospitals. Evidence from the monitoring visits indicated that in some homes (e.g. Pencolm and Allenby) the figures for turnover were much greater than the 32% previously mentioned.

It is accepted that pay is not the only factor in staff turnover and it would not be possible to establish a causal link between pay and turnover even if a correlation was found. However, there were suggestions of a link from other evidence in this case study. Comments from home managers (diary entry 15/6/94 for Pencolm and 15/3/94 for Allenby) indicated that low pay was one of the reasons for high staff turnover. The manager of Pencolm also indicated that staff sickness was higher at this home than others run by the same provider (A3), but turnover was no different. It was high in all the homes though this latter statement was contradicted at a meeting of BSS and senior provider managers (diary entry 2/3/94).

The Public Services Privatisation Research Unit (PSPRU) survey of homes in the independent sector in 1994 showed that care assistants in that sector received on average 17% less than council employed care assistants (£3.26 per hour compared to £3.91 per hour). Staff working with people with learning disabilities fared the best at £4.35 her hour (Wynn Davies 1994). The London School of Economics (LSE) low pay

unit did find a correlation between low wages and high staff turnover in private sector homes along the south coast. Their director Chris Pond felt this was a result of proprietors trying to undercut each other in order to maintain a low resident vacancy rate (Wynn Davies 1994). However staff costs in a residential home are not just a factor of how much an employer pays care workers per hour. Linda Davies (1988) pointed out that variations in staff costs were due to differences in staff:resident ratios - the need for smaller homes to have a greater total number of staff to maintain that ratio - as well as the differences in salary and employer costs.

Three of the respondents were acting as temporary keyworkers and were part of the management team in two of the contracts. Their responses were disregarded for the next section of the analysis which relates to keyworker pay and length of employment as it was felt their higher salary would distort the results.

Many respondents do not like revealing their salary and improvements could have been made to increase the accuracy of the results. In particular, allowance should have been made for staff on part-time contracts as well as some distinction between basic pay, overtime pay and sleep-in duties. A wider spread of salaries would have helped as a majority earned more than £11,000 per annum. The wording of the question could have been improved as 5 people did not respond to this question which was higher than other questions at the beginning of the questionnaire. Two of these respondents wrote that they were not paid any extra for being a keyworker and were coded as non response. A further answer was recorded as non response as the author was aware that the respondent worked part-time and she had not calculated her full time equivalent salary. Her response was less than £8,000 per annum. At Langley House one person responded in the category £9,000 to £10,000 and the author suspected that she probably worked less than full-time. Her response was coded as it was. Table 9.6 shows more detail about keyworker pay and Table 7 in Appendix 9 gives figures for each contract.

Knowing some of the background of the five employers of staff, it is possible to suggest reasons for the differences in salary scales. One local voluntary agency (Basildon Trust for Allenby) paid their keyworkers between £8,000 and £9,000 per year (3 out of 3 respondents) and it was known that keyworker salary scales are higher than other care support staff. The other voluntary organisation is a national organisation (Valley House, employer Care Unlimited) that had begun to tie its salaries more closely to those of local authority staff. At this home each of the 4 keyworker staff would be doing about 6 sleep-in duties a month which could increase their gross pay by nearly £1,500

per annum. Homes with higher staffing would give individual staff fewer opportunities to earn extra allowances for sleep-in duties and therefore reduce reported salary levels.

Table 9.6 *Keyworker pay in different providers. (Excludes temporary keyworkers). N = 55*

Keyworker pay	Provider			
	A	B1	B2	Total
Not answered	1	2	2	5
£8K to £9K	4	0	0	4
£9K to £10K	0	0	1	1
£10K to £11K	5	8	2	15
more than £11K	3	13	14	30
Total	13	23	19	55

The spread of salary (ranging from between £8,000 - £9,000 to more than £11,000) in the private provider which is part of a national company (Pencolm, which is highly staffed, employer Community Homes Ltd.) could be explained in two ways. Lower paid staff could be part-time or alternatively, the company may have realised that low pay was a factor in the high staff turnover and were paying staff wages more comparable to those employed by BSS. Some respondents may have been team-leaders and thereby attracting a higher salary. They may also have been restrictions about who was eligible to do "sleep-in" duties.

The difference in salary between two local providers (A1 - private and A2 - voluntary) was marked. Although the sample size was small, all of those that answered in A1 were paid between £10,000 to £11,000 and all those employed by Provider A2 were paid between £8,000 - £9,000 pa. Both homes were the same size (5 residents each) and both had high staff to resident ratios because the residents has high needs (high dependency and/or challenging behaviour).

With the exception of the part-timer in Langley House all staff employed by BSS were paid between £10,000 and £11,000 per annum (10 out of 39 who responded) or over £11,000 per annum (27 out of 39 respondents). The questionnaire design did not allow further analysis of those who earned more than £11,000 per year. Considering that the expectation of the role of the keyworker is the nearly the same in all care specifications, a difference of annual salary of more than £2,000 is considerable. It is not known if the terms and conditions of salary are different (local authority staff are contracted to work

37 hours per week and other providers often expect 39 or 40 hours per week with less holiday entitlement and no week-end, bank holiday and overtime rates). These salary scales reflect an hourly rate which ranges from £3.87 per hour (40 hour week) to more than £5.71 per hour (37 hour week) which is a 32% difference. The average for the independent sector in 1994 for this client group was £4.35 per hour (Wynn Davies 1994).

a) Length of time as keyworker and time worked at home

Keyworkers were asked how long they had been keyworker to this resident and also how long the had been working in the home. The homes staffed by BSS staff tended to have the longest serving staff. This was for two reasons. The Provider A homes with directly employed staff were all new homes which opened between October 1992 and March 1993. The Provider B homes were also new, but the residents and staff all came from BSS Part III hostels which were re-provided. Although 9 staff worked at the homes for longer than they had been open, most of the staff had worked for between 1 and 2 years in both types of provider. Similar numbers had worked for a year or less.

The questionnaire was not designed to elicit how often residents had changes in keyworker as this was to be monitored by the quarterly visits. However, if one assumes that changes in keyworker have more to do with changes in staff, one could expect that length of work at the home would be directly correlated with length of time as keyworker. If one further assumes that staff do not become keyworker until some months after they start work, it would be expected that a most staff would have worked longer than the time they were keyworker. This is summarised in Table 9.8 below and shows that this is true. There is evidence to suppose that staff become keyworkers soon after being appointed (27 respondents had keyworker length and time worked in the home in the same range) probably as their induction finished. In many homes all staff were keyworkers and this practice would be expected. Only in more highly staffed homes e.g. Mendip Way and Pencolm were all staff not keyworkers.

The figures in Table 9.8 are derived from Table 8 in Appendix 9 where the length of time a person was a keyworker (recorded in months) was re-coded into intervals. A cross tabulation was done for this against length of time worked. The one person who appeared to be a keyworker for longer than she had worked said she had been a keyworker for 25 months and worked in the home for between 1 and 2 years.

Table 9.7 *Provider type compared to length of employment. Excludes temporary keyworkers. N = 55*

Time worked in home	Provider		
	A	B	Total
No response	1 8%	0 0%	1 2%
< 1 year	4 31%	4 10%	8 15%
between 1 & 2 years	8 62%	29 69%	37 67%
> 3 years	0 0%	9 21%	9 16%
Total	13	42	55

Percentages by column.

Table 9.8 *Keyworker length in relation to time worked. Excludes temporary keyworkers. N = 55*

Keyworker length	**Responses**
keyworker length less than time worked in home	25
keyworker length the same as time worked in home	27
keyworker length greater than the time worked in the home	1
not answered	2
Total	**55**

b) Pay in relation to length of employment

An attempt was made to see if the length of service or time as keyworker affected salary paid. This is shown in Table 9.9. There did not appear to be a relationship between length of time worked and pay - two people working between 1 and 2 years were paid between £8,000 and £9,000 pa whereas two who were employed for less than a year were paid over £11,000. In view of previous comments this probably has more to do with the provider's pay policy than factors such as experience or length of time as keyworker.

Table 9.9. *Keyworker pay compared to employment length (excluding temporary keyworkers). N = 55*

Keyworker pay	Time worked at this home				
	no response	< 1 year	between 1 & 2 years	>3 years	Total
Not answered	0	0	5	0	5
£8K to £9K	1	1	2	0	4
£9K to £10K	0	0	1	0	1
£10K to £11K	0	5	10	0	15
more than £11K	0	2	19	9	30
Total	1	8	37	9	55

The cross-tabulation between length of time as keyworker and pay is shown in Table 9.10 below.

Table 9.10 *Keyworker pay compared to time as keyworker (excluding temporary keyworkers) N = 55*

Keyworker pay	Length as keyworker (months)					
	NV	0..5	6..11	12..23	24..49	Total
Not answered	0	0	3	1	1	5
£8K to £9K	0	3	0	1	0	4
£9K to £10K	0	0	1	0	0	1
£10K to £11K	0	4	6	5	0	15
more than £11K	1	5	5	13	6	30
Total	1	12	15	20	7	55

As with length of time worked, limited experience as a keyworker can lead to a salary difference of at least £2,000 pa. Bearing mind the limitations about the accuracy of the information concerning keyworker salary, one person acting as keyworker for between 1 and 2 years appeared to be paid in the lowest salary scale (£8,000 to £9,000 pa).

9.3 Ensuring quality staff

Griffiths (Griffiths Report, 1988) emphasised the implications for training for all groups concerned as a result of the shift away from institutional care and towards community care. Smith at al (1996) discusses how providers have in recent years recruited staff who are not from the traditional caring professions of nursing and social work and the difficulties this creates in in-service training. A survey of 68 community based

residential units was carried out in the West Midlands which had received people with learning disabilities discharged from long stay hospitals. The providers were NHS Trusts, local authorities, private and voluntary organisations. Their results which are relevant to this study are as follows:-

1. Less than 25% staff received an induction course on starting work.
2. The percentage of care staff attending courses in the last 5 years (this presumably would cover periods with different employers, bearing in mind staff turnover rates) varied from 25% in private establishments to 96% in NHS Trusts.
3. Courses on general precautions were most commonly cited, followed by those on challenging behaviour and philosophy of care.
4. Overall there was no difference between staff who received induction training and those who had not, in terms of their wish for more training
5. Components of training programmes were more likely to be determined by staff preferences and trainer choices, than by systematic analysis of job requirements.
6. Smith et al (1996) confirmed the findings of Allan et al (1990) that untrained staff expressed less need for training than qualified staff. The author's survey did not ask for the existing qualifications of keyworkers.

Mansell (1966) looked at three studies of staffed housing services and the levels of client engagement in meaningful activities and changes in adaptive behaviour. Although looking to explain the previously reported mixed results arising from "exemplary" staffed houses, "mainstream" houses and "institutions", he highlighted evidence that is born out by the keyworker survey in this study. Mansell cites three main reasons for the mixed results:-

1. Unclear goals for staff work with clients and lack of direction of staff by managers.
2. Insufficient preparation and help for staff especially in the area of induction of new staff and appropriate training.
3. An absence of monitoring and accountability especially in the area of outcomes for clients and holding people accountable for elements of the service.

Four areas were looked at in the author's survey which were thought to affect the quality of the staff working in the homes. They were:-

1. Induction
2. Supervision
3. Training
4. Job appraisal

9.3.1 Ensuring quality staff - induction

Clause 5 of the placement contract states that the care provider shall "employ .....sufficient staff of sufficient abilities to ensure the service (is) provided ....to the standard required....". The care specification also laid down performance indicators about supervision (once a month), induction programmes for new staff, training programmes to meet staff needs and preferably a staff appraisal. Although the specification indicated what should be included in the induction programme, questions in this survey were only asked about an induction checklist being used and how long the induction took to complete.

The number of staff in this survey receiving an induction (79%) was much higher than the Smith et al (1996) study (25%). However, Mansell (1966) showed that in the service with "active training" 75% of new staff had received induction. Twelve staff in the author's study (21% of sample) said they had not received a formal induction. Most of the "non-induction" was in homes with BSS staff but even within that B group, provider B1 had a higher percentage of staff receiving induction (83%) than B2 (65%) Figures are in Table 9.11 and Graph 9.11a. The "other" was one person who had transferred from relief staff in a nearby BSS home for children with learning disabilities to a permanent post in the Provider B2 home.

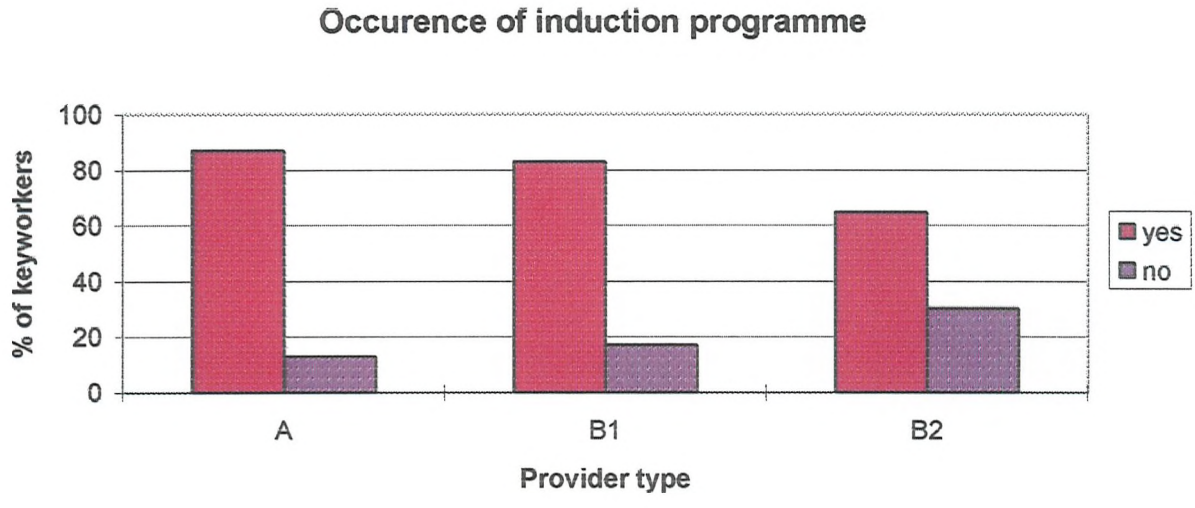
One of the reasons for not being part of an induction programme could be that these staff had worked longer in the home and started before induction programmes became obligatory. Provider B1 and B2 staff tended to be the longest serving.

Table 9.11. *New staff in receipt of formal induction programme. N = 58*

Induction programme	Provider			
	A	B1	B2	Total
yes	13 87%	19 83%	13 65%	45 78%
no	2 13%	4 17%	6 30%	12 21%
other	0 0%	0 0%	1 5%	1 2%
Total	15	23	20	58

Percentages by column.

Graph 9.11a. *Whether new staff had received a formal induction. The "other" in Provider B2 is not shown. N = 58*



Although the 12 without the benefit of an induction were the longer serving staff, half (6) had worked at the home for between 1 and 2 years and the other staff had worked for 3 years or more. The 10 staff who had been working for less than one year all had an induction programme. (see Table 9.12).

Table 9.12. Time worked in relation to formal induction programme. N = 58

Time worked in home	Induction occurs			
	yes	no	other	Total
not answered	1	0	0	1
less than one year	10	0	0	10
between 1 & 2 years	31	6	0	37
more than 3 years	3	6	1	10
Total	45	12	1	58

There did not appear to be a particular pattern in relation to induction and the age of keyworkers. The group of 12 without the induction were spread over the age range, though the oldest staff (6 were over 50 years) and the youngest member (under 20 years) all had an induction. See Table 9 in Appendix 9 for full analysis of induction against age.

Table 9.13 Age in relation to occurrence of formal induction programme. N = 58

Age of keyworker	Induction programme occurs			
	yes	no	other	Total
Under 30 years	22 49%	6 50%	0 0%	28 48%
30 to 39 years	11 24%	4 33%	1 100%	16 28%
40 years and over	12 27%	2 17%	0 0%	14 24%
Total	45	12	1	58

Percentages by column.

End of induction

Of the 45 who had an induction, all but one were completed within 3 months with nearly a third completed within one week. See Table 9.14 for full results.

The more detailed results (in Table 10 of Appendix 9) indicate that all the keyworkers in some (but not all) providers completed the induction within the same time span. e.g. Community Homes Ltd. all within one week and Basildon Trust all within one month and Mendip Way in the period 1 to 3 months. Without further investigation it would be difficult to suggest why there is such variation in induction within providers and it may

be a reflection of the small sample size in the contracts. Also, without knowing what is included in the induction programme it is difficult to know if a provider favours a shorter time because induction is a high priority or whether it is longer because the induction is more detailed and more items are included.

Table 9.14 *When induction programme ends (for those who had induction). N = 45*

Induction ends	Provider			
	A	B1	B2	Total
Not answered	0	1	1	2
Within 1 week of starting work	5	8	1	14
Within 1 month of starting work	2	2	3	7
Within 3 months of starting work	6	8	7	21
Within 6 months	0	0	1	1
Total	13	19	13	45

If a keyworker had an induction programme, all providers favoured the use of a checklist - 43 said they had one and there were 2 non-responses. See frequency counts in Table 18 in Appendix 8 for full details of these results. Again this was consistent with the expectations of the specification.

9.3.2 Ensuring quality staff - supervision.

The care specification stated that all staff should receive monthly supervision and all 58 respondents received regular supervision. Forty five (76%) received this monthly and 12 (21%) less than once a month. Provider B1 had the highest record for supervision with 91% receiving at least monthly supervision. One or two in the less frequent category wrote that they hardly ever received supervision. Only one person received supervision more than once a month and that was fortnightly. Table 9.15 shows the results for each main provider and Table 11 in Appendix 9 gives greater detail.

Some attempt was made to look at possible reasons why some keyworkers were receiving supervision less frequently than the "good practice " outlined in the specification. However, the small sub-sample (12) made this difficult. Cross-tabulations were made of frequency of supervision for those who had had an induction programme, those who had no induction, length of time workers and age (see Table 12 to 15 in Appendix 9 for full details).

Table 9.15. *Frequency of supervision. N = 58*

Frequency of supervision	Provider			
	A	B1	B2	Total
every week	0 0%	1 4%	0 0%	1 2%
every month	11 73%	20 87%	14 70%	45 78%
less than every month	4 27%	2 9%	6 30%	12 21%
Total	15	23	20	58

Percentages by column.

Ten of the 12 with infrequent supervision had been in post between 1 and 2 years and a further 2 between 6 and 12 months. The keyworker receiving supervision fortnightly had been in post more than 3 years. Again age did not seem to be a factor as the responses spread over the middle categories. Even taking into account the temporary keyworkers, there were still 12 receiving infrequent supervision (N = 55). (See Table 16 in Appendix 9). Therefore, no information from the questionnaire yielded information about reasons for different frequency of supervision.

9.3.3 Ensuring quality staff - training of staff

Nearly all staff had received some training during the previous year to help them with their keyworker role (Q7). Forty two keyworkers (30 women and 12 men) said they had attended some courses and 41 people (31 women and 10 men) said they had received some other training. (See Table 17 and 18 in Appendix 9).

Respondents were asked to write down the courses they had attended (Q7a) or any other sort of training they had received (Q7b). It was hoped to find out from this how much training was done as an informal level or ad hoc basis and how much was on a more formal basis, away from the workplace. However, respondents interpreted this question in different ways. A visiting speaker to talk about AIDS/HIV to one home would be regarded as "attending a course" by some respondents and "other training e.g. visiting speaker" by others in the same home.

Before looking at the more detailed answers, it was decided to combine the answers for "attending courses" (Q7a - a score of 1 if this was completed) with those with answers for "other training" (Q7b - also a score of 1). This became a column entitled "some training". Temporary keyworkers were excluded from this analysis

***Table 9.16**. Keyworker training received in last year. Excludes temporary keyworkers. N = 55*

Keyworker training	Provider			
	A	B1	B2	Total
Not answered	1 8%	0 0%	2 11%	3 5%
No training	0 0%	3 13%	1 5%	4 7%
Some training	19 146%	39 170%	21 111%	79 144%
Total	13	23	19	55

Percentages by column.

Provider B2 accessed the least training (score of 21 for 19 keyworkers), yet Provider B1 had three staff who received no training. See Table 19 in Appendix 9 for full results.

Raw counts of training inputs

Each course or record of training mentioned in the text answers was given a score of 1 and the sum of these became a raw count for each keyworker. The raw count scores were no more than an indication of the discrete numbers of training inputs the keyworkers had received in the previous year. This would lower the score for staff who had worked in the home for less than one year (10 keyworkers). (See Table 20 to 27 of Appendix 9 for full results relating to raw counts).

In all 172 different items were mentioned giving a mean score of 3.4 per keyworker. This is summarised in Table 9.18 below. Results of raw counts by contract are shown in Table 24 in Appendix 9.

Table 9.17 *Raw counts of training inputs. NV = no value, no training recorded. N = 58*

Raw count	Provider			
	A	B1	B2	Total
NV	1	3	3	7
	7%	13%	15%	12%
1	3	0	8	11
	20%	0%	40%	19%
2	4	5	1	10
	27%	22%	5%	17%
3	4	7	1	12
	27%	30%	5%	21%
4	0	4	0	4
	0%	17%	0%	7%
5	1	1	1	3
	7%	4%	5%	5%
6	2	1	2	5
	13%	4%	10%	9%
7	0	2	3	5
	0%	9%	15%	9%
9	0	0	1	1
	0%	0%	5%	2%
Total	15	23	20	58

Percentages by column.

Variety of training

An attempt was made to combine and categorise the text answers to the questions about training. The categorisation was under two main headings

1) Formal - either courses away from the home or visiting speakers or professionals
   e.g. basic course on people with learning disabilities; pharmacist coming to the home to talk about the Boots monitored dosage system; a community nurse coming to talk about continence; Family Planning Association on personal relationships and sexuality.
2) Informal - being shown how to do something or working alongside another staff member. e.g. help from previous keyworker on report writing; full team discussion on lifting methods for this client; staff reporting back on own training and experience

1) Formal training

Those with "formal " headings were further categorised into those areas mentioned in Clause 5.2 of placement contract and Section 11 of the care specification (operational policies). These formed the categories F1 to F6. The categories were:-

F1	fire precaution
F2	health and safety
F3	risk taking
F4	personal and sexual relationships
F5	sanctions
F6	management of aggression, including challenging behaviour

Other courses were categorised F7 to F10

F7	internal organisation e.g. report writing, supervision, anti-discrimination, appraisal, pensions
F8	general courses e.g. ICSC, NVQ which were day release
F9	courses relevant to this client group e.g. basic care, autism, bereavement, life story, Patterns for Living, Individual Programme Planning (IPPs)
F10	induction

Responses varied from one person at Allenby who said her only training was "from other staff and what I have picked up" (coded I1) to "I am deputy manager and am aware of keyworker role, responsibilities and care plans" - Pencolm (coded as no training).

If a keyworker had more than one training input in any category, this was counted as one for the purposes of looking at the areas of training. Consequently the total number of inputs for formal training (114) and for informal training (20) is less than the total score of raw counts (172). The full figures are in Table 26 and 27 in Appendix 9, but the Table 9.18 below combines those responses relating to "policies" training (areas F1 to F6) and the "other training" category is for areas F7 to F10.

Table 9.18 *"Formal" training received by keyworkers in previous year. N = 58*

Areas of "formal" training	Provider			
	A	B1	B2	Total
Not answered	3 20%	3 13%	4 20%	10 17%
Training relating to policies	11 73%	25 109%	24 120%	60 103%
Other training	12 80%	27 117%	15 75%	54 93%
Total	15	23	20	58

Percentages by column.

Courses relating to people with learning disabilities were mentioned 25 times (52%) in the formal training category as was health and safety (25 mentions) by the 48 keyworkers who responded to this part of the questionnaire. Managing aggression (10 or 21%), personal relationships (12 or 28%) and fire precautions (11 or 23%) were also mentioned fairly frequently.

Despite the fact that two providers who directly employ staff (Providers A - Pencolm and Mendip Way) were providing a service for residents who were known to have challenging behaviour which included aggression and unacceptable sexual behaviour, no staff in these contracts said they had received training in the management of aggression, personal relationships or risk taking. One keyworker from Pencolm said she had received training in sanctions and could be that some of the areas mentioned above were covered by training in health and safety at work.

Mansell (1996) highlighted the lack of appropriate training with $^{3}/_{4}$ not having any training in skill teaching or managing problem behaviour. He concluded that "community service were being set up without a cadre of well-trained staff at team leader level with many striking gaps in the training offered to unqualified staff in the team".

2) Informal training

Those under the "informal" heading was similarly sub-divided into

I1 general or non-specific

I2 fire precautions or health and safety

I3 relating to policies

I4 internal organisation

Table 9.19 *Frequency count for "informal" training. N = 17*

"Informal" training	Frequency
General	9
Fire, health + safety	3
Relate to other policies	3
Internal organization	5

Far fewer keyworkers made reference to informal methods of training (20 references from the 17 keyworkers who responded) - this may be because staff do not see informal methods as "training". Nearly half (9 - 45%) were in the general category (I1) and 2 people referred to supervision in this category. See Table 26 and 27 in Appendix 9.

Very few keyworkers (2 out of the total) received training in risk taking, though this may have been covered by the health and safety (F2) category. As will be seen on the section on care planning and individual programme planning, this was a live issue during the year of the questionnaire because of the death of a resident in a Berkshire home where staff were directly employed. This home was not part of the case study, although the provider did have block contracts with BSS which were part of this survey.

Various attempts were made to analyse why some keyworkers appeared to mention they received a lot of training whilst others felt they had little or nothing. It may be related to whether they had a formal induction. Nine out of the 12 (75%) with no induction received some training (raw counts ranged from 1 to 5 with a mean of 2.3 inputs). Forty-one of the 45 (91%) of the keyworkers who had an induction participated in more training in the previous year (raw counts ranged from 1 to 9 with a mean of 3.5 inputs). Those people who had an induction may have felt more positive about training and availed themselves of training opportunities. Alternatively, they may have recorded training inputs which staff without an induction did not consider as such (see Table 22 and 23 in Appendix 9 for full details). Only 4 staff included induction as part of training and in the case of Provider B1 this was Berkshire Social Services' induction to the whole department rather than to the home.

Identifying training needs

As well as staff being offered the opportunity to undertake training, this also needs to be planned to meet the specific needs of the staff member. Everyone answered this question. The most popular response (mentioned 43 times - 74%) was to the statement "my supervisor and I know where I need extra training as it is discussed in supervision

and we both keep an eye open for courses". BSS staff relied more heavily on supervision (about 80% of sample) compared to directly employed staff (A providers) who mentioned it 8 times (53%)

Staff also like to keep their own eye open for courses as this was mentioned 32 times (55% of group). There was a difference within the social services staffed homes where B1 keyworkers mentioned this 18 times (78% of the sub-sample) where B2 keyworkers only mentioned it 5 times (28% of sub-sample). Full answers are in Table 28 and 29 in Appendix 9 and Table 9.20 below gives a summary.

Table 9.20 *How training needs are identified. N = 58*

How training identifed	Provider			
	A	B1	B2	Total
Know what need, keep eye on courses	9 60%	18 78%	5 25%	32 55%
Discuss in supervision & keep eye open	8 53%	19 83%	16 80%	43 74%
Through supervision	3 20%	4 17%	2 10%	9 16%
Like more but not offered	0 0%	1 4%	2 10%	3 5%
Like more but courses full	0 0%	6 26%	2 10%	8 14%
Courses I like are too expensive	5 33%	0 0%	2 10%	7 12%
Courses offered and we wait our turn	2 13%	4 17%	3 15%	9 16%
Other	1 7%	1 4%	2 10%	4 7%
Total	15	23	20	58

Percentages by column.

Staff appraisals

The specification recommends that an annual appraisal would be a useful vehicle to having staff needs identified and a programme to meet these needs. Forty-two out of 58 (72%) said that they had a staff appraisal (Q13). Table 9.21 shows that staff appraisal systems were in operation but were better established with BSS staff (B providers) than with the directly employed staff (A providers). The answer "yes" or "no, but I will soon" were taken to assume that the appraisal system was in operation. In only one

individual provider (Allenby) did all the keyworkers believe there were no staff appraisals. See full details in Table 30 and 31 in Appendix 9.

However wide ranging and relevant the training undertaken by keyworkers, there is a need to ensure their training needs are identified. Again BSS staff had a much higher proportion of keyworkers who felt their training needs had been identified for the coming year (nearly $^{3}/_{4}$) whereas only 27% in provider A homes felt they had been so identified.

Table 9.21. *Use of staff appraisal systems by type of provider. N = 58*

Appraisal systems	Provider type		
	A	B	Total
Yes	10	35	45
	67%	81%	78%
No	5	7	12
	33%	16%	21%
Uncertain	0	1	1
	0%	2%	2%
Total	15	43	58

Percentages by column.

Table 9.22 *Whether training needs are identified for the next year. Excludes NR. N = 55*

Training identified this year	Provider			
	A	B1	B2	Total
yes	4	17	13	34
	27%	77%	72%	62%
no	11	5	5	21
	73%	23%	28%	38%
Total	15	22	18	55

Percentages by column.

The figures for staff who had participated in a staff appraisal are shown below and more detailed results are in Table 32 & 32a in Appendix 9.

Table 9.23 *Whether future training needs have been identified - staff who have had staff appraisal. N = 42*

Training identified thisyear	Provider			
	A	B1	B2	Total
Not answered	0	1	2	3
	0%	5%	12%	7%
yes	3	15	10	28
	43%	79%	62%	67%
no	4	3	4	11
	57%	16%	25%	26%
Total	7	19	16	42

Percentages by column.

Although the sub-sample was small (7 respondents) the number of staff having their training needs identified was an improvement for directly employed staff (A providers) - an increase from 27% to 43%. Social services staff in the B providers did not always use staff appraisals as a vehicle for identifying training needs, though the majority did. However good the provider was at offering courses and other training, 26% (11 out of 42) of staff having a staff appraisal did not feel their future needs in this area had been identified.

9.4 Overseeing the quality of care

Two perspectives were investigated - the proprietor and the keyworker

9.4.1 The Proprietor's view

A distinction was made in the questionnaire about who the keyworker felt oversaw the quality of care in the home and the ways used to review the service.

In August 1994 the author wrote to all six providers to ask how they consulted service users (clause 14.3 and 14.4 of the care specification) and how they monitored and evaluated their service (clause 14.5 of the care specification). Only two replies were received - one where BSS staff were working and one where the staff were employed directly. (Thames Consortium and Mendip Way). In both cases Berkshire Social Services was either the sole or major purchaser of care from that organisation which may have been the reason for the greater compliance with the purchaser who monitored.

Provider B2 (Thames Consortium) made no distinction between homes where BSS staff were supplied in kind or through a care contract. In all homes except one (Blossom

Cottage) regular residents' meetings were held where "residents are encouraged to comment on the care offered and to make suggestions for changes". Because of the communication difficulties of the residents in Blossom Cottage, residents' meeting were not felt to be appropriate and so parents' meeting are held instead every 4 to 5 months. In all the homes run by this proprietor, residents were encouraged to "make choices in their everyday life and staff work closely with relatives to ensure easy communication so that all feel confident to bring up concerns".

The consortium's management committee had established a quality assurance sub-committee which met six times a year. The Care Services Manager (CSM) reported back to the sub-committee on the monthly proprietor's visits (these visits are a legal requirement of the Registered Homes Act 1984). They had also commissioned a consultant clinical psychologist to carry out a quality of life study from July 1992 to December 1994. Only one of the homes which formed part of this study was excluded from the quality of life study. The results of this study were not shared with the author.

The other proprietor (Peter Brown) who employed his own staff listed the various ways the home consulted the service users and their families as well as monitored and improved the quality of the service provided. The residents in this home were some of the most dependent in all the homes surveyed and had major communication difficulties. A speech therapist was involved to help service users participate in activities designed to improve communication. Staff also offered as much choice and self determination in daily living as possible. The proprietor said the residents' families were closely involved, being invited to the six-monthly review and the annual service review. Parents also received monthly reports about the service user and were encouraged to read the daily diary relating to their son or daughter.

This proprietor monitored the care through his weekly supervision with the registered home manager. There was also regular supervision of other staff. He made reference to a new assessment and review process which would be soon implemented where objectives were to be set with service users and families and thereby improving the quality of care. Additionally an annual staff appraisal system was to be introduced.

As these two proprietors were clear about their role in consultation with the service user and monitoring, one would expect this to be reflected in the answers from the keyworker questionnaire.

9.4.2 The keyworkers' view

In the last section of the questionnaire keyworkers were asked about contract monitoring and to think about the home in general not just their particular resident. In the specific question about overseeing quality of care a list of options was presented and the opportunity to add other ways. All 58 keyworkers felt the registered manager was responsible for oversight and the next most commonly mentioned person was the inspector (45 or 78%) and the area manager of care services manager (43 or 74%). The keyworker also felt they were important (40 or 69% responses) and this was rated higher than the proprietor (33 or 57%) who under the Registered Homes Act 1984 is the responsible person. It was not certain how clear keyworkers were about who the proprietor was and what their role entails. Only 9 (39%) of Provider B1 keyworkers and none at Valley House (a national voluntary organisation) mentioned the proprietor. Table 9.24 gives the full results by provider type and Table 71 in Appendix 9 shows full results by contract.

Table 9.24 *Who the keyworker thinks oversees the quality of care. N = 58*

Who oversees quality of care	Provider type			
	A	B1	B2	Total
Proprietor	10	9	14	33
Registered manager	15	23	20	58
Senior person on duty	12	12	7	31
Inspectors at Shire Hall	10	20	15	45
Area manager or care services manager	9	19	15	43
Keyworker	12	11	17	40
Care manager (social worker)	4	8	7	19
Monitoring officer of SSD (purchasing)	9	3	9	21
Anyone else (stated)	5	7	4	16
Total	15	23	20	58

Table 72 and 75 in Appendix 9 compares responses for the two proprietors who replied to the author (Provider A1 and B2). At Mendip Way (Provider A1) all the keyworkers

mentioned the proprietor, the registered manager, the senior person on duty and the keyworker as overseeing the quality of care. The inspectors and care managers were mentioned only once (perhaps because they visit less frequently). The responses to who else oversees quality included the team as a whole as important (2 out of 2) and parents (1 out of 2). These responses fitted in with what was expected from the correspondence with the proprietor.

In terms of the correspondence with the proprietor of Provider B2, the author would have expected mention of the proprietor and the Care Services Manager (CSM), in addition to the registered manager. The proprietor was mentioned more frequently in B2 (70%) keyworkers than in B1 staff (39%). This was reversed for the CSM (75% in B2 compared with 83% in B1).

The BSS monitoring officer was not rated highly in B1 homes, and was mentioned most frequently in Provider A contracts, where most of the intensive visiting had taken place. A similar frequency (though lower percentage) was mentioned in the B2 homes but this may have been because of the relative newness (albeit limited) of the presence of the monitoring officer.

For the 16 keyworkers who mentioned other methods for overseeing the care, their responses were categorised into

1. the team as a whole
2. the resident
3. parents or relatives
4. advocates

The team as a whole was mentioned most frequently (11 times) and relatives 5 times. Frequency counts are in Table 73 of Appendix 9. Table 9.25 below gives the results of who else oversees the quality of care.

Table 9.25 *Who else the keyworker feels oversees the quality of care. N = 16*

Categories of other people who oversee quality of care	Provider type			
	A	B1	B2	Total
Team as whole	2	6	3	11
Resident	1	1	1	3
Parents/relatives	4	1	0	5
Advocates	1	0	0	1
Total	5	7	4	16

Pencolm (provider A3) keyworkers felt the proprietor was important (all 5 noted this) but they also made 5 responses to the registered manager, the senior person on duty and the area manager. This home had been relying on an acting manager for a year before a new registered manager was appointed in August 1994. The area manager had visited regularly throughout this inter-regnum and the inspectors had investigated concerns by care managers and relatives.

With other providers, the proprietor does not feature so highly. At Valley House (provider Care Unlimited - a national voluntary organisation), keyworkers make no reference to the proprietor, the care manager/social worker nor the senior person on duty. All mention the area manager (who is the local representative of the proprietor) and the keyworker. In this home staff often work on their own so there is unlikely to be a shift leader in the same way as in a more highly staffed home.

With Provider B1 where less than 40% mentioned the proprietor, new staff had continued to be employed by BSS with an existing management structure including a CSM. Provider B1 keyworkers also felt the team as a whole was important. In Provider B2 newly appointed staff were employed by the provider and seconded to BSS. The proprietor of B2 was also more conscientious about his monthly visits. In the early months when the organisation was small he had done these personally until an area manager was seconded to the provider from the BSS.

9.4.3 Reviewing the service

Every keyworker felt that the home had ways of reviewing the overall service. (NR = 1). The guidelines on the registration and inspection of residential care homes by Berkshire Social Services Department (BSS, 1994a, page 25) state as part of their mission statement that they wish to support good management and not replace it. "The responsibility for ensuring service delivery of the right quality and for monitoring outcomes rests primarily with those providing the service, whether they provide it directly or purchase it". It would be therefore be appropriate for the Inspector to include in their report an evaluation or judgement on the standard of the internal reviewing and monitoring methods as observed by them.

It was known that a number of ways of reviewing services were in operation and these were mentioned specifically in Q46 and there was also an opportunity to add other ways. The Annual Establishment Review (AER) had been the standard method in BSS but it was known that proprietors' own systems often included an annual (service)

review. Ten keyworkers ticked both boxes (Q46, part 2 and 3). Table 74 of Appendix 9 gives a frequency count for this question.

Nearly all keyworkers felt that the Inspectors from Shire Hall were part of the system for reviewing the service (54 out of 58 - 93%), as were staff meetings and supervision (52 or 90%). After this, residents' meetings were mentioned most frequently (44 or 76%). The contract specified that residents should be formally consulted every year by means of a questionnaire and 22 keyworkers (38%) mentioned this. How this differed from resident's meetings was not explored and the author had not seen any results of formal consultation with residents during the period of the research study. Seventeen (29%) said their employer had its own systems and 27 (47%) referred to an AER.

Eight keyworkers mentioned other ways of reviewing the service and gave further information. Three of the responses could best be described as the proprietor's monthly visit (an expectation if the proprietor is not the registered manager which was the case in all the contracts). One keyworker mentioned relatives and another the complaints/compliments book. There were 3 references to residents being involved and these ranged from "informal consultation with residents" to "monthly questionnaires to sort out any problems" to "residents have their own meetings where they can raise concerns". This latter would be distinct from residents meetings which tend to be facilitated by staff. One keyworker also referred to the annual business plan but they were one of the temporary keyworkers who was also the registered manager and it is not certain to what extent other keyworkers were involved with business plans. Table 9.26 gives a summary of the ways keyworkers feel the service is reviewed by provider.

In view of the comments by the proprietor of B2 (Thames Consortium) and Peter Brown, these results were looked at more closely. Those relating to Provider B1 were also compared to Provider B2 as staff were employed or managed by the same sub-contractor. Full results are in Table 75 and 76 in Appendix 9.

In Mendip Way (provider A1) the keyworkers mentioned an AER and/or their own system, inspectors visits (copies of reports are sent to families and care managers) and formal consultation with residents. Staff meetings/supervision were mentioned by all keyworkers whereas residents' meetings were only mentioned once.

With the Thames Consortium (provider B2), six (33% of respondents) mentioned the employer's system (only 1 - 4% referred to this in B1) and 11 (61%) made reference to an AER (7 or 30%- of B1 keyworkers referred to an AER). More than half (11 - 61%)

of the Thames Consortium keyworkers who responded referred to formal consultation with residents compared to 7 (30%) for Loddon Consortium (B1) keyworkers. Perhaps because of this, the response rate for residents' meetings was lower (15 - 83% for B2 and 22 - 96% for B1). Nearly all keyworkers in B1 and B2 referred to the inspector's role in reviewing the service. There appears to be only some similarity to the keyworkers' answers in Provider B2 and B1. Provider B1, in addition to the contracts that are part of the case study, also runs a number of other homes where the staff are directly employed and/or are seconded from an NHS Trust. Provider B2 is a smaller organisation with no homes run by directly employed staff so they may have found it easier to have established a corporate identity and policy for quality assurance.

Table 9.26 *Keyworkers' views about the ways the overall service is reviewed. N = 58*

Ways of reviewing service	Provider type		
	A	B	Total
Not answered	0 0%	2 5%	2 3%
Inspector's visits from Shire Hall	13 87%	41 95%	54 93%
Employer has own system	10 67%	7 16%	17 29%
Annual establishment review	9 60%	18 42%	27 47%
Staff meetings, supervision	13 87%	39 91%	52 90%
Residents' meetings	7 47%	37 86%	44 76%
Formal consultation with residents	4 27%	18 42%	22 38%
Any other (stated)	2 13%	6 14%	8 14%
Total	15	43	58

Percentages by column.

Keyworkers were also asked how they put forward their views about the quality of care. The answers were categorised into:

1. staff meeting
2. supervision
3. clients meetings

4. senior staff meeting
5. other
6. keyworker meetings (referred to in section on care planning and reviews).

Several keyworkers gave more than one answer and each different was coded into one of the 6 categories above. Table 9.27 gives a frequency count and Table 77 in Appendix 9 shows the results by provider type.

Table 9.27 *How keyworkers put forward their views on the quality of the service.*

Keyworker & quality	Frequency
Staff meetings	43
Supervision	33
Clients meetings	2
Senior staff meetings	3
Other	23
Keyworker meetings	8

The "other" category covered such suggestions as "I get on and do it" and "speak up when I need to" to liaising with other colleagues, care manager, relatives. Nevertheless, the majority of keyworkers relied on staff meetings (43 - 85% of 53 who answered) and supervision (33 -62%) to put forward their views. This was entirely consistent with the view that keyworkers hold that the way of reviewing the service (apart from the Inspectors' visits) is through staff meetings and supervision.

Chapter 10.

Responses to the questionnaire - residents' quality of life

This chapter concentrates on outcome measures as described in the way keyworkers carried out their responsibilities. Appendix 7 gives all the references in the contract documentation to keyworker roles and tasks. There are four main areas which cover the responsibilities of the keyworker in these texts. They are

1) appropriate care plan for the individual
2) helping to maintain relationships with friends and family and social activities
3) health needs for the individual
4) helping residents to make appropriate choices.

The questionnaire results were used to look at each of these four areas.

10.1 Appropriate Care Plan

Care planning has become an important tool in the delivery of services for people with learning disabilities. It was spelled out in section 5 of the care specification on the contacts in this research study and many proprietors make reference to them in their brochures. There was an established mechanism within Berkshire for care planning and review which is described in section 10.1.2. Section 10.1.1 is a review of literature which describes various methods of care planning and shows how they were transformed into individual programme planning (IPP) methods. The section also looks at evaluation that have been carried out on IPPs and highlights the limitation of existing mechanisms to work with people with learning disabilities to achieve valued services which meet their needs.

10.1.1 Background and development of individualised planning

During the 1970s attempts were made to formulate written plans for use with people with learning disabilities. Houtts and Scott (1975) was a good example of this method as was the Portage system for children (Shearer and Shearer 1972). The Beereweeke assessment and teaching scheme for adults (Felce et al. 1983) and Schater et al (1978) were other examples. Most of the authors came from a psychology background and encouraged staff to be more directed and focused in their work to improve the skill level

and overall level of independence of clients. As well as setting targets or "goals" to meet, these care planning systems often incorporated systematic learning packages and teaching methods. As time progressed practitioners realised that such goal planning was being done to service users and was not necessarily related to the needs and wishes of the individual nor did it reflect the range of services and others concerned with the service user's life. Attempts to make the services more individualised and needs-led gave rise to the development of individual planning (e.g. Blunden 1980) or individual programme planning (e.g. Jenkins et al. 1988).

It is helpful to distinguish goal planning (the process whereby specific goals for the individual and the means to achieve them are identified) and individual programme planning. IPPs are a mechanism for providing individually tailored help or services to people with learning disabilities and involves all those connected with that person included the person themselves (Miles, 1990c). Implementing IPPs into a service led to a variety of IPP systems or schemes. Apart from the two mentioned above (Blunden 1980 and Jenkins et al 1988) there are also STEP life planning (Chamberlain 1985 a, b), personal futures planning (O'Brien 1987b), shared action planning (Brechin and Swain 1986, 1987) and individual habilitation plan (Horrer et al. 1990 described in Sigafoos et al. 1991). The common elements of an IPP system are described later in this chapter (section 10.1.2) in the section on the Berkshire IPP system. Personal future planning and shared action planning are felt by Sigafoos to be more be user-led and person centred than some of the earlier IPP systems. More recently a Local Authority Circular (DOH 1992) stressed the aim of moving towards a "personally planned programme of day activities .... which make use of ordinary community facilities wherever practicable". Goal planning is often an integral part of individual programme planning but can happen in isolation or within other planning or review systems that do not rely so heavily on the assessment of individual needs (Dagnan and Sturmey 1993).

The evaluation of a number of IPP schemes has been described in the literature and Table 10.1 and 10.2 give a summary of the results (information from Sigafoos et al. 1991, Grant et al. 1986, Humphreys 1985, Fleming 1985 and 1988, de Kock et al 1985, Dagnan and Sturmey 1992, Laws et al 1988). A brief description of the various schemes follows (all of which were similar to the one described in section 10.1.2):

1. Fleming (1985) - an IPP system for 70 hospital residents which began in 1982 and where IPPs were held at approximately 10 month intervals.
2. Fleming (1988) - 85 IPPs developed between June and December 1985 for a local authority hostel (29 places) and an adjacent 70 place adult training centre in Salford.

3. Laws et al (1988) - showed the changes that had occurred in a long stay hospital when an existing review system (1984) was changed to an IPP system (1986).
4. Humphreys et al (1985) - evaluated the individual planning system developed by NIMROD (Blunden 1980). The NIMROD service was an experimental community based project to establish comprehensive services in one area of Cardiff. The 19 clients were a 23% sample of those NIMROD residents who had IP meetings during a 6 week period in 1984. These 19 clients were representative of the entire population of NIMROD clients in terms of age, residential settings, previous experience of the IP system and degree of handicap.
5. Dagnan and Sturmey (1993) - looked at joint case reviews and life plans for over 80 of the 125 residents of a long stay hospital in the West Midlands.
6. Wright and Moffatt (1992) - investigated the effectiveness of the IPP system they were involved with in 12 locally based hospital units (LBHUs) in East Dorset. They looked primarily at staff attitudes and there is less quantitative data than the other studies.

A number of authors have concentrated on the development and evaluation of IPPs in Wales under the All Wales Strategy which had grown out of the NIMROD initiative. Sweeney (1981) reported that 7 years after the All Wales Strategy began only 2,611 people out of the 10,129 people with learning disabilities in Wales (25%) had a "systematic individual plan". He also questioned the accuracy of how many IPs had been updated in 1989 as the range was 60% in Gwent to 100% in Mid-Glamorgan and Powys. McGrath (1991) in her chapter on individualised planning and service delivery described how IPPs have been implemented to varying degrees within the counties of Wales. She compared the plan co-ordinator role [described in the revised guidelines by Blunden et al (1987)] to the "case manager". This latter was a role that had been developed in the USA and incorporated into the publication of the Griffiths Report (Griffiths 1988) and the subsequent White Paper (DOH, 1989). Although not a prime area for exploration in this author's research study, it is interesting to note that McGrath felt a distinction should be made between case (care) management activities with parallels to traditional social work and a case (care) management system with mechanisms for inter-agency service co-ordination and for linking client co-ordination with service planning and development (McGrath op. cit. Chapter 5).

Greasley (1995) highlighted 3 areas of dissatisfaction with earlier IPP systems of assessment and planning:-

1) goals reflect service aims rather than client aims
2) insufficient involvement of clients and carers
3) too much emphasis on personal inadequacies rather than client strengths and capabilities

By only looking at who attended the IPP meetings and the goals set, these evaluations also indicate the limitations of IPP schemes is there is no emphasis put on O'Brien's five accomplishments or the degree of service users' involvement.

Who attended the IPP meeting - from review of literature

In most of the studies quite a large number of people attended the IPP meeting - about 6 or 7 per meeting though the range was much greater. Generally the service user and their relative attended although this was less likely in the Dorset study (Dagnan and Sturmey 1993). As with community presence and community participation, being at an IPP meeting or review does not guarantee meaningful participation. Wright and Moffatt (1992) showed that there were mixed opinions by staff about client/family involvement. Most said that client should be there "sometimes", 66% thought relatives should be there and the other third thought they should attend "sometimes". Humphreys and Blunden (1987) indicate that there is a fundamental conflict between client related issues (choice, expression and client involvement) and service related aims (efficiency, planning, economic use of time, organisation, co-ordination and other administrative duties).

Table 10.1 *Comparison of who attends IPP meetings from the review of literature*

	Fleming (1985)	**Fleming (1988)**	**Laws et al (1988)**	**Humphreys et al (1987) - NIMROD**	**Dagnan (1993) Joint review**	**Dagnan (1993) Life Plans**
Sample size	68	85	35	19	87	83
Number attending - (average)	6.39	5.86	7.8	7	6.7	6.1
No. attending (range or standard deviation)		3 to 11	5-11		S.D. = 1.7	S.D. = 1.7
Client attending		82.2%	8.6%	18 out of 19 (94.7%)	14 (16%)	30(30%)
Relatives attending		22.3%		14 out of 19 (73.6%)	13 (15%)	30 (35%)

Goals set at IPP meeting - from review of literature

A major element in individual programme planning (NIMROD, Shared Action Planning, Berkshire SSD) is that the needs of the service user are agreed upon and prioritised. Objectives or goals are then set to meet these priority needs. Reference to setting of objectives were contained in the care specification of the contracts which are part of this study. As far as possible goals should be written as performance statements or behavioural objectives - who will do what, under what conditions or with what help and how often (Miles, 1990c). The objectives are agreed by all those at the meeting and one person is responsible for ensuring that the goals happen. This one person is likely to be the keyworker in the residential home or a day centre, but it could also be a client or a relative depending on the objective. In order to limit the criticisms of Greasley (1995) most, if not all goals/objectives would be expected to be achieved by the time of the next IPP/review. If they were not, it could be because the objective set was unrealistic or too ambitious, external factors not known at the time intervened, or commitment to work within the framework set at the IPP was lacking.

In addition any evaluation of IPPs would need to look at the suitability of the goal or objective set. Dagnan and Sturmey (1993) give the most detail about how they evaluated the goals set at IPP meetings. They looked at technical adequacy, goal content and goal quality.

Technical adequacy -	goal should have a named individual responsible for its achievement, a date by which is to be achieved and stated such that the outcomes are objectively measured
Goal content -	classified by the life domain in which the goal fell (health, communication, self - help, social, vocational or community life)
Goal quality -	classified by functionality of goals and skills involved (whether the goal was age appropriate, involved use of naturalistic materials and settings). Quality was also assessed on how well it fitted the ideology of O'Brien's five accomplishments.

In Fleming's (1985) study only 38.5% of all goals were achieved but that was because in 50% of the cases, the achievement was not reviewed at the next IPP review so achievement level could have been artificially low. Although $^{2}/_{3}$ of the goals in the NIMROD evaluation (Humphreys et al, 1986) were said to be achieved, but only 8 of the 61 included conditions and criteria of attainment which allowed an accurate

evaluation of their outcome (Grant et al, 1986). In other words they were "fuzzy". In addition few goals (less than a third) were meeting O'Brien's five accomplishments especially in the area of community participation (e.g. promoting the use of non-segregated community facilities) or promoting independence. The authors (Grant et al, 1986) pointed out the need to ensure that any IP system had internal review procedures built into it. Without this it could appear to be efficient, on the basis of familiarity and regularity, but without any substantial effect on the lives of consumers.

The limitations of the Laws study (1988) was that the success or otherwise of review goals were evaluated only one month after the review/IPP meting. Nearly 40% were achieved which would imply they did not involve skill acquisition. If goals did involve other elements of O'Brien's 5 accomplishments (e.g. community presence, community participation, dignity, choice), one would want to know if these changes were sustained over a longer period than a month.

Table 10.2 *Comparison of goal planning in IPP schemes from the review of literature*

	Fleming (1985)	**Fleming (1988)**	**Humphrey et al(1986) NIMROD**	**Laws et al. (1988)**	**Dagnan (1993) Joint review**	**Dagnan (1993) Life Plans**
Sample size	85	68	19	35	87	83
Number goals set (average)	2.82	3.36	3 goals, 6 staff tasks		3	6.7
Goals set (range or S.D.)	1 to 6	2 to 5	0-7 goals 0-9 tasks	2 to 4	S.D. = 1.75	S.D. = 2.6
Named individual	74.8%	all	93.4% goals 99% tasks	95%	33%	100%
% goals achieved (All)	75% of 50% recorded outcome	38.8%	66.6%	40% within 1 month	no record	Av. 34% from 67 records (S.D. = 25)
% achieved - some		6.9%		18% progress after 1 month		
% achieved - none		21.5%		15% unrealistic, 13% lack of resources		28% goals ongoing

Sigafoos et al (1991), who reviewed IEPs (individual education plans) for children, found that 30-40% had non-functional or age-inappropriate objectives and felt that those for adults would have similar limitations. He found that a programme of technical assistance to direct care staff improved the quality of the IP and encouraged short term objectives to fit with longer term goals. There was still room for improvement in the areas of age appropriateness and being functional. Results from the NIMROD evaluation (Grant et al. 1986) showed that only 3 out of 61 goals set for clients (as opposed to staff tasks) were judged to be culturally and age appropriate.

In addition, Fleming (1988) noted that 32.8% of the original goals were found to be too ambitious for individuals within the time allowed, but individuals were presumably working towards the goal as they were making progress in the relevant areas of skill acquisition. Frequent IP meetings (such as those proposed by the NIMROD scheme) may fail to encourage an emphasis on the medium and long term planning element. Mansell et al. (1987) recognised the need to relate medium term objectives to long term life goals and thought that as services became more co-ordinated, there would be less need to use the IPP meeting to negotiate between agencies. Although the content of the goals/objectives of the IPP meeting was not requested in this survey, there did not always seem to be efforts to co-ordinate especially round the time of the IPP/review. Table 10.10 in section 10.1.4 shows that only 22 out of 41 keyworkers in this study contacted their opposite number in the day centre before the IPP review.

Dagnan and Sturmey (1993) reached similar conclusions about the quality of goals or objectives. Goals set through the later life plan system showed them to be of a higher "standard" than those set in the joint case review system. They were more likely to be functional, ideologically acceptable (i.e. met more of O'Brien's five accomplishments) and technically adequate. Despite this better standard between the old and revised system there was still room for much improvement. 100% of goals set in the life plan system were age appropriate and had a named individual responsible. However, only 12% used natural environments and involved community participation. Even looking at goals content in the life domain scores, community living was still a low priority

The later sections in this chapter relating to the implementation of IPPs/reviews from the survey results confirm much of what Greasley (1995) has written. For example the description of the links the keyworker had with other agencies showed it was rudimentary or non-existent, and the confusion between care plans and IPPs. The implications of this action research are that care managers and providers could do much

more to link together information gained at the client level to enhance service quality as well as feed this into areas of service planning and development.

10.1.2 Background to care planning and individual programme planning in Berkshire

Berkshire SSD have had a tradition of holding annual reviews for individuals who lived in SS residential homes or attended a SS day centre. These reviews were rarely held in conjunction with each other though in some areas there had been some changes. Since the late 1980s staff in the day centre at Bracknell attempted to combine the reviews held in the SS hostel with those of the SS day centre as well as set and review achievable goals for the individual. In the west of the county the author had established in 1988 a joint review system for 11 residents who attended one social services day centre and who all lived in 2 homes run by a national voluntary organisation (Care Unlimited).

The author also introduced to Berkshire individual programme planning (IPPs) based on the British Institute of Mental Handicap system (Jenkins et al. 1988) in the west of the county (Miles, 1990 a, b, c). The Berkshire IPP scheme had as its main components (Miles, 1990c):-

1. It was client centred and sought to be closely related to what the client wanted and needed
2. It was based on a set of values which were broadly those of a "ordinary life philosophy" or normalisation
3. It involved people within agencies working together as well as across agencies
4. It was practical and was built on the strengths of the client
5. Goals and objectives were explicit and each goal had a person responsible for seeing it through
6. Once the goals were set and the programmes drawn up, progress towards the goal was continually monitored
7. It set the person in the context of their life history
8. The results of the IPPs were to help to develop the service and improve the quality of life for all people with learning disabilities.

The Berkshire IPP scheme was developed in 1990 and used the same procedure for everyone who attended two different SS day centres and covered more than 300 people. It continued for a period of 3 years.

10.1.3 IPPs and Care planning

On-site monitoring visits during the research study had indicated a variety of care planning systems, IPPs and reviews. The author felt that many of the staff she spoke to were unclear about what they were doing in these areas. As the contracts continued over time, three other local factors occurred to add confusion to the definition and implementation of care plans.

1) Procedures for care management in Berkshire Social Services were written in July 1991 (BSS, 1991b) and revised in July 1993 (BSS, 1993). These procedures included details of the care plan which would be drawn up by the care manager after the assessment of need, prioritisation on the needs/risk matrix and establishment of the care package. The care plan was to be reviewed six weeks after its initial set-up and subsequently every 6 months. It was a purchaser responsibility and was one concept of a "care plan".

2) In January 1993 a change in the job description of the author led to a change in the responsibility for the maintenance and delivery of the IPP system. The value of the IPP as a tool for collaboration and co-operation in service delivery was recognised and the IPP programme was to be extended across the remaining $^{2}/_{3}$ of the county. However, resources were to be reduced. It would become an in-house provider responsibility, with no purchasers to chair the meetings and the frequency would be reduced to once every two years for those people who lived at home with relatives. The name would be changed from IPP to client appraisal. The effect of this in the two areas where the Berkshire IPP system had been running, was that IPPs ceased from February 1993 to January 1994. This was the time and the area where all of the block contract monitoring was taking place.

3) In February 1994 the death occurred of a resident with learning disabilities who had an epileptic fit whilst having a bath in a residential home run by one of the main providers of the block contracts. This led many local providers to undertake risk assessments for people diagnosed with epilepsy. In the case of BSS (who provided staff for all B1 and B2 contracts) this then led to the development of provider care plans for all people in residential care where BSS staff were employed.

The author's professional understanding and experience led her to believe there was a distinction to be made among three activities referred collectively as care planning.

They were linked to the 3 local factors mentioned above. They were not distinguished in the care specification but they were:

1) a care plan drawn up by a care manager for a particular individual to meet their assessed needs. It would cover the various elements which made up the person's care package of services (e.g. day care, domiciliary care, respite care) and some rationale behind the way the needs were being met (e.g. maintenance of existing level of functioning, greater independence or skill acquisition, respite for the carer to prevent admission to long-term residential care).
2) the care plan which was the review/IPP/client appraisal and was described in some detail in the care specification of the block contracts.
3) the care plans which would cover day to day activities within an operational unit and, for example, would help prevent the tragedy of the death in the bath described above. They could well be an element of the kind of care plan described in 2 above.

The whole of section 5 of the care specification in the block contracts is titled care planning. The care provider was expected to provide a "structured programme of meaningful activities" for each resident consistent with the principles of O'Brien's five accomplishments. Section 5.4 of the specification said that the programme of activities would be in accordance with "the care plan of the resident" and that it could be "described as an Individual Programme Plan (IPP) or review". It then went on to describe the annual care plan meeting, how it would be based on the resident's wishes, strengths and needs, would cover the whole of the person's life, would be written and include objectives and would only focus on a limited number of areas in a person's life.

The author felt that as a result of her site visits staff were mostly unaware of the purchaser or care management care plan (described in 1 above) and often used the term interchangeably to describe the IPP/review and the provider unit care plans (2 and 3 above).

10.1.4 Individual programme plans/reviews/client appraisals

The section on care planning in the author's questionnaire was designed to see to what extent that "care planning" as described in the care specification was being followed. In addition, questions were asked to try and elicit how clear keyworkers were about the differences between provider care plans and IPPs. The main indicators which were looked at were:

1. The frequency of IPP meetings and whether the last two meetings were within the expected time scale

2. Evidence that other agencies and stakeholders were involved (e.g. keyworkers at day centres, contact with colleges of further education, who was invited to the IPP meeting)
3. Whether goals and objectives for individuals were set at the meeting, how they were monitored and the extent to which objectives were met.
4. Whether the keyworker felt there was any difference between care plans drawn up for daily activities and IPPs and if so, how they were different.

The lives of all residents were covered by some sort of review which involved people closely involved in the resident's life. Each provider called it something different but "IPP" or "review" or "client appraisal" were the most common terms. Consequently the section in the author's questionnaire on care planning always referred to IPP/review/client appraisal.

Questions 21 to 24 of the keyworker survey were used to explore these areas of IPPs/reviews. It assumed a standard model for IPPs/reviews as outlined in section 10.1.2 which was similar to all the models which the providers said they followed (information from monitoring visits). The following areas were explored in the questionnaire.

a) Who was invited to the IPP/review
b) Contact between keyworkers in day centre and home
c) Setting of objectives for the individual
d) Monitoring of objectives
e) Achievement of objectives
f) Reasons why objectives not achieved

Whether IPPs/Reviews occurred and their frequency

All respondents said that their residents had an IPP/review or client appraisal though the frequency varied from one provider to the next. The expectation from the care specification was that the meeting should be held annually.

Table 10.3 *How often IPPs/reviews are held. N = 58*

IPP	Frequency
every year	45
every 6 months	12
other time gap	1
does not have review	0

The frequency for each contract is shown in Table 33 in Appendix 9. All the B providers (with social services staff) had annual IPPs/reviews (with the exception of one which was a 3 monthly review) and 3 out of the 4 of the A providers had them twice yearly.

Even if reviews are scheduled for specified intervals, this is no guarantee that they will be held within the expected period. One home (Valley House) indicated that reviews/IPPs were to be held in the 2 months after the keyworker survey but that there had not been a "previous" review. The on-site monitoring visit in June 1994 showed that most reviews for the seven residents had not happened since that home opened in 1993 nor were many care plans being written or implemented.

Predicted vs. actual

The actual gap between 6 monthly and annual reviews was calculated and it showed that in quite a number of instances the gap was greater than expected. The range for six monthly IPPs/reviews was from 2 months to 9 months and for annual IPPs/reviews was 6 months to 27 months. Seven out of 35 (20%) of residents who were expecting to have annual IPPs/reviews were more than 18 months apart and in total 13 out of 35 (37%) of annual IPPs/reviews were late. This is summarised in Table 10.4 below.

Table 10.4 *Actual vs. predicted frequency on IPPs/reviews - those who had 2 reviews. N = 45*

Gap between IPPs (months)	Expected frequency			
	every year	every 6 months	other time gap	Total
0..6	2	6	1	9
7..12	20	3	0	23
13..17	6	0	0	6
18..23	5	0	0	5
24..29	2	0	0	2
Total	35	9	1	45

Not every keyworker recorded 2 reviews. For example, a few reported only one because the resident was a recent admission and for others a second review had not been arranged. In all 13 keyworker responses could not be used be used to calculate the actual gap between reviews. Table 10.5 gives a frequency count of those who did not have 2 review dates.

Table 10.5. *IPP/review alternatives for those who had not had two reviews. Taken from information on dates of last and previous reviews*

IPP	Frequency
Only had one review (recent adm.)	2
Only had one review	7
Not yet had review	4

The responses from these 13 keyworkers were excluded from parts of the subsequent analysis of results. For example, if the resident had only one IPP/review, answers about setting objectives were retained but those relating to whether objectives had been achieved were coded as NR.

Table 34 in Appendix 9 shows how the gap between IPPs/reviews varied with the provider and the table below shows the results for the homes with BSS staff (B providers). As might be expected in view of the change from IPP to client appraisals in the west, most of the delayed IPPs/reviews were with Provider B1. This is shown for Provider B1 and B2 in Table 10.6 below. When IPPs/review were more frequent than once a year, Table 10.4 indicates that there was still delay (about one third were longer than expected) though this masks the differences between the two providers. Future monitoring would wish to indicate how much delay is acceptable.

Table 10.6. *Actual vs. predicted frequency on annual IPPs/reviews. Provider B (BSS staff) homes only. N = 45*

Gap between IPPs (months)	Provider B		
	B1	B2	Total
0..6	2 11%	1 6%	3 8%
7..12	8 42%	13 72%	21 57%
13..18	5 26%	3 17%	8 22%
19..29	4 21%	1 6%	5 14%
Total	19	18	37

Percentages by column.

Involvement of other stakeholders - Who was invited to the IPP/review

The care specification stated that, subject to their consent, the resident should be present at the IPP/review as should any relative or advocate, the resident's keyworker and "other people as appropriate". The frequency count below shows that generally these guidelines from the specification are kept. Results for each contract are in Table 35 in Appendix 9. No questions were asked in the survey about who actually attended the review/IPP, though anyone monitoring the contract in the future may well wish to explore this.

Table 10.7 *Who is invited to the IPPs/review. Excludes those who had not had an IPP/review. N = 54*

Who is invited to IPP/review	Frequency
Client	54
Keyworker	53
Home manager	53
Relatives	50
Care manager/social worker	37
Other agencies eg kw at day centre	43
Others	28

If the resident attended an outside day centre, the expectation would be that the keyworker from that centre would be invited to the IPP/review. This was generally the case with the B providers but not universal with the providers that employed their own staff (A providers). However, the small numbers in the A provider sample precludes drawing any conclusions.

Table 10.8 and 10.9 looks at those who attended a day centre and had reviews (N = 41) and shows that 37 out of 39 possible day centre keyworkers were invited by B providers and 2 out of 3 by the A providers.

If a care manager was allocated to the resident (i.e. was an open/active case), it was expected that they would be involved in the preparation of the IPP/review by the co-ordinator of that review - usually the keyworker at the home - as well as attending the meeting. Care managers were more involved with the A providers with B providers. The reason for this was because most of the residents in the B provider homes moved from larger BSS hostels and tended not to be allocated to care managers (i.e. they were

open/inactive to the CTPLD). Residents in the A provider homes had often been spot purchases before being named in a block contract. 100% of A providers invited care managers whereas only 63% of B providers invited care managers. Table 10.9 shows this in more detail though there are limitations with the small numbers in the A group.

Table 10.8 *Who is invited to the IPP/reviews. Excludes those have not had IPP (4 people) as well as those who did not attend day centre (a further 13). Excludes NR to this question. N = 41*

Who is invited to IPP/review	Frequency
Client	41
Keyworker	40
Home manager	40
Relatives	39
Care manager/social worker	27
Other agencies eg keyworker at day centre	39
Others	22

Table 10.9 *Who is invited to IPP/review if attend an outside day centre. Excludes those who never had IPP/review. N = 41*

Who is invited to IPP/review	Provider type		
	A	B	Total
client	3 100%	38 100%	41 100%
keyworker	3 100%	37 97%	40 98%
home manager	3 100%	37 97%	40 98%
relatives	3 100%	36 95%	39 95%
care manager/ social worker	3 100%	24 63%	27 66%
other agencies eg kw at day centre	2 67%	37 97%	39 95%
others	2 67%	20 53%	22 54%
Total	3	38	41

Percentages by column.

The text answers for "others invited to the review" (28 respondents) were coded into the following categories and frequency counts are in Table 26, Appendix 7.

1. IPP secretary or IPP co-ordinator
2. Work experience or opportunities officer
3. Other professionals (occupational therapist, psychiatrist, psychologist, physiotherapist, dietician, GP)
4. Senior manager
5. Other e.g. representative of proprietor

The most common group to be invited were other professionals (10 mentions) and half (5) of these came from one contract (Pencolm). For their 5 residents, they invited everyone - scoring 5 on all the categories in Q19. Full results are shown in Table 36 of Appendix 9.

Contact between keyworkers

The description about IPPs earlier in the chapter showed there was an expectation that co-operation between different providers of a person's care package would be fostered. This would be shown in two ways - whether the keyworker at the day centre was invited to the IPP/review and what level of contact there was between the two keyworkers. Table 10.9 showed that nearly all the keyworkers at the day centres were invited to the IPP/review. Responses about the frequency and reasons for contact indicate two units running in parallel rather than close liaison despite the requirements of the care specification (clause 5.1, 5.2 and 5.4). Mansell's (Mansell et al, 1987) view that IPP meetings would in time concentrate less on inter-agency co-operation does not seem justified in this study.

Table 10.10 *Frequency of contact between keyworker at residential home and keyworker at day care centre. Excludes those who never had IPP/review. N = 41*

Contact day centre	Frequency
Once a week	4
Once a month	8
Before the review	22
Never	1
Other times	26

Only 22 of a possible 41 keyworkers contacted the day centre before the review and 12 did so more frequently (once a week or once a month). These two groups are not mutually exclusive. One keyworker whose resident attended a BSS day centre said they never contacted the keyworker at the centre. Appendix 9 also includes a table (Table 37) which shows the frequency of contact with the various centres and colleges.

Full results of the reasons for contacting the keyworker at the centre at other times are given in Table 38 of Appendix 9. Of the 26 who responded that they contacted the keyworker at the day centre at other times, the most frequently given reason was discussion when necessary (18 mentions) or when passing on information (7 mentions).

10.1.5 Objectives and their monitoring

Setting of objectives

The third indicator about the way care planning was being carried out related to objectives or goals being set for the individual, how the goals were monitored and the extent to which objectives were met. In all but two instances goals or objectives were set at IPPs/reviews which indicated that the setting of goals was almost universal. However, there was less clarity about who was responsible for ensuring objectives happened. Sixteen keyworkers (29%) said no-one was responsible, everyone played their part and a further 33 (60%) said that the person responsible depended on the objective. Not having one person responsible for goals was a contrast to other IPP schemes in the literature that have been evaluated and was a deviation from the expected Berkshire model. Table 10.11 gives the results as a frequency count.

Table 10.11 *Whether someone was responsible for ensuring objectives set at IPPs happen. Excludes those who had not had IPP/review. NR = 3. N = 54*

goals	Frequency
yes, though it depended on the goal	33
no one person, all responsible	16
no goals/objectives set	2

Because of the length of the questionnaire respondents were not asked to record the objectives set at the last two IPP meetings. Without that, it was not possible to judge whether the achievement of objectives would be classed as positive outcomes for the client or just going through the procedure. (See comments by Grant et al. (1988) referred to earlier in this chapter). Determining how far objectives accorded with the

overall philosophy of the service and how well there was co-ordination with other agencies are areas for future monitoring.

The results of this question about who ensured that objectives happened were analysed across the 3 provider groups and are shown in Table 10.12 below.

Table 10.12. *Whether someone was responsible for ensuring objectives were set at IPPs/reviews. Excludes those residents who had not had any review (N = 54) and NR. N = 51*

Goals set at IPP/review	Provider			
	A	B1	B2	Total
Yes, though it depended on the goal	4 40%	15 71%	14 70%	33 65%
No one person, all responsible	5 50%	5 24%	6 30%	16 31%
No goals/ objectives set	1 10%	1 5%	0 0%	2 4%
Total	10	21	20	51

Percentages by column.

These figures show that the same inconsistencies occurred within the provider groups as in the total sample i.e. some keyworkers were working on the assumption that one person was responsible whilst other keyworkers were thinking everyone was responsible. Table 39 in Appendix 9 shows this for the individual homes.

Although the sub-samples were small, keyworkers were clear in 5 homes where the responsibility lay for ensuring objectives were set and carried through. In 2 of the homes, all agreed that everyone played their part (one from a Provider A home and one from a Provider B1 home) and in 3 of the contracts, who was responsible depended on the goal (two from a Provider B1 home and one from a Provider B2 home).

With the other 9 contracts, goals/objectives were set but there was a mixture of views about who was responsible for ensuring they happened. The preponderance was for one person, depending on the goal, but this was not universal.

Part of the reason for the inconsistency could be because of the difference between the systems of reviews/IPPs in the two halves of the county. More Provider B2 (BSS staff

in the east of the county) answers were mixed than Provider B1 (BSS staff in the west of the county) answers. Another reason could be that the question itself was confusing. An improved version could be "was someone **made** responsible for making sure **individual** goals happen".

Monitoring of objectives

In the survey various options (including a free text option) were given to respondents to describe how the monitoring of goals/objectives was carried out. Respondents could answer as many as they wished. These were categorised at the analysis stage. Only one respondent (a keyworkers at Hawker Lodge) said there was no monitoring.

Two of the categories could be described as "formal/collective" (staff meeting, keyworkers meeting), one was "formal/individual" (supervision) and one was "informal" (keeping an eye on resident records). The full results (by provider and contract) are in Table 40 to 42 of Appendix 9. Table 10.13 shows how monitoring was done by the providers in the 3 ways (formal/collective, formal/individual and informal).

The results show that all homes used formal/collective methods for monitoring goals/objectives and many used more informal methods. Because the answers are not mutually exclusive it is difficult to know whether keyworkers in some homes were concentrating on one method rather than another. In the large home (Warley Green) there appeared to be an emphasis on informal methods - keeping an eye on records was the most frequently mentioned method - and less use of staff meetings. Respondents in this contract had been keyworkers to up to 5 residents though at the time of the survey this had been reduced to three. Further investigation would be needed to see how information was communicated to other staff in the keyworker meetings at this home, especially associate keyworkers.

Rose Cottage did all its collective monitoring in keyworker meetings and none in staff meetings. In this home all staff were keyworkers except the home manager so this was effectively functioning as a staff meeting with a specific agenda. From the author's monitoring reports it was known that these meetings occurred monthly and the keyworker from the day centre (one keyworker was responsible for all 5 residents surveyed) was invited. In addition all keyworkers in this contract kept an eye on resident records and most (80%) used supervision for monitoring goals or objectives as well.

Whether the methods of Rose Cottage result in a higher rate of achievement of objectives is hard to tell. Table 44 in Appendix 9 show that for this contract (contract 7) all objectives were achieved in 2 cases, some were achieved in one case and goals were not looked at in the fourth case. This compares favourably with other homes (apart from the one case where goals were not reviewed).

Table 10.13 *Methods of monitoring achievement of objectives between IPPs/reviews. N = 54*

Goal monitoring	Provider			
	A	B1	B2	Total
Not answered	1 9%	1 4%	0 0%	2 4%
There is no monitoring	0 0%	1 4%	0 0%	1 2%
Formal/collective	7 64%	20 87%	24 120%	51 94%
Formal/individual	4 36%	11 48%	17 85%	32 59%
Informal	6 55%	17 74%	15 75%	38 70%
Any other ways	5 45%	6 26%	9 45%	20 37%
Total	11	23	20	54

Percentages by column.

The text answers for the sixth option (other ways) were coded into the categories (shown below) which were also grouped in the same three areas. Four out of the 6 were in the formal/individual category. For the 20 keyworkers who mentioned other ways of goal monitoring the predominance was for formal/individual methods.

1. monthly charts — formal/individual
2. daily records, diary — formal/individual
3. weekly records by k/w — formal/individual
4. liaison with others — informal/individual
5. reviewing care plans — formal/individual
6. liaison with relatives or care manager — informal/individual

Responses are shown in Table 10.14. Most keyworkers favoured the more formal methods, though keyworkers with Provider B2 favoured the informal "liaison" approach compared to the other providers. Full responses are in Table 43 in Appendix 9.

Table 10.14. *Categories of responses to other ways of monitoring. Excludes NR. N = 20*

Other ways of monitoring goals	Provider			
	A	B1	B2	Total
Formal/individual	7	5	3	15
Informal/individual	1	1	8	10
Total	5	6	9	20

Achievement of objectives

The process of IPPs/reviews should ensure that the goals set at one meeting are looked at before setting new goals or objectives at the subsequent meeting. Table 10.15 shows responses for how far goals were achieved for those residents who had 2 reviews and more detailed tables are in Table 44 of Appendix 9. Responses from those where no goals were set (2) or where the keyworker did not answer about achieving goal setting were excluded.

Table 10.15 *Degree to which goals were achieved. N = 42. NR = 9.*

How far goals achieved	Provider			
	A	B1	B2	Total
Goals not looked at	0 0%	1 6%	0 0%	1 2%
All were achieved	0 0%	5 28%	0 0%	5 12%
Most were achieved	2 25%	10 56%	10 62%	22 52%
Some achieved	5 62%	1 6%	6 38%	12 29%
None were achieved	1 12%	1 6%	0 0%	2 5%
Total	8	18	16	42

Percentages by column.

93% of keyworkers said that goals were achieved to some degree and in 64% (27 instances) all or most of the goals were achieved. In Rose Cottage (Provider B1) where objectives had not been looked at, the respondent wrote in Q24 that they found "no evidence in the 1994 review that the 1991 one was looked at". This attitude, plus the delay between the resident's IPPs/reviews gives the impression that care planning was not a major part of this keyworker's responsibility.

Reasons why goals or objectives not achieved

Keyworkers were asked to give any reasons why some objectives were not achieved. This was a free text question and the answers were categorised and coded as follows.

1) **Client factors 1** - since previous review
   - e.g. recent behaviour problems, health, bereavement
2) **External factors 1** - some degree of control by keyworker
   - e.g. waiting for equipment ordered
3) **External factors 2** - outside control of keyworker
   - e.g. swimming pool closed, services not available
4) **Organisational factors 1** - relating to the goal set
   - e.g. need longer time scale, goals carried over, too many goals set
5) **Organisational factors 2** - relating to the running of the home
   - e.g. old keyworker left, staff shortages, flash card not bought, other priorities in home
6) **Client factors 2** - long standing
   - e.g. objective realistic, client changed mind or unco-operative, age and mood swings, client set own goals as well
7) **not applicable**
   - only one or no reviews held, objectives not looked at

The first three categories were to some extent unpredictable, though it was not certain whether "some services not available" was because the objective/goal was over-ambitious or expected services did not materialise.

Factors in category 4 and 6 are more predictable and should be taken into account when agreeing objectives e.g. breaking down a long term goal into smaller achievable objectives. One respondent wrote that the "long term goal is to do with road safety and will take a long time to achieve". Further training and guidance is perhaps necessary in this area as it is not helpful to the resident's feeling of self worth if feedback from reviews/IPPs is not predominately positive.

Category 5 had more to do with the internal organisation of the home and most of the responses in this group came from the Allenby and Pencolm contracts (see Table 45 in Appendix 9) where is has already been noted that there was high staff turnover. Table 10.16 looks at the reasons why some or all of the goals were not achieved.

Table 10.16 *Why goals were not achieved. Includes those where 2 reviews were held (N = 45) and excludes those where no goals set (N = 43).*

Why goals not met	Frequency
Client factors 1	4
External 1	1
External 2	2
Organizational 1	8
Organizational 2	5
Client factors 2	6
Not applicable	4

A few keyworkers responded "no particular reason" or "no" and were coded as NR. The respondents who wrote "last review was very negative" or "we are trying to organise a holiday for this person" were also coded as NR. A telling comment came from one respondent in the Warley Green contract who wrote "no particular reason, better system of checking goals/objectives from the review is needed".

10.1.6 Care plans, IPPs/reviews and their differences

As was mentioned in the earlier part of this section about keyworker responsibilities, there was a degree of confusion about the use and terminology of care planning. The section on care plans were designed to elicit keyworkers' understanding about care plans and whether they differed from IPPs/reviews.

The author also hoped to find out if there was any consistency within particular providers about how care plans were different and what areas were covered. It was recognised that the small sample size of the 4 providers in the Provider A contracts (directly employed staff) would make this difficult, but it would be possible to compare internal consistency within the providers with BSS staff (Provider B1 and B2). If differences between them were detectable this might give an indication of how influential the proprietor was over the sub-contracted provider. It could also indicate that policies within social services were being implemented differently across the

county, but the effect of new staff being employed by Provider B2 and seconded to BSS could not be gauged.

Differences between care plan and IPP

Most keyworkers (52 out of 58) said that care plans were drawn up to cover daily activities and this is shown in Table 10.17. Analysis by contract is Table 46 in Appendix 9. The responses from Valley House (contract 4) were included as this question was not referring specifically to IPPs/reviews.

Table 10.17 *Whether care plans are drawn up for daily activities. N = 58*

Care plans drawn up	Provider			
	A	B1	B2	Total
yes	12 80%	22 96%	18 90%	52 90%
no	3 20%	1 4%	2 10%	6 10%
Total	15	23	20	58

Percentages by column.

This group of 52 keyworkers then indicated whether they thought the care plans for daily activities were different to the IPPs/reviews. About half thought they were different and the other half thought they were not. This is shown in Table 10.18 and the full results are in Table 47 of Appendix 9.

Table 10.18 *Whether care plans, when drawn up, are different to IPPs/reviews. Excludes NR. N = 50*

Care plans differ from IPP/review	Provider			
	A	B1	B2	Total
yes	6 60%	13 59%	8 44%	27 54%
no	4 40%	9 41%	10 56%	23 46%
Total	10	22	18	50

Percentages by column.

Taking the 52 keyworkers where care plans were drawn up, Table 10.19 shows there was little distinction between those who had IPPs every 6 months and those with annual

IPPs. In both groups about half said there was a difference and the other half said there was none though the sample for the six monthly reviews was small. Table 48 and 49 in Appendix 9 shows the difference by contract for annual and six monthly IPPs. In both A and B providers there was a degree of inconsistency within homes/contracts.

Table 10.19 *Care plans (when written) and their difference to IPPs when annual IPPs/reviews held (N =42) and six monthly IPPs/reviews held. N = 9*

Annual reviews

Care plans differ from IPP/review	Provider			
	A	B1	B2	Total
Not answered	1 33%	0 0%	0 0%	1 2%
yes	2 67%	13 62%	8 44%	23 55%
no	0 0%	8 38%	10 56%	18 43%
Total	3	21	18	42

Percentages by column.

Six monthly reviews

Care plans differ from IPP/review	Provider	
	A	Total
Not answered	1 11%	1 11%
yes	4 44%	4 44%
no	4 44%	4 44%
Total	9	9

Percentages by column.

How the care plans and IPPs/reviews are different

Because of the development of care plans over the previous two years of the study the author made some hypotheses about how daily care plans might be different and what they might cover.

Hypothesis 1. Risk assessments

In view of the concern over epilepsy and bathing, risk assessments would have been high on the list of ways care plans were different to IPPs, especially in homes where BSS staff worked (Provider B1 and B2 contracts). Risk assessments had been carried out on all homes were BSS staff worked by the end of 1994.

Hypothesis 2. Reflection of individuality

It would also be expected that care plans would concentrate more on particular areas that were being developed with a resident, and/or detailed guidelines for staff to follow when carrying out specific routines e.g. bathing, feeding, domestic chores. They might also include behaviour modification guidelines or ways of helping staff to deal consistently with particular behaviour patterns. Alternatively, they could include a step-by-step teaching plan (as shown in Houtts and Scott, 1975 and 1978) for tasks such as learning to set the table or learning to travel independently to shops.

Hypothesis 3. Within the framework of the IPP/review/client appraisal

A further expectation would be that care plans would emerge from the IPP/review which would have given a framework of the overall strengths and needs of the individual and specific objectives to work towards in the coming year. These objectives could be a step on the way to a longer term goal for the resident such as securing a job, making snack meals, moving to more independent accommodation, learning to exercise choice and control over different aspects of their lives.

Hypothesis 4. Involvement with a number of stakeholders

IPPs/reviews should include contributions from everyone involved with the client - relatives, residential care staff, day centre staff, college tutors, CTPLD staff. The prime focus would be the client as it would be for the care plan, but the involvement of a wider audience of an IPP would be more limited in the care plan.

Respondents were asked how care plans were different to IPPs. The 23 who said there was no difference did not, as expected, answer the next question about how they were different. However, 12 of them went on to answer Question 29 "What areas are covered by the care plan?" If the person did not answer Question 26 (Are care plans different to IPPs?) but then gave an explanation in Question 27 about how they were different, this was coded as a yes to Question 26.

Of the 27 who did record a difference, their text answers were coded into 9 categories and frequency counts are shown in Table 10.44.

1. more detailed
2. relate to stay back day, or relate only to the home i.e. only care staff in home use them - not other staff
3. include a risk assessment
4. personal hygiene
5. guidelines for staff especially behaviour
6. IPPs have longer term objectives or care plans follow on from IPPs
7. covers daily activities e.g. cooking, domestic tasks
8. new care plans are drawn up between IPPs
9. other ways e.g. social skills.

The nine categories were then assigned to the various hypotheses. Category 3 relates to hypothesis 1, category 1 and 5 to hypothesis 2 and category 6 and 8 relate to hypothesis 3. Categories 4, 7, and 9 do not fit in with the hypotheses. See Table 10.20.

From the comments in section 10.1.3 of this chapter one could predict which of the 9 categories above would be mentioned most often. These would be those relating to greater detail, risk, guidelines for staff or more frequently changed (categories 1, 3, 5, 6 & 8). In practice, the four most frequently used responses were in categories 1, 6, 7 and 8. Categories 3 and 5 (risk assessment and guidelines for staff) were 2 of the least mentioned categories. Full responses for each provider are shown in Table 50 in Appendix 9.

Apart from the fact that there was obvious uncertainty about the differences between IPPs/reviews and (residential) care plans it was disappointing that keyworkers did not seem to associate or incorporate risk assessments with care plans.

Table 10.20 *Areas covered by care plans for daily activities (when written) mentioned by keyworkers (where there is a difference between reviews and care plans). N = 27*

How care plans differed	Times mentioned	Order of frequency	Relates to hypothesis
1. More detailed	12	1	hypothesis 2
2. Relate to stay back day	4	5	none
3. Include risk assessment	1	9	hypothesis 1
4. Personal hygiene	4	5	none
5. Guidelines for staff on behaviour	2	8	hypothesis 2
6. IPPs are longer term	12	1	hypothesis 3
7. Daily activities	10	3	none
8. New plans drawn up between IP	7	4	hypotheses 3
9. Other e.g. social skills	4	5	none

Differences within providers

As staff in the B provider homes were all part of the BSS care contract, the responses for these providers (B1 and B2) were looked at separately to see if there was any internal consistency. This is shown in Table 10.21.

Eight out of the 18 keyworkers (44%) in the B2 homes said that IPPs and care plans were different whereas 13 out of 22 (59%) of keyworkers in B1 homes felt there was a difference.

Table 10.21 *Comparison of whether daily care plans were different to IPPs/reviews in West (B1) and East (B2) homes where social services staff worked. Includes those where care plans are written. N = 40*

Whether care plans different from IPP	Provider B		
	B1	B2	Total
yes	13 59%	8 44%	21 52%
no	9 41%	10 56%	19 48%
Total	22	18	40

Percentages by column.

The number in each contract that met the criteria was small so it was difficult to say whether some homes were more consistent than others. Full figures are in Appendix 9 (Table 51 and 52). No overall pattern was observed. The slightly higher rate of "yes" response in B1 homes may be due to the previous existence of a comprehensive IPP system in the area. On the other hand many staff had been employed for 2 years or less and their experience of IPPs may have been limited as IPPs ceased for at least a year from February 1993. The survey was carried out in November 1994. Table 53 in Appendix 9 shows how care plans differed from IPPs/reviews in Provider B1 and B2.

It would be worthwhile for future monitors to explore with staff, home managers and proprietors their concept of IPPs/reviews/client appraisals and care planning in greater depth than was done within this survey. This would involve looking at the policies and procedures for such care planning and IPPs/reviews to see how well the reality matches the policy.

10.1.7 Areas covered by the care plan

Returning to the 52 keyworkers who said daily care plans were written, they were asked to state the areas the care plan covered. It was hoped that the respondents would give a list of headings which related to this particular resident being surveyed.

The author expected there would be some common headings in view of the work done within the BSS providing stream. There would also have been some individual differences (e.g. not every resident has epilepsy, nor do all need behaviour guidelines overseen by a clinical psychologist). The text answers were coded as below into 14 categories. If there was some overlap between the answers to Q27 and Q29 (how the care plans are different and what areas the care plan covers) this was coded as 2 (partial overlap). If there was total overlap (e.g. if respondent wrote "as above") this was coded as 1. The 14 categories were:

1. same answers as Q27
2. partial overlap
3. personal hygiene
4. risk areas
5. behaviour
6. social relationships or social network
7. communication
8. work or day care
9. other area - leisure, travel
10. health
11. choice or decision making
12. general e.g. independent living or general development
13. supervision needs, staff support
14. gave list of areas covered.

Fourteen of the 52 did not respond and of the 38 who did, half (17) mentioned personal hygiene. Other frequently mentioned areas were work or day care, other areas (e.g. leisure or travel) and health. Full responses are given in Table 10.22 below.

Just over half (18) of the respondents gave a list of areas covered (referred to as list makers) which, as expected, followed the trends of the larger sample with frequently mentioned areas in health, work/day care, personal hygiene and other areas - leisure, travel etc. The frequency of areas mentioned by the list makers is shown in Table 10.23 below.

Table 10.22 *Areas covered by care plans (when written) mentioned by keyworkers. Non response = 14. N = 52*

Areas covered by care plans	Frequency
Same as Q27	2
Partial overlap	0
Personal hygiene	17
Risk areas	6
Behaviour	7
Social relat./network	9
Communication	8
Work or day care	14
Other areas- leisure, travel	17
Health	16
Choice, decision making	5
General eg indep. living	7
Supervision needs, staff support	9
Gave list of areas	18

Table 10.23 *Areas in care plans mentioned by keyworkers who were "list makers") and "non list-makers".*

List makers N = 18

Areas in care plans	Percentage
1. same as Q27	0%
2. partial overlap	0%
3. personal hygiene	67%
4. risk areas	6%
5. behaviour	22%
6. social relat./network	33%
7. communication	39%
8. work or day care	56%
9. other areas- leisure, travel	67%
10. health	72%
11. choice, decision making	28%
12. general eg indep. living	0%
13. supervision needs, staff support	11%
14. gave list of areas	100%

Non list makers N = 34

Areas in care plans	Percentage
1. same as Q27	10%
2. partial overlap	0%
3. personal hygiene	25%
4. risk areas	25%
5. behaviour	15%
6. social relat./network	15%
7. communication	5%
8. work or day care	20%
9. other areas- leisure, travel	25%
10. health	15%
11. choice, decision making	0%
12. general eg indep. living	35%
13. supervision needs, staff support	35%
14. gave list of areas	0%

Risk areas were only mentioned once in those that gave a list but was mentioned 5 times in the 34 non list-makers who answered this question. The non response rate for this question was high (14 out of 34). Seven of the 20 who answered made reference to supervision needs or staff support which could be a recognition that risk factors were being taken into account. Communication did not figure highly in this sub-set whereas it did amongst the 18 list makers.

Efforts were made to see if there was any similarity in the responses of Provider B1 and B2 keyworkers but this was not obvious. B1 keyworkers mentioned supervision needs and hygiene most frequently whereas B2 mentioned equally health, work and other areas. They did not record supervision or staff support needs. Table 10.24 gives the full responses (N = 40)

Table 10.24 *Comparisons of areas covered by care plans in Provider B1 and B2 keyworkers. N = 40*

Areas covered by care plans (B1 & B2 providers)	Provider		
	B1	B2	Total
Not answered	5	6	11
Same as Q27	1	1	2
Personal hygiene	6	7	13
Risk areas	4	2	6
Behaviour	3	2	5
Social relat. or network	5	3	8
Communication	2	5	7
Work or day care	5	8	13
Other areas- leisure, travel	4	8	12
Health	4	8	12
Choice, decision making	2	2	4
General eg indep. living	4	2	6
Supervision needs, staff support	8	0	8
Gave list of areas	5	9	14
Total	22	18	40

10.1.8 Discussion and improvements to this part of the questionnaire.

At the pilot stage, the questions in this section proved problematic and efforts were made to improve the questionnaire design. However, there was still some confusion in the respondents' answers. In particular, if the answer to Q26 ("Are care plans different to IPPs/client appraisal/reviews?") was no, respondents were requested to go to Q30 which was a new section. Twelve of the 23 respondents who answered no, then went on to answer Q28 ("who writes the care plan") and/or Q29 ("please state the areas the care plan covers") implies that they felt care plans were drawn up - if not necessarily for daily activities. It also implied that the words care plan and IPP/review were synonymous as it is in the care specification.

The instructions at the beginning of these two sections on reviews and care plans asked respondents to keep in mind one particular resident for questions 18 to 42. The answers to the section on care plans were often more general than expected. This meant that the hypothesis about relating to individuality was less often noted. Re-phrasing the questions (e.g. Q25 "Have care plans which cover daily activities been drawn up for this particular resident?", Q28 "Who wrote the care plan for this resident") might also have helped. Further clarification could have been sought by asking the areas that an IPP/review/client appraisal covered as well as other areas covered by the care plan.

Despite these reservations, the results indicate that there is confusion and inconsistency in the way IPPs/reviews are carried out and in the practice of keyworkers. Greater clarity in care planning at a provider and home level would make the task of monitoring (whether this is internal monitoring by the provider or external monitoring by the purchaser) easier and more consistent. Efforts have been made to reflect this in the revised care specification (BSS, 1995b).

10.2 Maintaining relationships and social activities

The section covering questions 30 to 43 of the survey were headed "meeting needs and quality of life". It looked primarily at social activities, maintaining social relationships and health needs.

A number of writers - Garvey and Stenfert-Kroese (1991), Richardson and Ritchie (1989), le Touze and Pahl (1992) - have shown that the relationships needs of people with learning disabilities are similar to the rest of the population. However, various limitations within their lifestyle restricts their opportunities to develop and maintain friendships. This applies not only with other people with learning disabilities but also

with non-handicapped people. Richardson and Ritchie (1989) interviewed 60 people with learning disabilities in two geographical areas who lived in a variety of community settings - at home with parents, large hostels, independent flats and houses. Despite the fact that there other people around at all times, the majority spent a high proportion of their time in large groups e.g. at the day centre, living with others and few went out on their own. There was a limited range of real contacts and connections. Relationships tended to be with members of the person's family, paid or voluntary workers or other people with learning disabilities. They were a reflection of the limited often segregated activities in which they participated. Those in hostels or staffed houses (the group that was most comparable to the residents in this case study) seemed to spend most of their spare time with other residents or with paid care staff.

Garvey and Stenfert-Kroese (1991) revealed in one study of 17 people who had moved out of long stay hospital to group homes that there was low community presence and even less community participation. Few of the activities of the residents were integrated and evening outings were about once a fortnight.

The basis of how people with learning disabilities might be helped to develop new relationships as opposed to maintain existing ones was not pursued in the survey. It is an area for future monitoring as it enhances resident's quality of life and is one of O'Brien's five service accomplishments. Richardson and Ritchie (1989) found that the 60 people they interviewed were often channelled into activities that others had chosen for them. Leisure activities would be more satisfying in the context of more satisfying relationships. In order for relationships to develop into friendships there need to be the opportunity to meet people, to learn appropriate behaviours, develop self confidence and support/encouragement to maintain friendships perhaps through "befriending" or advocacy schemes. The survey by le Touze and Pahl (1992) indicated that service providers should give more attention to this social aspect of people's lives, offering transport to enable the person to go out more. In addition they felt that all ways to foster social networks, develop social skills and to go out socially to places and events which are not exclusively people with learning disabilities should be developed. Facilities that are predominately for people with learning disabilities are often referred to as "segregated".

10.2.1 Results from this survey

Thirty five (61%) keyworkers said that their resident needed help to maintain relationships, 22 (39%) said they did not and there was one NR. One keyworker who answered "no" added that "this person has no relatives", although the question had made

reference to friends and relatives. No home had sufficiently independent residents that none needed any help, although in 2 homes (Warley Heath and 1, Green Close) all the residents needed help. Full results are in Table 54 of Appendix 9.

The results for the frequency of contact with relatives were collapsed to make one category (contact with relatives). This became the most frequently mentioned way of helping maintain relationships, closely followed by helping make telephone calls and arranging visits for the 35 residents who needed it. This is shown is Table 10.25 and the full results are in Table 54 and 55 of Appendix 9.

Table 10.25 *Ways of helping residents maintain relationships. N = 35*

How help relationships	Frequency
write letters for them	19
help make telephone calls	25
arrange visits	27
any other stated	7
contact with relatives	34

The other ways stated were mostly to do with frequency of contact but several keyworkers went into more detail. At 3 Green Road the keyworker said that the resident was capable of making initial contact but needed "assistance with communication her needs in a positive/polite way". This keyworker also referred to writing letters for the resident and speaking to relatives when they contacted her.

10.2.2 Day time activities

The questions about formal day care and day activities were intended to check out that residents were pursuing activities away from the home and how these were organised. This was partly because use of day centres, as well as social and leisure activities were mentioned specifically in the care specification. In addition it was known that all three types of activities provided opportunities to develop and maintain people's social networks and relationships, even if the day centres were primarily segregated venues.

Forty five (76%) of residents attended a day centre, though it varied from 1 day to 5 days a week. The majority (21 - 47%) attended 4 days a week. See Table 10.26 and 10.27. Nearly all the day care was provided by social services or at colleges of further education. Some residents had a mixture of sites for their day care. Only one provider (A2 - Allenby) did not use outside day centres and Provider A1 - Mendip Way - used a private facility for one resident.

Table 10.26 *Whether resident attends an outside day centre. N = 58*

Attends day centre	Provider type A	B	Total
yes	7 47%	38 88%	45 78%
no	8 53%	5 12%	13 22%
Total	15	43	58

Percentages by column.

Table 56 of Appendix 9 gives the full results of where the residents attended and Table 57 in the same appendix shows the frequency of attendance by centre or college.

Table 10.27 *Frequency of attendance at day centre. N = 45*

Frequency at day centre	**Number attending**	**% of total**
1 day	3	7%
2 days	4	9%
3 days	6	13%
4 days	21	47%
5 days	11	24%
Total	45	100%

Table 10.28 *Social activities for those who did not attend day centre or college. N = 13*

Social/leisure activities	**Frequency**
more than once a week	8
once a week	2
2 or 3 times a month	1
once a month	1
less than once a month	1
other	0

Of the 13 residents who did not attend a specialised day service, most (8 out of 13) had access to leisure and/or social activities away from the home more than once a week and a further 2 participated once a week. (See Table 10.28). Only 1 resident had such

opportunities less than once a month. This would not necessarily mean that the resident never left the home or was unoccupied. The resident could be undertaking work experience or prefer home based activities. Whoever is monitoring would want to ensure that activities (whether provided in a formal day service or arranged by the home) meet the residents' needs and preferences.

10.2.3 Organisation of activities outside of formal day care

In terms of the organisation of weekday activities outside of formalised day care, the keyworker and the resident were the persons most frequently reported. Respondents could circle more than one option and "resident in discussion with staff on duty the day the resident is based at home" was mentioned 46 (79%) times.

In Contract 1 (Mendip Way), a member of staff was employed as a day-care co-ordinator and all the keyworkers delegated this responsibility to her. A day care co-ordinator was mentioned 8 other times in 5 contracts, but the author was not aware that any other designated co-ordinators. Table 58 and 59 of Appendix 9 gives the full results by contract and provider.

Similar responses were obtained about the person who was responsible for organising week-end activities, though there was less emphasis on the IPP/review giving a framework and residents and parents were more frequently mentioned. Table 10.29 shows the frequency counts for both weekday and week-end activity (Table 60 and 61 in Appendix 9 give the full results.)

Table 10.29 *Frequency counts of who has responsibility for organising weekday and week-end activities outside of formal day care. N = 58.*

Person responsible	**week day**	**week-end**
keyworker at home	34	31
day care co-ordinator	11	8
resident and keyworker at review to give framework	21	14
resident and staff on duty	45	48
someone else - parent	5	5
- resident	3	4
- friend/others	5	5

10.3 Meeting health needs

It is well accepted (BSS 1995e, Kerr et al. 1996, Royal College of General Practitioners, 1990) that people with learning disabilities have a higher incidence of basic health problems compared to the rest of the population (sight, hearing, obesity, dentistry, ear nose and throat condition, mobility, digestive problems). Kerr et al (1996) remarked that social services and other agencies that provide accommodation for people with learning disabilities need to retain a specific awareness of health issues. Identification of unmet need has often to rely on sensitive and informed carers. This author hoped to elicit from keyworkers how aware they were of this information and what health conditions were being monitored. All residents needed help in this area.

When the questionnaire was analysed it emerged that Q39 ("How are this resident's health needs met?") led to some confusion in its content and layout. Part 5 of this question ("Regular check-ups with GP/clinic - state which and for what condition") would have been better worded as "Regular check-ups with GP/clinic for long standing health problems". Answers to all parts of this question were coded in the most appropriate section (e.g. a reference to regular chiropody checks in "other" was coded under the regular check-ups section).

Only 12 keyworkers referred to regular check-ups and gave a particular condition. A number of answers clearly indicated that this was a routine health check (e.g. every 6 months) and were coded as routine check-ups with the doctor. Epilepsy (4 out of 12) and chiropody (also 4) were most frequently mentioned. Table 10.30 gives frequency counts for this question and Tables 62a, b and 63 of Appendix 9 gives the full picture.

Only 43 (74%) out of the 58 had regular check-ups with the dentist. Without knowing the number of residents who had neither teeth nor dentures, it is difficult to know whether this number should have been greater.

Many residents (40 - 69%) were able to tell staff if they felt unwell and a similar number of staff (37 - 64%) could tell if the resident was unwell. In 26 instances the keyworker answered yes to both these parts. This meant that at least 11 residents (19% of total) were solely dependent on the keyworker or other staff member for noticing when they were unwell. Fifty (86%) residents were taken to the doctor when needed.

Table 10.30 *How residents health needs are met. N = 58*

How health needs are met	Frequency
Routine check-up with doctor	13
Taken to doctor when required	50
Routine check-up with dentist	43
Routine check-up with optician	29
Regular check-up with GP or clinic (stated)	12
Resident tells staff if unwell	40
Staff can tell when resident is unwell	37
Resident does not need any help	0
Any other ways (stated)	5

In the "other ways" section three keyworkers made reference to particular methods relating to individual residents. They were: "charting things to see pattern and then getting professional advice e.g. incontinence" (1 Green Close); "resident known to be prone to illness in bad weather" (3 Green Road); and "plan for signs of client's illness devised because of communication difficulties" (Blossom Cottage). All 3 keyworkers worked in Provider B2 contracts.

Most (74%) keyworkers felt they were responsible for meeting the health needs of their residents and this is shown in Table 10.31.

Table 10.31 *Whether the keyworker is responsible for meeting health needs. N = 58*

K/worker role in health	Provider type			
	A	B1	B2	Total
yes	15 100%	13 57%	15 75%	43 74%
no	0 0%	10 43%	5 25%	15 26%
Total	15	23	20	58

Percentages by column.

Keyworkers in Provider A contracts (directly employed staff) were all clear it was their responsibility. Although there was a mixed response in the Provider B contracts, the

keyworkers in Sheridan Way (Contract 6) were all clear that the whole staff team was responsible and not the keyworker. Table 10.32 shows that 10 out of 15 keyworkers who said they were not the responsible person did not answer the question about who was. These keyworkers all worked in homes where there was a mixed response about where the responsibility lay. The question about who carries the responsibility needs to be clarified with the provider if health needs are to be adequately met. Table 64 and 65 in Appendix 9 shows the response re. responsibility by contract.

Table 10.32 *Who else is responsible for meeting health needs , if not the keyworker. N = 15. (NR = 10)*

Who is responsible for health	Frequency
All staff/staff team	3
Resident	1
Other e.g with UM and parent	1

10.3.1 Health Promotion

Keyworkers were asked in the questionnaire about whether their home pursued health promotion policies and if so, what they were. This was a free text question with no pre-determined categories. Forty four keyworkers replied positively and of these 40 (91%) mentioned healthy eating and 26 (59%) referred to no smoking for staff. Frequency counts are in Table 10.33 and full results by provider in Table 67 and 68 of Appendix 9.

Table 10.33 *Which health promotion policies are pursued. N = 44*

What health promotion ways	Frequency
Healthy eating	40
Weight reduction under doctor	9
No smoking for residents	5
No smoking for staff	26
Give-up smoking for residents	4
Give-up smoking for staff	7
Any others	11

The 11 keyworkers who mentioned other policies mostly made reference to monitoring weight and plenty of exercise. Only 1 keyworker mentioned the no alcohol policy for staff (Contract 11 -Langley House) which had been introduced into BSS in 1994. Subsequently

the social services committee had made adherence to this policy a condition of all new contracts.

In view of the high rate of physical disability associated with learning disability and the limited ability of this client group to communicate how they feel physically, this showed a disappointing and unimaginative response by keyworkers,

10.4 Advocacy and promoting choice

A natural concomitant of the principle of normalisation is the desire of people with learning disabilities to speak out for themselves and express their own views as other people in society do. The term "People First" arose within Canada in the early 1970s and was imported into the UK in 1984 after 9 self advocates attended the first People First international self-advocacy leadership conference in the US.

10.4.1 Definitions

There are various definitions of advocacy which reflect the various forms that advocacy takes. Atkinson and Williams (1990) identifies four.

1. **Advocacy within services** by individuals working in the service. This may lead to conflicts of interest when staff are trying to represent the needs of individual service users
2. **Self-advocacy** involves the enabling and encouragement of advocacy on their own behalf by people with learning disabilities. People First (1988) described "self advocacy as speaking up for yourself rather than let others speak or act on your behalf. It involves being aware of what your rights are and having skills to express your needs and ensure those needs are met". Most self advocacy groups cover a limited locality e.g. clients from a day centre or residents from a particular home
3. **Citizen advocacy** has as its basis a one to one relationship which is voluntary and unpaid and is independent of the service provider. Sang and O'Brien (1984) describe it as follows. "An ordinary citizen develops a relationship with another person who risks social exclusion or other unfair treatment because of a handicap. As the relationship develops, this advocacy develops ways to understand, respond to and represent the person's interests as if they were the advocates own".
4. **Support circles** are a co-ordinated group of people who provide advocacy for an individual person. The emphasis is on "non-service providers" people such as friends, family, co-workers, neighbours who are not paid to be there but are involved because they care - who meet on a regular basis to provide help and support in accomplishing

goals and visions. They are described by Mount et al. (1988) and O'Brien (1987b) and advocated by Atkinson and Williams (1990).

In addition there is **legal advocacy** which is described by Malin (1986) as ".. the broad range of methods and activities by which lawyers and other skilled individuals help ..... mentally handicapped people to defend their rights". The lawyer is unlikely to become involved in the life of the client in the way the citizen advocate or a member of a circle of support does.

Reference to advocacy only appears in the later Type 2 contracts (clause 15) where it states

> "Advocacy will be promoted as a matter of course, this being the joint responsibility of the resident's keyworker and care manager".

This clause is rather nebulous, particularly as it is not clear which types of advocacy were being promoted nor through which channel they were to be pursued.

10.4.2 Promoting advocacy

Keyworkers were asked specifically how they promoted advocacy and given various options to answer, together with the opportunity to mention other ways. The options were aimed to reflect the range of advocacy functions. Of the 57 who answered 33 (58%) said their resident was able to say what they wanted without help. Thirty said their resident did need help and 10 answered yes to both questions. This latter result implied that in some circumstances residents needed help and in others they did not. When coding, a separate category was included for those who answered both 1 (able to say what they want without help) and 2 (able say what they want with help).

Residents' meetings were seen as a popular way of encouraging residents to say what they wanted (27 - 47% mentions). Only one resident had an outside advocate and 2 more were awaiting an advocate. Eight had someone else as an advocate (parent or social worker/care manager). See Table 69 in Appendix 9 for full frequency count.

When the answers to the questions about advocacy (Q38 - part 2 what sort of help is given so that residents can say what they want) were compared with the question about help with relationships, it would appear that residents needed more help than was indicated. The keyworkers of 3 of the residents at Pencolm said they needed no help in maintaining relationships but in the section on advocacy made references to "has trouble expressing himself, staff offer informal choices" or "has no speech but offered choice by staff ...

keyworker builds close relationship so more aware of resident's needs". Although not all relationships need verbal communication to be sustained, without help from the keyworker the resident would be limited to staff and other residents for social relationships as these were the people with whom they spent regular time. The two tables below show how advocacy is promoted for those that need no help with relationships (Table 10.34a) and those that do need help with relationships (Table 10.34b)

Table 10.34a *N = 22 (no help with relationships)*

How promote advocacy	Frequency
Able to speak for self	14
Able to say what wants with help	10
Through resident's meetings	10
Has outside advocate	0
Someone else is the advocate	4
Other ways	4
No advocate yet	0
Answers both 1 and 2	4

Table 10.34b *N = 35 (need help with relationships)*

How promote advocacy	Frequency
Able to speak for self	19
Able to say what wants with help	19
Through resident's meetings	16
Has outside advocate	1
Someone else is the advocate	4
Other ways	5
No advocate yet	2
Answers both 1 and 2	6

The figures for each sub-group are fairly similar - about 45% in both groups used residents' meetings and about 17% answered both question 1 and 2. As might be expected a higher proportion were able to speak for themselves (64%) in the group who did not need help with maintaining relationships compared to those that did need help (54%). These responses implies that it is not straightforward about when and how a person needs support to express wishes or to make and maintain friendships.

The answers from these questions also give an indication that much of what the resident expresses is internalised to the home and it is important for whoever is monitoring the service checks out the views of the outside advocates (who are a small proportion of the total) about what the resident is expressing. Alternatively the monitor could speak directly to the resident or look at the notes of the residents' meetings.

It was also clear from the written text answers in this section that advocacy is either interpreted as offering choice (often in small ways such as what to wear or which drink to have) or the keyworker supporting the resident to say what they want having talked through the options on a 1 to 1 basis beforehand. The relationship between the keyworker and resident is often close and both sides need to feel that the service users' voice is correctly

interpreted and heard. Full results of how advocacy is promoted are in Table 70 of Appendix 9.

10.5 Summary

Chapters 9 and 10 have given a full analysis of the results of the questionnaire and related them to the relevant literature. It has highlighted inconsistencies of keyworker care practice within homes and within providers. This was particularly so in the case of care planning and meeting health needs. The chapters also indicated which areas of the care service warranted more emphasis in future monitoring. The next chapter (Chapter 11) describes how the author utilised this information to formulate pointers for future contract monitoring in the second part of the research study.

Chapter 11.

The second phase of the study - putting results into practice

11.1 The phases of the study

The end of chapter 3 (section 3.8 and 3.9) outlines the main parts of this research study which were

1. the experience of monitoring block contracts of residential care for people with learning disabilities together with the survey of keyworkers and
2. the changes initiated within the SSD by the author in the area of contract monitoring.

This chapter describes how the first part of the study influenced action and process in the second part of the study during 1995/96. Before that there is a discussion (section 11.2) about the extent to which the starting assumptions influenced the development of the study followed by the implications of the keyworker survey on future monitoring. Section 11.4 describes in some detail part two of the study which is the impact on BSS practice. This is followed in section 11.5 by the author's recommendations made in July 1996 to senior managers in the purchasing stream of BSS. The chapter concludes with a consideration of the extent to which the original aims of the study have been met.

11.2 Review and discussion about the original assumptions

Chapter 3 (section 3.1.1) described the starting assumptions the author made at both the personal and organisational level which informed the initial aims of the study. These were:-

1. Author's personal style
2. Purchasing/providing split
3. Contracting being a new concept
4. Ability to detect differences in the quality of care

11.2.1 Author's personal style

From a personal view the author favoured a collaborative style of monitoring rather than a confrontational one. The research literature reviewed in Chapter 6 confirmed that a collaborative style of monitoring is more effective in engaging providers than one that is combative. It is the preferred method espoused in government guidance as shown

by the publications relating to the new community care legislation. (e.g. Gleave and Peck 1992a). In addition publications by the voluntary sector who were destined to become providers around the time of the development and implementation of the 1990 Act supported this view and it was the model espoused in Berkshire.

There are costs and risks in any style of contract management. Knapp et al (1994) describes the transaction costs associated with contract drafting, monitoring and enforcement and how these could be especially significant for complex services. They defined complex services as those used by people who had few opportunities or abilities to voice their opinions of quality or where user outcomes were of long gestation. Both these criteria would apply to the care service which are the subject of this research study (long term residential care for people with learning disabilities).

These authors also highlight the balance needed between costs (and burdens) on all sides of suitable quality and outcome monitoring and the risk costs of occasional or superficial monitoring of inputs in terms of the effects on the lives of vulnerable adults. Winkler (1990) who visited Macomb Oakland Regional Centre (MORC) in Michigan, USA (MORC is also described in Gupta and Gatiss, 1993) concluded that this American service was not reliant on the "cosy contracts between the purchaser of care and provider" which she felt was a feature of the UK scene. MORC purchases 2000+ individual residential places. One of the ways MORC used to reduce transaction costs was through monitoring of the service by parents and ancillary staff. Other ways (e.g. fostering a culture of concern by care staff for the rights of consumers) reduced the risk costs (i.e. of abuse and neglect) but increased monitoring costs. Staff were encouraged to report incidents of any non-routine event which might have an adverse effect on a resident. There were 5000 such incidents reported monthly which were screened by a senior officer of MORC. Of these 25-30 were allegations of abuse or neglect and 50% of these were substantiated. Although not referred to by Winkler there are inevitable resource costs involved in responding to substantiated allegations of abuse to vulnerable adults.

Although the author did not test out with individual providers how they felt about her particular style of monitoring, there was rarely any resistance to her interventions. Provider staff were co-operative with the visits made, complied with providing information when requested and generally responded to recommendations and suggestions. The questionnaire to keyworkers did not ask about the style of monitoring per se but instead asked about who the respondents felt oversaw the quality of care (which implied a monitoring function) and how the service was reviewed.

The keyworkers showed some recognition of the role of the monitoring officer but most staff mentioned the role of the inspection/quality assurance team in securing standards. The method of contract monitoring took some time to establish and was in operation for a relatively short period of time. Further work would be needed to explore the value of the process adopted and which is now enshrined in current contract documentation. A suggested method would be structured interviews with home managers and/or proprietors on a regular basis. If the recommendations by the author to BSS (section 11.5) are adopted then 18-24 months after implementation it would be possible to assess whether such a collaborative approach is favoured by providers.

11.2.2 The effect of the purchaser/provider split in BSS

Although the separation into purchasing and providing in Berkshire occurred in 1991, at the time the case study began there was still a degree of uncertainty about the role of purchasers and providers within the SS department. Where the contracts were with external agencies with no care contracts (Provider A contracts), the roles were more easily defined and were a continuation of previous relationships. Social service departments have been used to working with non social services agencies especially in the field of residential care for people with learning disabilities.

There was more role ambiguity in the Provider B contracts where SSD staff were working as part of a care contract with the external agencies. Although there were in-house service agreements between purchasers and providers for all services provided by BSS, in the area of learning disability there was little or no monitoring of these in the way that was being developed for the block contracts in this study. The original intention was that after the first year of 100% block booking in service agreements, the purchasing stream would move towards the purchase of a more individualised person centred approach for the use of in-house services. This has never happened.

An added factor was that there was a difference in emphasis in the care contracts for the two Provider B contracts which reflected the views of the BSS providing stream group managers. Both sets of contracts had provision for staff in the care contracts to be transferred to the external provider in time. However, with the east provider there was provision for any replacement staff to be employed by the provider and seconded back to the BSS. In the west this was not possible and all staff leaving the homes with care contracts were replaced with staff directly employed by BSS. At the time of transfer of staff in 1996 less than 20% were still employed by BSS in the east but 100% were so employed in the west. (See also section 5.10).

It is interesting to note how the role and influence of the provider changed since the case study started in April 1993. If the style of monitoring advocated is one of collaboration, then one would expect the provider to influence the method of monitoring. Evidence described in Chapter 7 showed that collaboration in 1993 and early 1994 was largely of a passive nature - providers complied with what was proposed but did not really influence what the author suggested. The author feels this was due to two reasons

1. Contracts were very new and purchasers and providers had little idea about what contracts and monitoring meant in practice.
2. The people responsible for delivering the services (primarily home managers) and the person monitoring the contract were not involved in drawing up the care specification or terms and conditions of contract which stated what was to monitored and how it was to be done. They had no "ownership" of the process and some home managers could not see the relevance outside of the role of inspection.

The later section 11.4 shows that there has been more involvement of providers, purchasers and service users in the development of contract documentation and hopefully in the future in contract monitoring. The influence of the purchasing stream on monitoring was also essentially passive in nature. Only the author felt it was important and has concluded elsewhere in this chapter (section 11.5) the necessity of having one person designated to monitor particular contracts. In theory, each contract had a "contract owner" but this was interpreted in different ways across the county. Chapter 7 described how contracts in the east of the county were not monitored for the first 12 months of their life. In addition, after the author was transferred to other duties in July 1994, her replacement was unable to continue with the monitoring of block contracts. Without the incentive of a designated contract "owner" and with no impetus from senior management, regular monitoring of block contracts became a thing of the past.

11.2.3 Contracting as a new concept

The introduction of social care contracting as one of the mechanisms to implement a new government policy meant there needed to be a cultural shift within the local authority SSDs. Neither the staff providing the care nor the author who was monitoring the care on behalf of purchasers had any clear idea about how monitoring should be carried out when the study began. Any monitoring that was done was a pragmatic response to this new concept of contracting in the social care market.

The limited period of formal data collection within this research study showed a few changes which were either a response to circumstances (e.g. half yearly meetings with care managers) or an attempt to streamline the process (e.g. developing a proforma for quarterly visits). Evidence from the USA reviewed in Chapter 6 indicated that changing performance indicators or monitoring information required was the most unhelpful action a purchaser could do in terms of maintaining a collaborative approach with the provider. In addition it did little to help the purchaser compare performance over time or one provider with another as a change in indicators was not comparing like with like. On the other hand, supplying monitoring and statistical information that is not used to improve standards and quality or flag up potential problem areas is counter-productive to all participants. The author tried as far as possible to ensure that monitoring information requested was compatible with what was already being collected and was not counter-productive.

Answers from the keyworker questionnaire carried out in November 1994 are described in chapters 9 and 10. The keyworkers showed a greater knowledge of the existence of the care specification than was revealed in the diary entries (April 1993 to May 1994). It could be that the operationalisation of the care specification by the author in December 1993 had encouraged staff to find or look again at the contract documentation. Home managers were not interviewed by the author as part of the study so this conclusion is difficult to verify.

At the same time, some important contractual requirements in the purchasing contract were not met. In particular the annual review of the contract was not held on any contract from their inception.

11.2.4 Detecting differences in the standards and quality of care

In the discussions in chapter 3 about the study assumptions, the author raised methodological questions about

1. How to measure standards of care
2. Whether the chosen method would detect differences
3. Whether any measured differences were material to the contract

Measuring standards

The standard is described in the care specification which varies slightly between the 3 different types of contract. These variations did not affect what providers did - in practice they were working to similar standards determined by the local registering

authority and the aims and objectives of the provider organisation. Because the expectation from legislation and government guidance is that care is individualised service responses should reflect the range of needs (viz. O'Brien's five accomplishments, the emphasis on individual care planning in the All Wales strategy and the BSS care specification). These responses need to be evaluated both objectively and subjectively. The methods used in this study concentrated primarily on site visits and the survey of keyworkers. The sample size of each contract for the survey was small and one cannot with confidence interpret apparent differences among the contracts. Where providers had more than one contract (Provider B1 and B2) it was possible to interpret differences in results, though with caution.

Chapter 10 described the results of the keyworker survey relating to the responsibilities of their role as drawn up in the care specification. It looked more at whether and how the keyworkers were carrying out their responsibilities which would enhance the quality of life of the residents rather than the quality of the outcomes for individual residents.

Detecting differences

There was some attempt to look at differences between the standard of different providers and the internal consistency of providers who ran a number of homes. If differences in performance of providers is detected, one would also want to know the reasons for the differences. As with many areas of social sciences the answer is likely to be many-faceted though some tentative explanations were given in Chapter 9 and 10.

Taking the care planning function and reviews/IPPs as an example, the author noted inconsistencies within a number of contracts relating to this area (e.g. whether care plans for daily activities were drawn up, differences between care plans and reviews/IPPs). Various reasons can be advocated to explain this lack of clarity. New staff may not have been properly inducted (overall 30% had no induction), or the provider may not have a clear policy and procedure in this area (though this would not be borne out by written documentation from the proprietors). Alternatively, the interpretation of the central procedure may vary at the local level, or staff turnover was high which with poor induction lead to inconsistencies, or there is no training in this area to reinforce good practice and the "provider's" model. When this is supplemented by information from diary entries which indicated that changes in the leadership/management of the home always led to changes in the way information was recorded in the resident files, then inconsistency in care practices would be expected. From the purchaser's perspective (and presumably also the service user) one would want to work with the provider to address any shortcomings in specified areas and

thereby improve the standard and quality of care. If applied well and related to the underlying philosophy of service it would then improve the service outcomes for individual service users.

It was hoped that the results of the monitoring would indicate certain consistencies within providers, especially those that had several homes within the research study. This would only apply to Provider B1 and B2 though Provider A2, A3 and A4 had other homes within the county which were outside the study and could have been used for comparison.

Although the case study did not reach this level of evaluation, it is pointless to do monitoring without the follow-through. The annual review of the contract would be the most appropriate time to evaluate the service against the service performance criteria set using the information and views collated during monitoring.

Differences material to the contract

The case study covered a period when the contract monitoring method was being established and it was at the very early stages of development. If the author felt that the standard of care was below what was expected from the contract, her style was to try and work with the provider to improve things rather than use procedures for breach of contract. Inevitably, as social care contracting becomes more widespread, case law will develop and this will give guidance to purchasers and providers about what evidence is successful in the civil courts which may force an improvement in record keeping. In addition, the writing of care specifications and terms and conditions of contract will become more explicit so that both sides will have clearer expectations about what is required. For example, during the term of the case study there was one instance where the author collated information from the monitoring visits to try and show that the provider was not supplying "sufficient staff with sufficient abilities to ensure the service is provided at all times to the standard required by the specification". The solicitor felt that this information would not be robust enough in a court of law. Resorting to legal action is not the only remedy but the period that the author actively monitored the block contracts (between 3 and 15 months depending on the contract) was not sufficiently long to evaluate the effectiveness of the various interventions/remedies she attempted.

11.3 Implications of the survey on future contract monitoring

The keyworker survey was carried out in November 1994 and the next few months were spent analysing the data (described in chapter 9 and 10) and looking at the implications of

the survey. This led the author to postulate 8 pointers for future contract monitoring which arose from the survey. They are described in some detail below.

1. **Knowledge of care specification**. One would want to know why some providers were familiar with what was included in the care specification whilst others were not. Apart from the fact that compliance to the care specification was part of the contract, if the provider was not implementing it the purchaser would want to know what model and standard of care they were delivering. On the other hand, as neither the purchaser nor the provider had complied with the first review which was expected to take place annually on the anniversary of the contract date, then the purchasers could not necessarily know what model and standard of care was being delivered.

2. **Staff changes**. Although staff turnover was not addressed in the keyworker survey, it was clear from the length of time the staff had been in employment that staff did change quite frequently. 84% had worked less than 2 years and all the homes (with the exception of the Type 3 contracts) had been open for between 20 and 24 months. The contracts themselves had been in existence between 20 and 27 months. Changes in staff means that the provider needs to give attention to staff induction and training to ensure there is consistency of care. For homes where there is exceptionally high staff turnover, one would want to know what factors were affecting this (stress of job, management practices, types of resident, staff pay etc.)

3. **Induction**. From the survey it would appear that some of the providers were not very consistent about ensuring their staff had a formal induction programme. 30% of staff had no induction and even in the "best" organisation (provider B1), 19% had not had an induction.

4. **Staff training offered**. Training that was offered appeared varied and was given to staff somewhat haphazardly. Although the sub-sample was small, priority training needs did not seem to be related to the needs of the client group e.g. staff working with challenging behaviour and known sexual difficulties were not receiving training about personal relationships, risk taking and dealing with aggressive and challenging behaviour.

5. **Need for future training**. Staff did not feel their training needs had been identified for the coming year. Numbers varied from one quarter in providers B to three-quarters in providers A. Even those who had a staff appraisal (suggested in the care

specification as a suitable vehicle for identifying training need), up to a quarter in providers B and over a half in providers A felt this was not clear.

6. **Care planning in care reviews/IPPs**. There appears to be a lack of clarity about care planning and how it related to IPPs/reviews. Even within the same provider there was a lack of consistency. The following areas were identified as needing improvement.

a) overlong gaps between reviews/IPPs
b) the potential for a lack of co-ordination of care plans and care practices within the different agencies especially residential unites with day centres and colleges
c) a lack of clarity about objectives or goals, who was responsible for implementing them, how they are monitored from one IPP to the next and the degree of "success" in achieving goals
d) more importantly, greater emphasis should be given to the appropriateness of the objective both in terms of medium and longer term planning, how this relates to positive outcomes for residents and to what extent they can be evaluated against the values and principles underlying the service

7. **Meeting health needs**. Despite the limitations set by the design of the questionnaire on meeting health needs, there are pointers that more emphasis needs to be given in this area (e.g. 26% of residents do not have a regular check-up with the dentist, 19% are dependent on the keyworker to notice if they are unwell, health promotion activities are concentrated on healthy eating and no smoking for staff). There was also a lack of clarity in the B providers about who was responsible for meeting health needs.

8. **Provider quality assurance**. Only 2 out of providers responded to a request by the author to describe how their internal quality assurance processes were carried out. Experience of the 15 months when the author had responsibility for contract monitoring and the rest of the time covered by the research study indicates that contract monitoring only occurs when a purchaser was designated to carry out this function. It is therefore imperative that the provider has a robust internal monitoring system which can be externally verified. It also needs to take into account the views of various stakeholders, in particular to ensure that the services users' voice is heard; and to be proactive in improving quality and standards as highlighted in the previous chapter (section 9.4).

11.4 Impact of the first part of the study on subsequent BSS practice

The implications of the keyworker survey highlighted in the previous section (section 11.3) were used in a number of ways by the author during the second part of the study. These, together with reflections on the process of monitoring and the review of literature informed the author's practice and the policies of the purchasing stream of Berkshire SSD. The ways are described below:-

11.4.1 Redrafting the residential care specification

The thrust for this came from two quarters - the advent of joint commissioning and the experience of care managers in using the specification in practice.

The decision by BSS and BHA to jointly commission services for people with learning disabilities came to fruition in October 1995 when chief officers in both authorities signed a Section 28A agreement. One of the priority areas of this agreement was for BSS to take responsibility for purchasing residential care on behalf of BHA for the 240+ people who had been discharged from long stay hospitals between 1991 and 1993. Contract documentation was to be within the Berkshire model and a new care specification was imperative. As many of the homes had been established as a result of the re-provision of the long stay hospital most of the new contracts would be block ones rather than spot purchases. In addition a further 250 people were to be discharged from hospitals in the east of county between 1996 and 1999 and although BHA was taking the lead in commissioning the new services, Berkshire SSD would be purchasing accommodation, support and day opportunities from the point of discharge.

The other influence was the realisation by the author and care managers within the CTPLDs that there were a number of limitations to the care specification (BSS, 1993c) and the terms and conditions of contract (BSS, 1993a). The latter had been revised once (BSS, 1994b) but the care specification needed improvement too. The experience of care managers was mainly in the area of spot purchases though they were involved with some of the block contracts run by the A Providers. In particular the author felt that, since her secondment in 1994 had limited the purchaser role in monitoring, the care specification needed strengthening to give more emphasis on the provider to improve and maintain a quality service.

The re-drafting of the specification was a collaborative effort within social services - primarily purchaser led but with feedback from social services providers. However, the input was from the middle management level - not the care managers in the community

teams. There was no collaboration requested from independent providers (home managers or keyworkers), service users or relatives.

The following key areas were strengthened in the final specification (BSS, 1995b):-

- Increased emphasis on the providers' internal quality assurance systems which would be shared with the purchaser
- Attempts to clarify and refine the clauses about care planning and IPPs/reviews. This needed to incorporate procedures and definitions already agreed by the working party looking at the care management guidelines.
- Increased emphasis on outcomes for service users, in particular a requirement to look at review outcomes, quality monitoring etc. against the philosophy of care set out in the first part of the specification (essentially O'Brien's five service accomplishments).

11.4.2 Accreditation

The accreditation of providers became an important element in Berkshire's attempt to improve the standard and quality of care Berkshire purchased. Being an accredited provider did not guarantee the department's business, but care managers were only permitted to purchase with an accredited supplier (except within the parameters of the choice directive (DOH, 1992e). Accreditation was applicable to private and voluntary suppliers (not in-house BSS providers) and although initially for residential and nursing homes it was extended to domiciliary and day care providers. Just as joint commissioning had become a priority for BSS, so had accreditation and monitoring. The author was seconded to work on joint commissioning and the person seconded into her substantive post developed the accreditation and monitoring team. Apart from the accreditation of suppliers, this team was involved in monitoring annual reviews in residential and nursing homes for elderly people. Such client reviews were not commonplace as they were in homes for people with learning disabilities. Because the emphasis was on this kind of monitoring, then the monitoring of block contracts developed during the first part of this research study did not feature on the agenda of the accreditation and monitoring team.

The author was involved with the accreditation of many of the providers applying to supply residential services for people with learning disabilities. She took an particular interest in how care planning and reviews were carried out, how service users were involved in the delivery of service as well as how staff training and induction was provided. The reason for concentrating on these areas was because of her previous experience of monitoring and the results of the keyworker survey.

11.4.3 Development of specification for day opportunities

When the hospitals in the west of Berkshire closed in 1993 the local NHS Trust decided not to become a residential provider, preferring to concentrate their resources on providing individualised day opportunities to the residents discharged locally. As joint commissioning developed, the purchase of day opportunities for people with learning disabilities discharged from long stay hospital came under the ambit of BSS. This included not only those services which were up and running in the west but also the new services being commissioned in the east as those hospitals were closing. The west NHS Trust had developed expertise in services for people with complex needs whereas the SSD offered a more mainstream service. At the same time the closure of the long stay institution and its associated "day hospital" meant that BSS day centres were finding it increasingly difficult to meet the needs of a wider range of clients. It was felt that the desire to achieve integrated access to the two different styles of day opportunities, thereby enabling clients to receive a service according to need rather than past history, could best be met within the joint commissioning framework.

Most provision of day care was "purchased" within the service agreement of the in-house providers. In order to contract with other providers it was necessary to develop a care specification as well as terms and conditions of contract for non-residential services. The author took the lead in late 1995 to prepare a care specification for day opportunities and involved purchasers and providers in both health and social services. The underlying intention was to work within a collaborative style that valued the experience and expertise of the various stakeholders. In August 1996 the specification was circulated in draft form to over 100 individuals and organisations - local Mencap groups, existing providers of day care, CTPLDs, citizen advocacy groups - and their comments invited. Attempts to involve service users have been limited but funds have been made available to a video group run by people with learning disabilities. They will ask for the views of service users about existing services and also look at innovative practice in the surrounding area.

11.4.4 Contract monitoring

The introduction of joint commissioning within Berkshire enabled 3 further care managers/social workers to be appointed in early 1996 to the west CTPLDs using Section 28A funding. Their brief was initially to take responsibility for the care management of the people already discharged from long stay hospital and for whom the SSD was now purchasing residential care. Many of the homes where people lived had been set up as part of the re-settlement programme and were effectively block contracts. Because health funding for people discharged from hospital is not always ring-fenced, it

was necessary to establish reducing block contracts. Funding would be reduced pro rata after a specified time following the death or move of a resident from a particular home. A few placements, especially those further afield, were spot purchases. The new group of care managers wished to develop consistent monitoring methods which fitted in with the department's care management guidelines and procedures and might be used by other members of the community teams. The author was involved in giving feedback on their work and asked them to comment on contract documentation being prepared for the Section 28A funded placements.

11.4.5 Re-negotiation of existing block contracts

In May and July 1996 new 5 year block contracts were signed with Provider B2 and B1. Although they covered 11 of the contracts of this study, they also formalised a number of ad hoc agreements in relation to other residential homes. The new contracts did not need to include care contracts as all existing BSS staff were transferring to Provider B1 and B2 under TUPE regulations. The author felt that removing the care contract would simplify the monitoring arrangements.

Many of the conclusions of the early part of the study were included in the contract documentation (e.g. provider to supply quarterly reports to purchaser, the annual contract review given greater prominence with a specified agenda including performance indicators and feedback of providers internal quality assurance systems). The care specification in both sets of contracts was essentially the one used for spot purchases (BSS, 1995b) though at the point of final negotiation one or two changes were made to ease clarification (e.g. use of a shared bedroom if both residents wished this).

11.5 Recommendations to Berkshire Social Services

In mid-1996 the author circulated to senior staff in the purchasing stream who were involved with services for people with learning disabilities and to the head of the inspection unit a summary of the recommendations arising from the case study and the action research. These recommendations covered the following areas:-

1. Monitoring of block contract should be a priority task
2. Annual review of contracts should take place
3. Establish a consistent method of monitoring to include spot purchases
4. More emphasis on providers' internal quality assurance
5. Relationship between service development, contract management and contract monitoring

The justification for these recommendations is given in the following paragraphs.

11.5.1 The priority of monitoring block contracts

The monitoring of block contracts for residential care should be re-instated as a priority task within the purchasing stream. Apart from the 14 five-year block contracts funded through the BSS agency budget there were also 33 reducing block contracts for people already discharged from long stay hospital and potentially another 50+ block contracts for people still to be discharged. There were also two large block contracts for day services with the local NHS Trusts. The author suggested that each block contract would have one nominated purchaser - preferably someone at the level of the CTPLDs rather than a centrally based person. The contract documentation referred to the "purchaser's nominated representative" and the author felt it would be helpful to have someone at the local level rather than the central level. Not only would the home be in that team's patch it would also help with the disaggregation of function resulting from the move to unitary authorities in 1998.

11.5.2 Annual contract review

The annual review of contract should be carried out as a priority. The annual review should evaluate as well as review the monitoring that had been continuing since the previous review. If there is more than one contract with the same provider there is an advantage in the one person being the monitor for all these contracts. This will enable the purchaser to see that similar good practice is maintained across all the homes. For large providers e.g. Community Homes Ltd. which have more than a dozen block contracts across the county, this may not be practical.

11.5.3 Consistent monitoring method

There needs to be established a consistent method of monitoring which is used across all contracts within this client group. The author recommended that the purchaser and provider agreed which performance indicators were to be used, who was to collect the information, how this information was to be evaluated and when. Although performance indicators and other monitoring methods were much clearer in the revised documentation (e.g. 1995 care specification , terms and conditions for reducing block contracts) it would still need to be agreed on an individual contract basis.

There were a number of providers, some local and some national, where BSS purchased several places, often in the same home, on a spot purchase basis. The author proposed that if the department purchases several places in one home (the suggestion was 3 or

more but the number would need agreement) one person should be given the responsibility to monitor and review the overall service on the same lines that the department would review a block contract. If the department purchases several places from one provider (e.g. a large national organisation) then efforts should be made to link relevant care managers so that information can be shared. Bu establishing a relationship between purchaser and provider (hopefully one of trust and collaboration) there would be benefit in knowing that the service which was purchased was appropriate, of the correct standard and provided value for money. It would also minimise "risk costs" and provide information about service gaps and where service developments could occur. All this involves a shift by care mangers away from the traditional "review of placement" or even a review of the components of a care package to a more proactive role in relation to contract management and support of the contract officer.

11.5.4 Provider internal quality assurance

There needs to be more emphasis on internal quality assurance by the provider - this to be shared with the purchaser and related to good practice and improved outcomes for individual residents. The author felt the providers' internal QA could start by tackling many of the areas highlighted by the keyworker survey e.g. induction of staff, appropriate training of staff, care planning and reviews, meeting health needs. Emphasis should also be given to collecting and evaluating the perspectives and experiences of other stakeholders e.g. residents, relatives, care managers, service providers who are part of the service users' care package.

The purchaser should not take over the rightful responsibilities of the provider to supply a service that complied with the contract. Instead the responsibility is laid on the provider and effectively this is the home manager, with the option for the purchaser to spot check the quality control if required. In the most recent contract documentation for reducing block contracts the author has written some guidelines for monitoring (see Appendix 10) which attempt to lay out the respective responsibilities of purchaser and provider. The advantage of writing guidelines rather than clauses in a contract is that they can be more easily revised and also form a useful arena for discussion with the provider about their own mechanisms for evaluating and monitoring their service.

The author was aware of the criticisms that have been levied (e.g. Knapp et al, 1994; Lewis et al, 1996 and Mansell, 1996) about the bureaucratisation of provider agencies in response to the burdens of contracting which may divert resources away from service

delivery to administration. She hoped that the guidelines would reinforce what were the necessary and sufficient mechanisms to achieve a quality service.

11.5.5. Service development

The department needs to think about how an element of service development and contract management can be built into the contract monitoring process. With many small homes and possibly small providers, it is in the purchaser's interest to have ways of supporting and sustaining these homes so they do not become too isolated and staff and residents feel they are integrated into the wider community. The author made the following suggestions:

1. Provider forums split into small and large providers. Thought needs to be given to whether and how day care providers fit in to any forums
2. Training of care managers in the practice of monitoring and contract management
3. "Technical support" role to small providers e.g. developing provider internal quality assurance systems, encouragement of shared staff training.
4. Involving interested outsiders in visiting and "befriending" homes and residents.

Lewis et al (1996) emphasises that, as well as ultimately the money being in the hands of the purchaser, the purchasing task also involves activities such as macro-needs identification, market mapping and market management. They also refer to Flynn et al's seminar (Flynn et al, 1994) promoting collaboration between providers through "networks" and "clans" instead of introducing market principles. Provider forums and shared training could help to promote such networks. Encouraging such networks and clans could not prevent them becoming collusive and possibly becoming price cartels. On the other hand strong purchaser direction is given by MORC (described by Winkler, 1990 and Gupta & Gatiss, 1993). They retain control of providers' in-service training thereby assuring that training is provided according to the MORC philosophy. All direct care staff had to undertake a specified amount of training annually. A personal visit to a similar organisation in Oakland, California by the author in 1994 observed the practice of the purchasing agency laying on suitable courses which provider care staff could access at minimal cost

11.6 Summary

Section 3.1.2 of this thesis outlined the twin aims which were set at the beginning of the study.

1. Develop a method of monitoring block contracts
2. To see if this method had a more universal application e.g. to individual or spot purchases.

Chapter 7 shows how the monitoring method was developed by the author and meets this first aim of the study. This chapter has described how the results of the monitoring were utilised in subsequent practice and goes some way to meet the second aim. The next chapter draws some conclusion about monitoring in the context of social care contracting and postulates some good practice guidelines.

Chapter 12

Conclusions

This chapter reviews the main finding from the research study as a whole and postulates some "good practice guidelines" for contract monitoring. It also offers some conclusions on its wider relevance to contracting in social care with independent suppliers. When services are entirely in-house formal contract monitoring procedures are rarely considered. When they are, their nature may depend more on the internal structure of the department (e.g. the split between purchasing and providing and the level of contracted out business) than concern for the service user.

12.1 The context of monitoring

Monitoring of contracts is a means to an end and not an end in itself. Nor is it the only way of achieving quality in service delivery within the goals of normalisation. It is a process occurring within a context - political, administrative, economic, social and individual. There are the policy objectives of implementing the community care reforms and ensuring that standards of care are upheld. For the foreseeable future the public sector is likely to remain the major purchaser of (formal) social care (Knapp et al, 1994) and from a political point of view cannot be seen to be slack - they will need to know what they are purchasing in a market oriented operation. They will want to ensure there are quality services at a reasonable cost and also want to support service users' rights - their right to play a part in the community in a way that is valued by the rest of the society and their right to be protected from abuse and neglect if they are vulnerable.

The author feels that from the monitoring method developed during this research study there is sufficient evidence to put forward some "good practice guidelines" for contract monitoring. Such guidelines could be utilised by any SSD purchasing services for people with learning disabilities . They would need to be set within the strategic framework and purchasing intentions of both social services and health for this client group. By taking heed to this element of the purchasing cycle, it is likely that the SSD will be better able to meet its obligations under the new community care legislation.

12.2 "Good practice guidelines"

The following guidelines are postulated and arise from the results and conclusions of the study. Further research is needed to ascertain whether these are the only important elements in the contractual relationship and whether they meet the needs of purchasers, providers and users.

12.2.1 The importance of monitoring

As more and more services are contracted out from the local authority and the mixed economy of care is developed, the purchaser is faced with a huge task of monitoring and reviewing the services for which they contract. Many of these services are inspected under the Registered Homes Act 1984 but this sets a minimum standard (some of which are enhanced by local standards). This Act has little to do with individualised or person centred purchasing as residential care is only one element of a person's package of care. The Act does not necessarily concern itself with whether it is the right quality for that person or meets any criteria about value for money or delivering better outcomes for service users. The author has argued in Chapter 6 that social care contracting gives a greater opportunity to improve the quality of life of service users than does the inspection process, notwithstanding the importance of monitoring minimum standards for homes.

It is important that the purchaser as the budget holder monitors the contracts. To achieve this, there needs to be a commitment by the organisation to this task. This means that an individual purchaser is given the responsibility to carry out that monitoring role, that there are consistent contract monitoring processes which reflect the nature of the service being provided, for whom it is being provided and how well it meets the needs of the individual. It cannot be done in isolation. The results of the monitoring needs to be fed back into organisation to aid the overall review of service purchased - its quality, its relevance to the assessed needs of the eligible population, its priority compared to other service responses and its flexibility in delivery. In addition, an effective monitoring system will (hopefully) spot potential difficulties. A collaborative approach which aims to solve problems will provide remedies to difficulties in most instances. The overall aim of monitoring is not to collect evidence to support a court case but to ensure that the overall policy objects outlined in section 12.1 above are met. On the other hand, there are other viewpoints to consider and more work needs to be done to incorporate other stakeholders in the monitoring process.

12.2.2 Provider internal quality assurance

There is a need for robust internal quality assurance mechanisms by the provider which are open to verification by the purchaser. There are many reasons for this - professional commitment and self-regulation ensures that professionalism is valued and this is cheaper than extensive surveillance (Walsh 1991). The provider delivering the service is closer to the service user and if the provider aspires to improve the quality of their service it follows that they need to monitor and review their standards.

The areas of service that were identified in the study as needing improvement and particular attention were:

- induction and training of staff - especially training relevant to the needs of the clients receiving the service
- care planning and IPPs/reviews. Not only the care planning that goes on within the residential home but also its compatibility with care planning in other agencies (e.g. day centres) and the overall purchaser (care management) care plan.
- meeting health needs
- an emphasis on looking at individual service outcomes as measured against O'Brien's five service accomplishments. In terms of improving quality of life one of the simplest and most effect way of improving this would be for the provider to regularly measure how much choice/autonomy the resident has within their day to day activities and to what degree the activities they participate in are in non-segregated settings.

12.2.3 The role of the care manager

A major consequence of the new contracting culture in that care managers in CTPLDs need to move beyond the individual package of care and take on a more contract management role for the SS department. With social service departments having lead responsibility for purchasing, whether or not within a framework of joint commissioning, care managers need to be aware and actively participate in the commissioning cycle (DOH, 1995b and Harris, 1996 especially chapter 2). The residential service someone receives in a home is as much the result of the overall quality of service in the home as it is the individual care plan or IPP/review. It is dependent on the proprietor's strategic, policy and procedural framework as well as the way the registered manager interprets that at the home level and implements service responses to meet users' needs. In addition the care manager needs to take into account and influence the purchasing policy of the department - to include strategic direction, value for money, effective responses to priority needs, eligibility criteria etc. Being part of the contract monitoring process for contracts for residential care will enable care managers to more effectively participate and shape this purchasing policy.

12.3 Concluding thoughts

It is clear from the author's work that there is a need for greater involvement in monitoring by other stakeholders especially service users. This was only briefly addressed in the case study, although the intention in contracting is there in spirit if not in practice. In recent

years emphasis has been placed on the participation of purchasers and providers (both health and social services) as well as involving the many independent providers emerging in the mixed economy of care. The service user and his/her advocate has yet to find a voice.

In the field of learning disability the voice of the carer, especially parents who continue to provide support in the family home, is often louder than the person with learning disabilities. Many of the clients with learning disabilities have complex and diverse needs which can only be met by the collaboration and co-operation of all agencies, professional and other stakeholders. Concerted efforts need to be made to involve service users and the monitoring of contracts for services they receive is an excellent place to start.

12.4 Recommendations for further research

It is accepted that there are other important aspects of contract monitoring and contract management that are not covered by this research study e.g. financial probity of suppliers, value for money in terms of outcomes for service users, the effect of purchasers "managing the market", equity issues as eligibility criteria and prioritisation are changed to meet tighter funding levels which will affect who receives a service from a spot or a block contract. However, from this research study the following recommendations for further research are made:-

1. The balance between provider internal quality assurance mechanisms and purchaser contract management control procedures.
2. The role of the care manger in contract monitoring and management generally e.g. in relation to the social work task.
3. The relationship between the effectiveness of the 1984 Registered Homes Act in setting minimum standards and the role of contracting in achieving high quality service delivery.
4. How to involve the service user, who is not purchasing care directly, in monitoring and evaluating the service they receive.

Table 9.24 *Who the keyworker thinks oversees the quality of care. N = 58*

Who oversees quality of care	Provider type			
	A	B1	B2	Total
Proprietor	10	9	14	33
Registered manager	15	23	20	58
Senior person on duty	12	12	7	31
Inspectors at Shire Hall	10	20	15	45
Area manager or care services manager	9	19	15	43
Keyworker	12	11	17	40
Care manager (social worker)	4	8	7	19
Monitoring officer of SSD (purchasing)	9	3	9	21
Anyone else (stated)	5	7	4	16
Total	15	23	20	58

Table 72 and 75 in Appendix 9 compares responses for the two proprietors who replied to the author (Provider A1 and B2). At Mendip Way (Provider A1) all the keyworkers mentioned the proprietor, the registered manager, the senior person on duty and the keyworker as overseeing the quality of care. The inspectors and care managers were mentioned only once (perhaps because they visit less frequently). The responses to who else oversees quality included the team as a whole as important (2 out of 2) and parents (1 out of 2). These responses fitted in with what was expected from the correspondence with the proprietor.

In terms of the correspondence with the proprietor of Provider B2, the author would have expected mention of the proprietor and the Care Services Manager (CSM), in addition to the registered manager. The proprietor was mentioned more frequently in B2 (70%) keyworkers than in B1 staff (39%). This was reversed for the CSM (75% in B2 compared with 83% in B1).

The BSS monitoring officer was not rated highly in B1 homes, and was mentioned most frequently in Provider A contracts, where most of the intensive visiting had taken place. A similar frequency (though lower percentage) was mentioned in the B2 homes but this

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UNIVERSITY OF SOUTHAMPTON

THE DEVELOPMENT OF A METHOD FOR MONITORING LOCAL AUTHORITY BLOCK CONTRACTS FOR RESIDENTIAL CARE FOR PEOPLE WITH LEARNING DISABILITIES

Volume 2 of 2

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Appendices

APPENDIX 1

Example of the care specification

Type 2 contract (care sub-contracted)

text in italics are where it differs from the specification for the Type 1 (provider employs staff direct) contracts

SCHEDULE 2

CONTENTS **CARE SPECIFICATION**

1. PRINCIPLES

1.1 The values and principles which will guide care are based on the philosophy of normalisation and in particular the five "accomplishments" which accompany this philosophy.

Presence in the mainstream of community life for living, work and leisure activities.

Participation in the activities and patterns of community life appropriate to the individual's age and culture

Choice over all aspects of daily living which affect the individual, and where necessary assistance for the individual in reaching informed choices

Respect for the individual as a person of worth and status.

Competence in enabling the individual to acquire and practise those skills relevant to leading an ordinary life in their home and community

1.2 The Specification below will give examples of the application of these principles to specific parts of the service. It is expected that these principles will inform and guide all action and decisions taken by the Care Provider in relation to the services.

2 ACCOMMODATION

2.1 The Care Provider will ensure that the property provides a safe comfortable home and that it is suitably adapted to meet the needs of the people residing at the premises.

2.2 The residents shall enjoy the maximum possible use of the accommodation provided for them. Space designated purely for the use of staff shall be kept to a minimum, and may include an office for administration, a facility for staff to make secure any personal belongings, and an area for staff on sleep-in duty.

2.3 Normally, residents will enjoy the sole use of their own bedrooms. Bedrooms should not usually be entered by staff without the residents' permission. Where locks are fitted to bedroom doors, these will be capable of being opened from the outside in case of emergencies.

2.4 Each resident will be provided with the minimum of a bed, a wardrobe, a chair and a chest of drawers. Residents will be encouraged to bring or purchase furnishings for their own rooms, if they so wish. *All furnishings must comply with the furniture and furnishing (Fire) (Safety) Regulations 1988 and the Furniture and Furnishings (Fire) (Safety) Amendment Regulations 1989.*

2.5 Furnishings will be domestic in style and size, and new items will be chosen by residents and staff in the property. In respect of internal decoration, those living in the property will be involved in choosing colour schemes, and will be encouraged and enabled to do their own decorating if they so wish. *Internal decoration is the responsibility of the care provider and there will be a 5 year rolling programme of redecoration.*

2.6 All rooms intended for the use of residents will be centrally heated to an ambient temperature of at least 68 degrees Fahrenheit. Free standing oil heaters and portable electric/liquid gas heaters will not be used.

2.7 A phone which can be used by residents must be provided.

2.8 The Care Provider will ensure that a cleaning programme is devised which meets the required Environmental Health standards. *Residents will be encouraged, within their capabilities, to participate in the cleaning.*

2.9 Commissioning must be started for any repairs to the building within *three* working days of discovery of the fault. Where damage has occurred which renders the property unsafe or insecure, steps must be taken to make the building secure and safe immediately on discovery.

2.10 The gardens of the property will be designed to be of low maintenance and will normally be looked after by those working and living in the property. The gardens must be kept mown and tidy, in keeping with what might be expected of normal domestic accommodation in the neighbourhood. The gardens must be accessible to all residents of the property.

2.11 All paths and driveways will be maintained to ensure that there are no hazardous surfaces.

2.12 There will be a light outside the property at night, to facilitate safe access for residents, staff and visitors.

2.13 No sign indicating the specialist nature of the property will be displayed.

3. STAFFING

3.1 Staffing will be provided of such a nature as to ensure the safety, health and support of residents in accordance with the principles set out in Section 1 above. *A specification of staffing levels for the property evil be provided in accordance with the staffing specification attached as Annex 2 hereto.*

3.2 Staff appointments should be made in accordance with legislation concerning equal opportunities: the Race Relations Act 1977, Sex Discriminations Act 1975 and 1976, Equal Pay Act 1970 and Disabled Persons Act 1944, 1958 and 1986.

3.3. Each resident will have a keyworker, whose responsibilities include:

- ensuring that the resident has an appropriate care plan and helping implement it.
- helping the resident to maintain or establish appropriate relationships with family and friends and keeping such people informed of the resident's situation where permitted by the resident.
- ensuring that the resident's health needs are monitored and addressed. Health needs will include dental, health, eyesight and hearing requirements covered by any specialist profession regulated by the Professions Supplementary to Medicine Act 1960.
- Helping the resident to make appropriate choices in his/her life.

3.4 Every member of staff will receive a minimum of one hour's individual professional supervision per month from his/her line manager. An induction programme will be available to every new member of staff; this programme will be written down and signed by the staff member to confirm that it has been given. Every staff member will have the opportunity of identifying strengths and weaknesses in skills and having a training programme to meet these needs. It is recommended that this be carried out through an annual staff appraisal.

The induction programme will include:

- A statement of the need for confidentiality
- Health and safety policies and information, including first aid information
- Instruction in fire procedures
- Instruction in methods of lifting and handling residents

4. FINANCE

4.1 *Each Resident will pay a charge to the Care Provider for accommodation food heating laundry and care services. In return for this payment, the Resident will have access to all amenities in the Property at no extra costs and will be given access to all necessary health care.*

4.2 Residents will be generally encouraged to take responsibility for their finances to the best of their ability. They will have an individual savings account for their money, and will be encouraged to acquire and use their own possessions and to save for such purchases. Where it is necessary to have an appointee for the resident's finances, the Care Provider will try to find an appointee other than a member of staff in the property concerned. These attempts will be recorded; if they are unsuccessful the Care Provider may allow a member of staff in the property to act as appointee. The Care Provider shall inform the resident's Care Manager about who is acting as appointee.

4.3 *Residents will be informed of any insurance cover provided for the Property which affects their possessions. They* will be encouraged to take out their own cover on possessions not covered by the property's policy.

4.4 Residents will be informed that all personal gifts to staff are against the policy of the Care Provider, except for small token presents.

4.5 The Care Provider will ensure that residents are offered the facility for secure storage for valuable possessions. Receipts will be given when items are placed in such storage, and a record kept.

4.6 Any monetary donations made to an individual property will be kept in an amenity fund for *that specific* property.

5. PLACEMENTS

5.1 *In the event of a Resident requiring inpatient assessment and/or treatment in a health authority, the Car Provider may not deem the Resident's place "vacant" until the Resident has been in such a facility for at least eight weeks - such a decision must first be discussed with the responsible medical officer, the Resident's nearest relative , the Resident's Care Manager if appropriate, and the Council.*

5.2 *Residents in the Property will usually be allowed to remain Resident in the Property for as long as they choose. In the event of a Resident's needs being unmanageable by the Care Provider on the grounds of a severe threat to the health and safety or comfort of the Resident or of other Residents or staff, the Care Provider may exercise the right to terminate the Resident's occupation. Such termination shall first be discussed with the Resident's general practitioner or other relevant medical officer where appropriate, the Resident's nearest relative, the Resident's Care Manager. The Care Provider will give sufficient notice of termination in accordance with the Licence Agreement to enable an alternative placement to be found. The Council shall take ultimate responsibility for arranging such a an alternative placement.*

5.3 *The Care Provider shall ensure there is an established admission procedure involving the Council to ensure compatibility and appropriateness all placements. In accordance with the Placement Contract the Council has the right to refer residents and the Care Provider shall not without good reason refuse to accept those residents proposed by the Council.*

6. CARE PLANNING

6.1 The Care Provider will ensure that there is a structured programme of meaningful activity for everyone living in the property. Such a programme will be in accordance with the principles listed above in *paragraph* 1.

6.2 Such activity will normally include activities away from the property where the resident lives, and may include the use of day centres, open or sheltered employment, continuing education, the use of leisure facilities and therapy sessions.

6.3 Where residents receive a programme of activities within their own home, such a programme will involve the active interaction of staff with the resident for at least 50% of the time

6.4 Any programme available for the each resident will be in accordance with a care plan for that resident. This care plan may be described as an Individual Programme Plan or Review. Essential elements of a any care plan will be:

- a care plan meeting must occur at least once a year. Present at this meeting will be the resident if he/she chooses, any relative or advocate of the resident if the resident so chooses, the resident's keyworker, *the Resident's Care Manager* and other people as appropriate
- the care plan will be based on an analysis of the resident's strengths, needs and wishes.
- the care plan should be written and should include objectives agreed with the residents. A copy of this care plan will be available for the Resident.
- the plan will embrace all aspects of the resident's life, although objectives will focus on a limited number of these aspects.

7 LEISURE, SOCIAL AND RELIGIOUS ACTIVITIES

7.1 Residents will be encouraged and enabled to pursue leisure, social and religious activities which are appropriate for their age, culture and beliefs.

7.2 As far as possible such activities will be away from the property. In addition, there shall be at least one leisure activity provided per week for a group of residents; such activities will be discussed and agreed with the residents in advance. *Resident's rights will be respected if they decline or refuse to take part in such activities*

7.3 Residents will be encouraged to exercise their rights and responsibilities as citizens. All those eligible to vote will be assisted to enrol on the electoral register, to obtain information about policies and political parties, and to vote if they so choose.

8. USE OF COMMUNITY SERVICES

8.1 Residents should, as far as possible, have access to the full range of services used by the rest of the community and neighbourhood in which they live.

8.2 Residents living in the property will choose and register with their own General Practitioner and other like professionals such as dentists and opticians.

8.3 Residents will be encouraged to use services which are appropriate for their age, sex and cultural background.

9. FOOD AND CLOTHING

9.1 Residents will be involved in the choice and preparation of menus. They will be advised of the benefits of a balanced diet and of the consequence of eating certain foods.

9.2 Residents will be given the opportunity of participating in the preparation and cooking of food, using equipment of domestic size and style.

9.3 Residents will be offered fresh meat and seasonal fruit and vegetables as part of their diets. Overall diets should be balanced, nutritious and varied: the advice of a community dietician may be sought.

9.4 Special diets must be provided - on medical, cultural or religious grounds - at no extra cost to the resident.

9.5 Residents will choose their clothing in the usual manner of comparing what is offered by ordinary shops. It may be necessary to offer assistance in this.

9.6 Clothes will be identified as belonging to a particular resident, and items will not be shared between residents. To this end, care will be seen to be taken in the process of laundering clothes.

9.7 Bed linen (sheets, pillowcases, duvet covers) will be changed and laundered weekly or when soiled, whichever is more frequent.

10. PRIVACY

10.1 Staff should at all times remember that the property is home for those residents living there, and that their privacy should be respected.

10.2 All assistance with personal care - washing, bathing, using the toilet or receiving medication - will be given in private.

10.3 Residents will be able to send and receive mail and make and receive phone calls with due privacy.

10.4 Entry to the property will not be offered on an "open door" basis. Visitors will be required to announce their presence by knocking or ringing in the usual way before being offered admission.

10.5 When visits are requested for reasons other than for the welfare of the property/residents (for example, people involved in developing housing or wanting to look at examples), as far as possible meetings should be offered away from the property with any looks around the property kept to a minimum. Bedrooms will not be entered unless with the prior and express consent of the residents.

10.6 Visits and meetings will not take place at times which may disrupt the ordinary life of the residents.

11. POLICIES

11.1 The Care Provider will ensure that there are written operational policies for the guidance of all staff involved in the care of residents. Policies will, among others, address those areas here listed:

11.2 *Risk Taking*

Residents should be free to undertaken all activities considered acceptable to their peer group in ordinary life unless there are demonstrable reasons for not permitting this: the resident not being able to understand the nature of the risk or the full consequences of the action, or unacceptable danger to the resident or other people.

Residents will be assisted in learning to make informed choices and to calculate the risk involved in certain actions. This will be part of the resident's care plan and the views of relatives will be taken into consideration.

11.3 *Personal and Sexual Relationships*

Residents will be given help, advice, education and information, in order to promote their making of informed choices and to protect them from exploitation.

Such help, advice, education and information will be provided to the resident in accordance with the individual's level of understanding and taking the views of relatives into account.

The written policy will take into account:

- The variety of roles and relationships within the family
- The emotions associated with close personal relationships, and how these can be handled
- Action to be taken in the event of anti-social sexual behaviour
- The circumstances and ways in which contraception, sterilisation and termination of pregnancy might be discussed with the resident and family or advocate
- Guidance on marriage, cohabitation and parenthood
- Access to any necessary bereavement counselling

11.4 *Sanctions*

There will be policies on acceptable sanctions which may be used due to the resident's behaviour and concern over the health, safety and rights of other residents. When sanctions are used, the explicit reason and the actual sanction applied shall be recorded; such records will be available for inspection.

11.5 *Management of Aggression and Violence*

The policy will address the prevention of aggression and violence, strategies for defusing potentially violent situations, acceptable times and method of restraint, the recording of violent incidents and the training and support of staff.

12. RECORD KEEPING

12.1 The following records will be kept on respect of the property

- A record of any cash float or imprest account for financial management
- A record of all accounts held in respect of individual residents
- A record of any valuables held on behalf of residents
- A record of all medication administered by staff
- An accident book
- A record of any violent incidents and their resolution
- A record of fire drills and of fire equipment maintenance
- For respite care places, a record of all applications, and of places actually used

12.2 A record shall be maintained in respect of every resident, and shall include:

- Name, date of birth, address prior to admission, next of kin, responsible authority
- Information about the resident's health, including up to date reviews
- Any professional staff involved with the resident
- Any sanction imposed on the resident

- All written care plans
- All records required pursuant to any regulations made under the Registered Homes Act 1984

Such records will be kept locked away in a secure place.

12.3 The Care Provider will operate the Berkshire County Council's policy in respect of access to records for its residents.

13. HEALTH AND SAFETY

13.1 There shall be written health and safety procedures for each property in accordance with relevant legislation. Amongst other items, the procedures will cover:

- The safe lifting and handling of residents
- First aid procedures
- Infection control and management
- Procedure to be followed in the event of a missing person
- Procedures to be followed in the event of a drug overdose

13.2 The property will be inspected at least annually by a person nominated to do so by the Care Provider and competent so to do under the Health and Safety at Work Act. There will be a written record of the inspections.

13.3 The Care Provider will ensure that the property meets the required fire safety standard. Any necessary adaptations to the property will be done in such a way as to keep the property of ordinary domestic appearance, so far as possible.

13.4 The Care Provider will ensure that staff working in the property are informed of procedures to minimise fire risks. Regular fire drills will be carried out and recorded: such drills will involve the evacuation of the building, and there shall be an evacuation between 23.00 and *07.00* at least once a year.

13.5 The Care Provider will ensure that all fire alarms and detection equipment are regularly maintained.

13.6 No one shall be permitted to smoke in bedrooms. The Care Provider shall ensure that the property adopts a smoking policy which respects the views of all residents, protects residents from the risks of inhaling other people's smoke and takes into account the physical layout of the building. For those residents who choose to smoke, a clear explanation shall be given about the associated risks to health.

13.7 The Care Provider shall follow and use the Council's procedure on the administration, storage and disposal of drugs. *A copy of this procedure is attached as Appendix B*

14 MONITORING

14.1 The Care Provider shall facilitate the compliance with all statutory monitoring processes such as under the Registered Homes Act, the Health and Safety at Work (etc.) Act, and legislation concerning Environmental Health.

14.2 The Care Provider shall ensure that in the property there is a complaints procedure which is displayed and explained to all staff and residents.

14.3 The Care Provider shall set in place arrangements which ensure that residents are regularly consulted about the service they receive. Such arrangements will include a resident's meeting which takes place at least once every three months, is given at least three weeks prior notice, is minuted and is held at a time when as many residents as possible may participate.

Arrangements will be made to enable residents to draw up an agenda in advance. *Staff should assist in facilitating this process bearing in mind the limited ability of some Residents to fully contribute to this process.*

14.4 At least once a year, users shall be formally consulted about the service which they receive, *using pre-set questions based on the principles in paragraph 1 of this Specification.* Answers to such questions shall be systematically collated, recorded and discussed. An action plan shall be written and include timescales. Families and carers of Residents using this service should also be formally consulted.

14.5 If the Property offers a respite care service the Care Provider shall ensure that the families and carers of Residents using this service are asked for their opinions about the service at least once every two years. Such opinions shall be recorded.

14.6 The Care Provider shall ensure that mangers and staff within the property are encouraged and enabled to evaluate the service which they are delivering.

14.7 The Care Provider shall allow access to the Property to the appropriate person proposed by the Council. The person proposed by the Council or Resident's Care Manager shall be allowed to ask for comments from the Residents or the Resident's nearest relative.

14.8 The Care Provider shall make the following records available as necessary

- The Registration Officer's most recent inspection of the property
- Audited accounts of the property' finances
- Audited accounts of funds held for any resident
- Audited accounts of any amenities fund for the property
- Records of medication
- Accident books
- Records of violent incidents
- Records of fire drills
- Records of fire equipment maintenance
- A record of the most recent inspection under the Health and Safety at Work Act
- A record of all admissions and discharges, including those for respite care places
- Records of staff meetings
- Records of Residents' meetings
- The current and two other most recent staff rotas
- A record of staff turnover

15 ADVOCACY

Advocacy for all Residents will be promoted as a matter of principle, this being the joint responsibility of the Resident's Care Manager and the keyworker.

APPENDIX 2

Example of Placement Agreement

(Type 1 contract)

This agreement is made the [.....] day of [.....] 199[..] between BERKSHIRE COUNTY COUNCIL of Shire Hall Shinfield Park Reading Berkshire ("the Council") of the one part and [.....] whose registered office is situate [.....] ("the Care Provider") of the other part

WHEREAS:-

(1) The Care Provider has agreed to provide the Service to the Council in consideration of the Annual Recurring Revenue Sum

(2) This Agreement is intended to set out the terms on which the Services are provided to the Council and to identify the objectives of the provision of the Services and to regulate the relationship of the parties inter se.

INTERPRETATION

In this Agreement the following expressions shall have the following meanings:-

"The Annual Recurring Revenue Sum"	means the sum to be paid by the Council to the Care Provider in consideration of the provision of the Services for each year of the Term which sum is detailed in Schedule 1 hereto
"the Services"	means the provision by the Care Provider of community residential and day resources for the Residents at the Property pursuant to this Agreement and in accordance with the Specification
"the Term"	means the term of this Agreement commencing on the date hereof and terminating in accordance with Clause 12 hereof
"the Residents"	means those persons placed by the Council in the Property from time to time in accordance with Clause 9 hereof (being persons with severe learning or other disabilities)
"the Index"	means the Retail Prices Index (all items) produced by the Central Statistical Office or any substituted index for the month of [.....] in any one year of the Term
"the Specification"	means the Specification attached as Schedule 2 hereto
"the Property	means [.....]
"the Manager"	means the person who manages the Property and the Services on behalf of the Care Provider

1.2 In this Agreement, unless the contrary intention appears:

(a) A reference to an Act of Parliament or any Order, Regulation Statutory Instrument or the like shall include a reference to any amendment or re-enactment of the same

(b) Words importing the masculine gender include the feminine words in the singular include the plural and words in the plural include the singular

2 NOTICES

2.1 Any notice to be served on the Care Provider shall be valid and effective if delivered by hand or sent by recorded delivery to the Property addressed to the Care Provider

2.2 No notice to be served upon the Council shall be valid or effective unless it is delivered by hand or sent by recorded delivery to the County Solicitor, Berkshire County Council Shire Hall Shinfield Park Reading Berkshire.

2.3 Any notice to be served shall be deemed to be given on the date that it is delivered by hand or if sent by recorded delivery on the date when it would be delivered in the ordinary course of post.

3 ALTERATIONS TO THIS AGREEMENT

3.1 Without prejudice to any other term of this Agreement no omission from addition to or variation of this Agreement shall be valid or of any effect unless it is agreed in writing and signed by the Council's Director of Social Services and by the Care Provider.

4 THE SERVICES

4.1 The Care Provider shall provide the Council with the Services for [.....] Residents in accordance at all times with the Specification.

4.2 The Care Provider shall be deemed to have satisfied himself as to the accuracy, nature and extent of the Services required by the Specification before the execution of this Agreement.

4.3 The Property shall be maintained altered or repaired during the Term to accord at all times with the Specification.

4.4 The Services shall be provided to the standard required in the Specification. The Care Provider shall ensure that such a standard is maintained at all times.

5 THE CARE PROVIDER'S STAFF

5.1 The Care Provider shall at all times during the Term employ sufficient staff with sufficient abilities to ensure that the Services are provided at all times to the standard required in the Specification. Without prejudice to the generality of this obligation, it shall be the duty of the Care Provider to ensure that a sufficient reserve of staff is available to provide the Services to the said standard during staff holidays or absence through sickness or voluntary absence.

5.2 The Care Provider shall ensure that every person employed by him in the provision of the Services is at all times properly and sufficiently trained and instructed with regard to:-

i the task or tasks that that person has to perform; and
ii health and safety at work; and
iii fire risks and fire precautions; and
iv the need to observe the highest standards of courtesy and consideration

5.3 The Care Provider shall not knowingly employ in the Property anyone previously dismissed from employment with the Council without the express permission of the Council.

5.4 The Care Provider shall at all times take all such precautions as are necessary to protect the health and safety of all persons employed by him and shall comply with the requirements of the Health and Safety at Work etc. Act 1974 (and any amendment or re-enactment thereof) and of any other Acts, Regulations or Orders pertaining to the health and safety of employed persons. The Care Provider shall nominate a person to be responsible for the health and safety matters as required by the Act.

5.5 The Care Provider shall at all times be fully responsible for the payment of all income or other taxes, national insurance contributions or levies of any kind, relating to or arising out of the employment of any person employed by the Contractor and shall fully and promptly indemnify the Council against any liability in respect thereof

(i) The Contractor shall not unlawfully discriminate within the meaning and scope of the provisions of the Race Relations Act 1976 or any statutory modification or re-enactment thereof relating to discrimination in employment.

5.6 [insert any other requirement (e.g. professional standards/qualifications) of staff unless they are detailed in the Specification)]

6 ASSIGNMENT AND SUBLETTING

6.1 The Council shall be entitled to assign the benefit of this Agreement in whole only to a statutory or other public body and shall give at least 14 days written notice of any assignment to the Care Provider.

6.2 The Care Provider shall not transfer or assign directly or indirectly, to any person or persons whatever, any portion of this Agreement without written permission given on behalf of the Council by the Chief Officer concerned.

7 REVIEW OF SERVICES

7.1 The provision of the Services by the Care Provider shall be monitored on an annual basis by both parties with a view to:-

(i) evaluating the effectiveness efficiency and quality of the Services against the Specification

(ii) monitoring the quality of life of the Residents and the implementation of individual development plans

7.2 The Services shall first be monitored six months from the date of this Agreement and thereafter annually on the anniversary of the first date of monitoring

7.3 Each monitoring process shall result in a written report prepared by an officer nominated by the Council's Director of Social Services. The report will contain inter alia details of any breaches by the Care Provider of the Specification

7.4 On the fourth anniversary of the date of this Agreement and every fifth year thereafter a strategic review will be carried out jointly by the parties. The strategic review will constitute a review of the Services generally including the quality of the Property

staffing and the financing of the Services. If the parties agree the strategic review shall lead to a modification of the Specification

7.5 The reviews referred to in this Clause 7 shall be effected by:-

(i) the Care Provider and the Manager; and

(ii) two representatives of the Council who shall be nominated by the Council's Director of Social Services

8 PAYMENTS

8.1 The Council shall pay to the Care Provider the Annual Recurring Revenue Sum detailed in Schedule 1 which shall be reviewed on an annual basis in accordance with Schedule 1

8.2 Invoices for the Annual Recurring Revenue Sum will be submitted by the Care Provider at the times and in the manner prescribed by Schedule 1

8.3 Invoices for the Annual Recurring Revenue Sum shall be paid by the Council in accordance with Schedule 1

9 PLACEMENT OF RESIDENTS

9.1 The number of Residents to be supplied with the Services and the means by which those Residents are placed in the Property by the Council are detailed in Schedule 3

9.2 The Care Provider shall give prompt notice to the Council of any vacancy arising at the Property

10 DSS BENEFITS: REFUND TO THE COUNCIL

10.1 The Care Provider shall ensure that each Resident claims his or her full entitlement to DSS benefits

10.2 The Care Provider shall give to each Resident that Resident's personal DSS allowance

10.3 The Care Provider will credit the Council with the balance of all other allowances claimed from the DSS for each of the Residents. All credits given to the Council will be detailed on the invoices for the Annual Recurring Revenue Sum and shall be shown as a credit against the sum due from the Council to the Care Provider on such invoice. A reconciliation of all sums owing to the Council shall occur at the end of the Term.

11 PROVISION OF ACCOUNTS

If required by the Council the Care Provider shall provide the Council with certified accounts for the Service. If required the Care Provider will also supply an estimate of running costs of the Service for the forthcoming year

12 TERMINATION AND TERM

12.1 This Agreement shall commence on the date hereof and shall determine upon six month's notice by either party such notice to expire no earlier than the fifth anniversary of the date of this Agreement

12.2 The Council may, but not unreasonably or vexatiously determine all or part of this Agreement

(1) after seven days written notice to the Care Provider following the occurrence of any of the following events:

(a) if the Care Provider shall become bankrupt or have a receiving order made against him or shall present his petition in bankruptcy or shall make an arrangement with or assignment in favour of his creditors or shall agree to carry out this Agreement under the committee of inspection of his creditors or (being a corporation) shall go into liquidation (other than a voluntary liquidation for the purposes of amalgamation or reconstruction) or if the Care Provider shall assign this Agreement without the consent in writing of the Council first obtained or shall have an execution levied on his goods; or

(b) if the Care Provider has failed to comply with Clause 16 relating to Bribery and Corruption

(2) After 28 days written notice to the Care Provider (during which period such breach has not been remedied to the reasonable satisfaction of the Supervising Officer) if the Supervising Officer shall certify in writing that in his reasonable opinion the Care Provider;

(a) has abandoned this Agreement; or

(b) without reasonable excuse has failed to commence the performance of the Services under the terms of this Agreement

(c) has failed to rectify within the time stated in the notice breaches of this Agreement specified in the report detailed at Clause 7.3

(d) despite previous warning by the Council in writing is failing to perform the Services with due diligence or is otherwise persistently or fundamentally in breach of his obligations under this Agreement

(e) is in breach of Clause 6 hereof (assignment and subletting)

(f) has failed to comply with the terms of this Agreement

12.4 **Effects of Determination**

Upon determination of all or any part of this Agreement by the Council in accordance with Clause 12.1 in addition to such consequences as are set out in the other provisions of the Agreement:

(i) The Care Provider shall forthwith cease to perform the Agreement or such part thereof as has been determined.

(ii) The Care Provider shall fully and promptly indemnify the Council in respect of the cost of causing to be performed the Agreement or such part thereof as would have been performed by the Care Provider during the remainder of the Agreement paid to the extent that such cost exceeds such sum as would have been lawfully payable to the Care Provider for performing the Services. The Council shall be at liberty to have this Agreement performed by any persons (whether or not servants of the Council) as the Council reasonably deems fit; the Council shall be under a duty to mitigate its loss in accordance with the principles of common law.

(iii) To the extent the Agreement has been determined and sums are due in respect hereof the Council shall be under no obligation to make further immediate payment to the Care Provider and shall be entitled to retain in its hand any payments which may have fallen due to the Care Provider before determination until the Care Provider has paid in full to the Council all sums due under the Agreement or that part thereof which has been determined or to deduct

therefrom any sum due from the Care Provider to the Council under the Agreement.

13 CONFIDENTIALITY

The Care Provider and the Care Provider's staff shall treat as confidential and shall not disclose to any person any confidential information acquired by the Care Provider or his staff in connection with the provision of the Services

14 INSURANCE

(a) The Care Provider shall at all times maintain in force such policies of insurance with reputable Insurers or underwriters as shall fully insure and indemnify the Care Provider and the Council against all sums which shall become legally liable to be paid by way of compensation for accidental bodily injury (including death or otherwise) or accidental damage to property:-

(i) to the Council and to any employee of the Council; and

(ii) to the employees of the Care Provider; and

(iii) to any other person.

The insurance cover shall be in the sum of at least £2,500,000 for any one occurrence or series of occurrences arising out of any one event. The insurance cover may be reasonably increased from time to time at the reasonable request of the County Treasurer.

(b) The Care Provider shall prior to the commencement of the Agreement and thereafter annually and at such other times as the Council may require supply the Council with copies of all insurance policies cover notes premium receipts and other documents necessary to comply with Clause (a) hereof.

(c) Without prejudice to his liability to indemnify the Council under sub-clauses (a) and (b) of this clause of these conditions and in addition to any insurances required by statute to be maintained by the Care Provider as the case may be the Care Provider shall maintain such insurances as are necessary to cover the liability of the Care Provider in respect of:-

(i) personal injury or death arising out of or in the course of or caused by the carrying out of the Services not due to any act or neglect of the Council or of any person for whom the Council is responsible; and

(ii) injury or damage to property real or personal arising out of or in the course of or by reason of the carrying out of the Services and caused by any negligent act, omission or default of the Care Provider his servants or agents as the case may be.

(d) The insurance in respect of claims for personal injury to or the death of any person under a contract of service or apprenticeship with the Care Provider and arising out of and in the course of such person's employment shall comply with the Employer's Liability (Compulsory Insurance) Act 1969 and any Statutory Orders made thereunder or any amendment or re-enactment thereof.

(e) The Care Provider shall prior to the commencement of this Agreement and thereafter annually and at such other times as the Council may require supply the Council with copies of all insurance policies cover notes premium receipts and other documents necessary to comply with Clause (c) hereof.

(f) The Care Provider shall immediately notify the Council and the Care Provider's Insurers of any happening or event which may give rise to a claim demand proceeding damage cost or charge whatsoever arising out of this Agreement and the Care Provider shall indemnify the Council against any loss whatsoever which may be occasioned to the Council by the Care Provider's failure to give such notification.

(g) The Council shall be entitled to notify the Care Provider in writing that in the opinion of the Council any such policy of insurance does not effect sufficient cover to comply with this Clause and to require that the Care Provider shall forthwith procure and effect such insurance as the Council shall require and in default the Council may itself cause such insurance to be effected whereupon the Care Provider shall pay to the Council as liquidated damages such sum as the Council shall certify as being the cost to the Council of effecting such insurance.

15 OBSERVANCE OF STATUTORY REQUIREMENTS

The Care Provider shall comply with all statutes, rulings or orders or any regulation or bye-law applicable to the performance of the Agreement and shall indemnify the Council accordingly.

16 BRIBERY AND CORRUPTION

The Council shall be entitled to cancel this Agreement with immediate effect and to recover from the Care Provider the amount of any loss resulting from such cancellation, if:

(a) The Care Provider shall have offered or given or agreed to give to any person any gift or consideration of any kind as inducement or reward for doing or forbearing to do or having done or forborne to do any action in relation to this Agreement or any other contract with the Council; or

(b) The like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the Care Provider); or

(c) In relation to any contract with the Council, the Care Provider or person employed by him or acting on his behalf shall:-

(i) have committed any offence under the Prevention of Corruption Acts 1889 to 1916, or

(ii) have given any fee or reward the receipt of which is an offence under Section 117 (2) of the Local Government Act 1972.

17 DATA PROTECTION

The Care Provider shall comply in all respects with the provisions of the Data Protection Act 1984 and will indemnify the Council against all actions costs expenses claims proceedings and demands which may be made or brought against the Council for breach of statutory duty under the Act which arises from the use disclosure or transfer of personal data by the Care Provider and his servants and agents.

18 LIABILITY OF COUNCIL

The Council in no way warrants the truth or accuracy of any representation which may have been made to the Care Provider prior to his entering into the Agreement and the Care Provider acknowledges that he did not rely upon any such representation made by or on behalf of the Council when entering into the Agreement.

19 CLAUSE HEADINGS

The clause headings shall not be construed as part of these conditions.

20 WAIVER

No delay neglect or forbearance on the part of either party in enforcing against the other party any term or condition of the Agreement shall either be or be deemed to be a waiver or in any way prejudice any right of that party under this Agreement.

21 ALTERNATIVE DISPUTE RESOLUTION

21.1 In the event of any dispute or difference arising between the parties in connection with this Agreement the Council's County Solicitor and the Care Provider shall within 10 days of a written request from either party to the other addressed to the said County Solicitor and the said Care Provider meet in good faith in an effort to resolve the dispute without recourse to legal proceedings.

21.2 If the dispute of difference is not resolved as a result of such meeting either party may (at such meeting or within 14 days from its conclusion) propose to the other in writing that structured negotiations be entered into with the assistance of a neutral adviser or mediator ("Neutral Adviser").

21.3 If the parties are unable to agree on a Neutral Adviser or if the Neutral Adviser agreed upon is unable or unwilling to act either party shall within fourteen days from the date of the proposal to appoint a Neutral Adviser or within fourteen days of notice to either party that he or she is unable or unwilling to act apply to the Centre for Dispute Resolution ("CEDR") to appoint a Neutral Adviser.

21.4 The parties shall within 14 days of the appointment of the Neutral Adviser meet with him/her in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the negotiations. If considered appropriate the parties may at any stage seek assistance from CEDR to provide guidance on a suitable procedure.

21.5 Unless concluded with a written legally binding agreement all negotiations connected with the dispute shall be conducted in confidence and without prejudice to the rights of the parties in any future proceedings.

21.6 If the parties accept the Neutral Adviser's recommendations or otherwise reach agreement on the resolution of the dispute such agreement shall be reduced to writing and once it is signed by their duly authorised representatives shall be binding on the parties.

21.7 Failing agreement either of the parties may invite the Neutral Adviser to provide a non-binding but informative opinion in writing. Such opinion shall be provided on a without prejudice basis and shall not be used in evidence in any proceedings commenced pursuant to the terms of this Agreement without the prior written consent of both parties.

21.8 If the parties fail to reach agreement in the structured negotiations within 60 days of the Neutral Adviser being appointed then any dispute or difference between them may be referred to the Courts unless within such period the parties agree to refer matter to arbitration before an arbitrator whose method of appointment is agreed between them.

22 INCONSISTENCY

In the event of a conflict between any of the provisions of these conditions and any provision of the Specification, the former shall prevail.

23 SEVERANCE

If any provision of the Agreement shall become or shall be declared by any court of competent jurisdiction to be invalid or unenforceable in any way such invalidity or unenforceability shall in no way impair or affect any other provision all of which shall remain in full force and effect.

24 JURISDICTION

The Agreement shall be considered as a contract made in England and subject to English Law.

signed by the)
Care Provider in)
the presence of:-)

signed by)
the duly authorised)
officer of the Council)
in the presence of:-)

SCHEDULE 1

(The Annual Recurring Revenue Sum)

1.1 The Annual Recurring Revenue Sum shall be the sum of [£.....]

1.2 Annual Recurring Revenue Sum ("A.R.R.S") set out in this Schedule I is the A.R.R.S. applicable as at [.....] the A.R.R.S. payable by the Council to the Care Provider from that date shall be the A.R.R.S. adjusted in accordance with the formula set out below.

1.3 As from [.....] the A.R.R.S. shall be adjusted annually in accordance with the formula set out below.

1.4 In the event of there being any change in the reference base used to compile the Indices referred to in the formula the figure taken to be shown in the said reference base after such change shall be the figure which would have been shown if the said reference base current at [.....] been retained

1.5 In the event of the Indices referred to in the formula being replaced or becoming in any way permanently unavailable the Council and the Care Provider shall agree as to the appropriate Indices to be used in substitution for the original Indices and in default of agreement being reached either party may refer the matter to the independent mediator in accordance with clause 21 hereto who shall decide which Indices are in the circumstances most appropriate

1.6 In the event of there being a delay in the publication of the Indices under which the A.R.R.S is to be adjusted the Council shall then continue to pay at the current A.R.R.S. and the Care Provider shall (immediately following such publication) submit an invoice to the Council showing the amount by which underpayment or overpayment has been made and with full details as to how such amount has been calculated such invoice to be paid by the Council within 28 days of receipt thereof in the case of underpayment or the amount thereof deducted by the Council from the next payment due to the Care Provider in the case of overpayment

1.7 The formula for adjustment of the A.R.R.S. shall be as follows;

$$Ap = Op + 0.80 \left(Op \times \frac{D-C}{C}\right)$$

where

Ap = adjusted A.R.R.S.
Op = original A.R.R.S. at [.....] shown in Schedule I
C = the index figure for the month of November 1992 contained in the General Index of Retail Prices All Items published by HMSO
D = the index figure for the month of November for the year of adjustment contained in the General Index of Retail Prices All Items published by HMSO

1.8 Invoices for the Annual Recurring Revenue Sum shall be submitted to the Council by the Care provider quarterly and shall include details reasonably requested by the Council. The first payment shall be for the period [.....] to [.....] and shall be

calculated pro rata for that period. Thereafter invoices shall be submitted by the Care Provider 21 days prior to the 1st [.....], 1st [.....], 1st [.....], 1st [.....] and for each year of the Term.

1.9 The Council shall pay all correct invoices within 14 days of receipt by the Council. The Council will pay interest at the rate of 2% above Barclays Bank PLC's base rate from time to time in force on any late payment.

1.10 In the event that the Care Provider shall place a resident at the Property in accordance with paragraph 1.4 of Schedule 3 then the Annual Recurring Revenue Sum shall be adjusted downwards by one [.....] for each resident placed by the Care Provider from the date of such new resident being placed so as to reflect the reduction in the value of the Service to the Council.

SCHEDULE 2
(The Specification)

SCHEDULE 3

(Placement of Residents)

1.1 The Property is suitable for[.....] Residents and the Care Provider agrees to limit the number of Residents to a maximum number of [.....] at any one time

1.2 On the date of this Agreement the first [.....] Residents shall be those people detailed in Appendix A to this Schedule 3.

1.3 If a place or places for a Resident or Residents (whether placed by the Council pursuant to this Agreement or not) shall become vacant at the Property for any reason the Council shall have the right to nominate a replacement Resident or Residents at any one time for the first six months after such vacancy arising.

1.4 In the event that the Council is unable to nominate a replacement Resident within the time scale referred to at paragraph 1.3 above then the Care Provider shall use all reasonable endeavours to find a replacement resident provided always that so long as the vacancy remains available then the Council shall be free to nominate a suitable replacement Resident at any time.

1.5 The Council wishes to ensure compatibility of existing Residents with any new resident proposed by the Care Provider pursuant to clause 1.4. To that end the Council shall be entitled to veto any resident proposed by the Care Provider. The Care Provider shall give to the Council such details of the new resident proposed by the Care Provider requested by the Council before the new resident is placed.

1.6 In the event that the Care Provider shall place a resident in the Property pursuant to paragraph 1.4 of the Schedule (where the Council is unable to make such a placement pursuant to paragraph 1.3) then the Care Provider shall refund to the Council one [.....] of the Annual Recurring Revenue sum such refund to commence upon the date of the placement of the new resident

APPENDIX A

(Names of the First Residents).

APPENDIX 3

Dates of visits made to homes or meetings held in connection with the contracts

Contract	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Date	Mendip Way	Allenby	Pencolm	Valley House	Hawker Lodge	Sheridan Way	Rose Cottage	Main Road	1 Green Close	2 Green Close	3 Green Road	Langley House	Blossom Cottage	Warley Green
Mar- 93		16th	31st											
Apr - 93	27th	6th, 25th	25th		15th	15th								
May - 93		11th					26th	26th						24th
Jun - 93		10th		23rd										
Jul - 93		12th, 16th	6th, 21st, 27th		8th	8th								
Aug - 93	4th, 24th	20th	10th, 16th	9th										
Sep - 93		14th		9th				9th						8th, 28th
Oct - 93		26th, 27th												
Nov - 93	13th, 6th	9th	8th											
Dec - 93		13th	13th					23rd						
Jan - 94			10th											
Feb - 94		2nd, 21st, 22nd	24th	14th										
Mar- 94	1st	15th	2nd											
Apr - 94	18th	11th												
May - 94				16th										4th
Jun - 94	13th	9th		14th	22nd	22nd	20th	29th	15th	15th	15th	21st	8th	30th
No. visits	**8**	**19**	**12**	**6**	**3**	**3**	**1**	**4**	**1**	**1**	**1**	**1**	**1**	**5**

APPENDIX 4

Operationalising the care specification (example of a Type 2 contract)

Operationalising the specification -Loddon Consortium

CLAUSE	HOW MONITOR
2. Accommodation	
2.1 Safe, comfortable, adapted to individual needs	Check what are the needs of the residents to see if need specific adaptation e.g. stair rail, OT equipment. Should consider needs of ST people in respite bed Value judgement about whether comfortable
2.2. minimum use of staff facilities	allowed office, sleep-in area, place for personal belongings. No staff toilet
2.3. sole use of bedrooms, consent for shared rooms, suitable locks	bedrooms not used for respite care. check if single or double check type of lock - this done at annual inspection by QA
2.4 furniture in room - personalised - meeting fire regulations	should have bed, wardrobe and chest of drawers. How much is personalised? brought from previous home? bought since moved in? How check when trying to respect privacy of resident?
2.5 furnishings - domestic in style. Chosen by residents and staff, residents choose colour schemes, help with re-decorating if wish. 5 year programme of internal decoration	value judgement about domestic. Choice ?reflected in minutes of residents meetings, colour schemes and re-decorating ?resident's personal record. Programme of decorating - see if drawn up, check annually what done
2.6 temperature of room no portable gas/electric or oil heaters	check whenever visit
2.7 Resident's phone	visual check - ?is this not part of initial registration
2.8. cleaning programme to meet EHO standards. Residents to be involved	visual check when visiting - care plans, daily activity sheet to see if residents involved
2.9. repairs - 3 working days of discovery, if building unsafe on discovery	handover book and/or record of messages to proprietor, estimates and invoices. Record of monthly visits of proprietor
2.10 garden - low maintenance, mown and tidy. Accessible to all residents	visual check whenever visit - record of monthly visit by proprietor
2.11 paths and driveways safe	visual check whenever visit - record of monthly visit by proprietor
2.12 Light outside for night	Visual check whenever visit. Is this a registration requirement?

2.13 No specialist sign	visual check when visit
3. Staffing	
3.1. quality of staff. staff specification in Annex 2	experience and qualifications, direct observation of interaction when visit. Number of staff vacancies, length of time to fill vacancies. Cover for vacancies, sickness and holidays
3.2. Staff appointments according to equal opportunities legislation	Providers guidelines, how they monitor it
3.3 Keyworker & their role - care plan - maintaining relationships with friends and relatives - health needs - helping to make choices	Named keyworker all from resident's personal folder, minutes of staff meetings
3.4. staff supervision - one hour per month	Record of dates of supervision - not legitimate to see content of supervision Ask individual staff Look in daily diary - will it be recorded there?
Induction programme	Induction packs - check if completed, check all new staff since last visit Check if induction pack meets standard
annual appraisal identify training needs	Dates of annual appraisals Records of training needs and means of addressing
4. Finance	
4.1. Resident charged Access to amenities of property and all necessary health care	Rent book check with care plan for health needs, personal record for visits to doctor, dentist, optician. ?regular medical whether care plan takes into account ability of resident to describe symptoms
4.2. savings account encouraged to save & spend personal allowance. Appointee - try to get someone who is not staff. Inform care manager of appointee	Own account - building society or post office Evidence of savings and spending - how often, what check with c/m. If no c/m who do they inform?
4.3. Insurance structure and contents. Inform residents if not cover personal items	Cover notices mentioned in main contract. Evidence of separate insurance policies.
4.4 Gifts to staff - inform residents	Written policy about gifts Evidence in personal record if gifts offered and how dealt
4.5 Secure storage for valuable possessions	Receipts and record of storage
4.6 Amenity fund for donations to home	Accounts, records of transactions.

5. Placement

5.1. In-patient treatment, discuss with doctor, relative, c/m and BCC	For those admitted to hospital - evidence in personal record of meeting. If no c/m who to replace? Should be inactive open case and allocated to a team.
5.2 Termination of licence to occupy Council responsible for making alternative placement	For those where breakdown, evidence of meeting as in 5.1. Resident moves
5.3 Admission procedure Council to nominate. Care provider not to vexatiously obstruct	Written procedure How carried out in real instance

6. Care Planning

6.1. Structured programme of meaningful activities for each relating to principles in 1. (O'Brien)	Day programme Measure against O'Brien. Would old style IPP format suffice?
6.2 Include activities away from home	detail where day centre open/sheltered employ contain. education leisure facilities therapy sessions
6.3 If home based , interaction with staff 50% of time	Programme for stay back day & week-ends. Daily personal record. ?spot check
6.4 Programme relates to care plan (IPP) elements - annual -who is there -based on strengths/needs -written objectives agreed -available to resident - all aspects but objectives only a few	IPP record dates who invited/attends IPP record Objectives in behavioural terms - person responsible at meeting strengths/needs covers all aspects

7. Leisure, social and religious activities

7.1 Appropriate for - age - culture - religion	Record of age, ethnicity/culture, religion Assess activities for appropriateness - sample, value judgement
7.2 Activities away from home. 1 activity a week - discuss with resident before. Residents rights respected	Minutes of residents meetings Daily diary Personal record notes of choosing not to go
7.3 Citizen rights Get information about political parties	Who registered to vote - if not, why not Who goes to vote?

Vote if choose	Personal record to see if discussed
8. Use of community facilities	
8.1 Range of services that rest of neighbourhood uses	list of local amenities - pub, restaurants, shops, clubs, health, transport
8.2 Registered with GP of choice	Personal record to show who registered for GP dentist use of optician
8.3 Appropriate for age, sex and culture	Record of age, ethnicity/culture, religion Assess activities for appropriateness - sample, value judgement
9. Food and clothing	
9.1 Involved in choice and preparation of meals. knowledge of foods/diet	? minutes of residents meetings Daily living programme ?infor. from day centre programme
9.2 Preparation and cooking food in domestic style	as above visit sometimes at meal times
9.3 Fresh meat & fruit and veg. balanced diet	menu sheets check store cupboard
9.4 Special diets at no extra cost	Personal record should note special diet e.g. medical, religious (e.g. halal, vegetarian), choice (e.g. vegetarian) Reflected in menu sheets
9.5 Clothing - compare and buy in ordinary shops	Personal record sheets Daily record/handover Invoices
9.6 Individualised clothing. Care over laundry	How home deals with laundry e.g. mark all, separate laundry days
10. Privacy	
10.1 Home for residents	Induction pack Evidence of interaction when visit Minutes of residents meetings Minutes of staff meetings
10.2 Personal care in private	Induction where medicines kept/given architecture of building e.g. wash basins in bedrooms, no double bathrooms
10.3 Mail and phone calls	separate call box (see accommodation section) - where placed

10.4 Entry to property. Visitors to ring bell etc.

10.5 Other visits
entering bedrooms — visitor's record book - time, duration

10.6 Not disruptive time — relate to daily activity sheets

11. Policies

Written policies:
risk taking
personal relationships
sanctions
management of aggression and violence

see evidence of same
Implementation:
induction pack
staff meeting minutes

12. Record keeping

12.1 Imprest a/c
individual accounts
valuables — see before 4.2
medication by staff — see before 4.5
accident book — ?what about self medication
violent incidents & resolution
fire drills & fire maintenance — some assessment about level of incidents/accidents

for respite - applications and places used — relate to monitoring i.e. views canvassed every 2 years

12.2 Resident records
name, DOB — see care plan
health — see 3.3. role of k/w
other professionals
written care plans
locked away — check where stored

12.3 Access to records. Operate BCC policy — written policy available
part of induction
notes in personal record about access events

13. Health and safety

13.1 written procedures to conform to legislation — check vs. specification
lifting and handling
1st aid
infection control
missing persons
drug overdose
Induction pack
minutes of staff meetings

13.2 Health and safety inspection
Care provider nominee — Name of nominated person
written report annually — record of inspection - plans to rectify and implement

13.3. Required fire safety standard — Fire officers report/inspection

Adaptation as domestic as possible	Value judgement if domestic
13.4 Staff know about fire risks and how to minimise Regular fire drills and record One night time drill p.a.	Induction ?written guidelines Does registration set number? record of fire drill - note date and time
13.5 Maintenance of fire alarms	Fire maintenance record
13.6 No smoking in bedrooms, smoking policy for residents Risks of smoking	?written policy about smoking ?induction ?minutes of staff meetings Notes who smokes - check if told about risks
13.7 Use BCC policy in drug administration. Copy in Appendix B.	Availability of policy Induction pack Includes inspection by QA and pharmacist
14. Monitoring	
14.1 Comply with statutory monitoring by H & S, EHO, 1984 Act	evident from other parts of specification
14.2 Complaints procedure - explained to staff and residents	Written policy Induction Residents meeting minutes ?What about relatives Look at complaints book and how resolved Judgement about number and how dealt with
14.3 Regular consultation with residents Residents meeting 4 X pa with 3/52 notice Minuted Facilitate less able residents	Record of residents meetings Preparation Minutes of staff meeting ?attend staff meeting prior to residents meeting
14.4 Formal consultation Pre-set questions based on O'Brien Action plan drawn up Residents and relatives consulted	Record of questions collation of answers written action plan and time-scales
14.5 If respite service, consultation with families & carers every 2 years Ask for opinion	Record of questions -written, telephone - through' care manager Record of opinion ?what about the users
14.6 Manager and staff to evaluate service	Ask provider how intends to do this ?staff meeting minutes ?formal service review e.g. QUALSAT (Murray & Roberts, 1992)

14.7 Access to appropriate persons Care managers to speak to residents and relatives	how easy to make appointment to visit ?what about if spot check ?what if not care manager
14.8 Records to be made available Registration report audited a/c property's finances audited a/c resident's a/c audited a/c amenity fund medication accident book fire drills fire equipment maintenance health and safety inspection reports staff rotas, current and 2 more staff turnover	Should all these be seen at same time If home in Berks. get this anyway ?see or have copy sent see ?see or have copy sent What form? I already keep some information about this
14.9 Care provider also to monitor provision and report annually - refers to placement contract	Effectiveness, efficiency and quality of service vs. the specification Quality of life and implementation of IPPs Much of this is value judgement

15. <u>Advocacy</u>

To be promoted by keyworker and care manager	Discuss with care managers as group, also keyworkers either as group of individually

APPENDIX 5

Model of contract monitoring and example of pre-visit monitoring form

BLOCK CONTRACT MONITORING

Residential care for people with learning disabilities

MONITORING SPECIFIED IN THE CONTRACT

1. Clause 7.1 of placement contract states review should occur annually and
   (a) Evaluate the effectiveness, efficiently and quality of the services against the specification
   (b) Monitor the quality of life of the residents and the implementation of individual development plans

2. Schedule 2 - care specification
   Section 14 on monitoring includes 14.6 and 14.9 the care provider evaluating and monitoring the service and 14.3, 14.4, 14.5 about consultation with service users

3. Where there is a care contract
   Clause 9.1 - Annual review of service

MONITORING TO BE CARRIED OUT BY THE PURCHASER

The Placement and Monitoring Officer (Learning Disability/) has the responsibility for monitoring the block contracts and it is proposed that visits are made four times a year. the visits should include the following as a minimum

TO CHECK 4 TIMES A YEAR

Name of keyworker of each resident
Name of Care Manager (if allocated) of each resident
Names of current staff and any resignation since last visit
Training undertaken by staff and how this is incorporated in their practice
Dates of reviews in previous 3 months
Dates of reviews in next 3 months
If no allocated care manager look at paperwork relating to review/outcome/action plans/progress
Complaints book
Visitors book
Date of last Inspector's report. Check implementation of recommendations, bearing in mind time limits set by inspector
Proprietor's monthly visit report
Records for the residents' meetings
Any changes in appointeeship
Record of staff meetings

TO CHECK 2 TIMES A YEAR

Induction of new staff
Discussion with care managers if allocated
Discussion with residents/service users
Methods provider uses to evaluate quality of service by manager and staff
Discussion with sample of keyworkers about care planning and advocacy

TO CHECK ONCE A YEAR

Availability of procedures - risk taking
- personal and sexual relationships
- sanctions
- management of aggression and violence

Insurance cover
Health and safety report
Discussion with relatives/advocates
Results of formal consultation with service users
Budget out-turns
Amenity fund accounts
Review of care contract if part of placement contract

FOR RESPITE CARE

Returns of overnight stays to be sent by provider to Monitoring officer every month
Every 3 months check with provider assurance of occupancy figures
Every 2 years - results of consultation with families about respite care

INFORMATION TO CHECK AT BEGINNING OF CONTRACT

Licence to occupy
Appointeeship
Availability of all procedures
Name of existing staff, how long been in post, qualifications & experience

Marilyn Miles
Placement and Monitoring Officer
May 1994

PRE MONITORING VISIT INFORMATION
CONTRACT MONITORING QUARTERLY VISIT

LAST VISIT: PROPOSED DATE:
TIME:

CONTRACT : _____
HOME : _____
PROVIDER : _____
CARE CONTRACT : _____
DATE OF CONTRACT : _____
REGISTERED MANAGER : _____

1) CHANGES SINCE LAST VISIT

Name	Grade	Started	Left	Promoted

2) CHANGES - RESIDENTS' KEYWORKER OR CARE MANAGER

Name	Admission	Discharge	Keyworker	C/Manager

3) TRAINING UNDERTAKEN BY STAFF SINCE LAST VISIT

Name of staff	Course	Venue	Length

4) DATES OF REVIEWS COMPETED SINCE LAST VISIT

Name	Date	C/Manager present

5) DATES OF REVIEWS DUE IN NEXT 3 MONTHS

Name	Date due	Keyworker

6) INSPECTOR'S REPORT

Date of last inspection:
Announced/unannounced:

Recommendation Time Limit Outcome

7) PROPRIETOR'S MONTHLY VISIT

Dates of proprietors' (or their representative) since last monitoring visit

8) CHANGES IN APPOINTEESHIP

Name	Previous appointee	New appointee

APPENDIX 6

1. Questionnaire to keyworkers

2. Letter to keyworkers

3. Letter to home managers

1. Contract Monitoring Questionnaire for Keyworkers in Residential Homes

This questionnaire asks about your role as keyworker in a residential home where Berkshire Social Services has a contract or purchasing agreement for more than one place.

Everyone in this home who is a keyworker will be asked to complete a questionnaire. It is important that you write in your answers without having talked to anyone else about how they have answered. Your home manager will give you time alone to complete this questionnaire.

If you are keyworker to more than one resident please decide on one of them and complete the questionnaire with reference to that person. The last part of the questionnaire refers to the home in general. It will take about 30 minutes to answer the questions and you will need to have the resident's file available. You may also need to refer to your staff training record.

Thank you for your time.

Year: 1994 Today's date: .....

Name of Home: .....

If the question has several answers, please circle the number as requested. For some questions you need to write the answer in the space provided.

About You

For question 1 to 4 circle only one answer

Q1 What is your gender? 1 Female 2 Male

Q2 What is your age?

1 under 20
2 20 - 29
3 30 -39
4 40 to 49
5 over 50

Q3 How long have you worked at this home?

1 less than 6 months
2 6 - 12 months
3 between 1 and 2 years
4 between 3 and 5 years
5 more than 5 years

Q4 How long have you been keyworker to this resident? ____mths

Keyworker Training and Supervision

Q5 How often do you have supervision with your line manager? (circle only one)

1 every week
2 every month
3 less than every month
4 I don't have supervision

Q6 Please say what is the post of **your line manager** (circle only one)

Post. 1 registered home manager
2 team leader
3 other (please state) _____

Q7 What training have you received **in the last year** to help you do your job as a keyworker? (circle as many as apply)

1 none
2 I have attended some courses (Please state which)

_____

_____

_____

3 any other sort of training e.g. visiting speakers to the home, being shown how to do something by another member of staff (please give details)

_____

_____

_____

_____

Q8 How are your training needs identified? (circle as many as apply)

1 I know what I need and keep an eye open for suitable courses
2 My supervisor and I know where I need extra training as it is discussed in supervision and we both keep an eye open for suitable courses
3 Most of my training and development happens during supervision
4 I would like more training but it is not offered
5 I would like more training but the courses I applied for were all full
6 The courses I would like to go on are too expensive for the home.
7 Courses and training are offered to the home or unit and we have to wait our turn to get a place
8 Any other (please state) _____

Q9 My training needs have been identified for the coming year (circle only one)

1 Yes 2 No

Now think back to when your started working at THIS home

(For questions 10 to 16 circle only one answer)

Q10 When you started working here was there a formal induction programme?

1 Yes 2 No

If there was no formal induction go to Q13

Q11 Was an induction checklist used?

1 Yes 2 No

Q12 When did you complete your induction?

1 within 1 week of starting
2 within 1 month of starting
3 within 3 months
4 it is not finished yet

Q13 Do you have regular staff appraisals or performance reviews?

1 Yes 2 No

If there was no staff appraisal go to Q15

Q14 When was the last staff appraisal or performance review? (complete only one)

1 Date _____mth/yr 2 I've not had one yet

Q15 How much are you paid per annum to be a keyworker at this home?

1 less than £8,000
2 £8,000 to £8,999
3 £9,000 to £9,999
4 £10,000 to £10,999
5 more than £11,000

Q16 Are pay rises dependent on positive staff appraisals?

1 Yes 2 No 3 Not sure

Q17 Is there anyone in this home who is **NOT** a keyworker?
(circle as many as apply)

1 Registered manager
2 Deputy manager

3 Team leaders or unit managers
4 Some care workers
5 Night staff
6 Any other staff
7 Some people are associate keyworkers

Reviews/IPPs/Client appraisals

*When answering Questions 18 to 42 please think about **the resident for whom you are keyworker**. Remember, if you are keyworker to more than one resident please choose only one. To answer some of these questions you will need to refer to the resident's file.*

Q18 This resident has a review or IPP or client appraisal
NB this does not refer to case conferences (circle one only)

1 Every year
2 Every 6 months
3 Other time gap (please specify)
4 Does not have a review/IPP/appraisal

If the resident does not have a review or IPP or client appraisal please go to question 25

Q19 Who was invited to this client's **last** review/IPP/client appraisal?
(Circle as many as apply)

1 Client
2 Yourself as keyworker
3 Home manager
4 Relatives
5 Care manager (social worker) - if there is one
6 Other agencies (e.g. keyworker at day centre)
7 Others (please list) _____

_____

Q20 The resident's most recent review/IPP/appraisal was

1 Date of last review _____(mth/yr)
2 Date of review before that _____(mth/yr)

*Now think about this resident's last **TWO** reviews/IPPs*

Q21 Was someone responsible for making sure that goals or objectives set at the review/IPP/appraisal happen?
(circle only one)

1 **Yes**, though who it was depended on the goal/objective
2 **No one person** was responsible, we all play our part
3 There were **no goals/objectives set**

If NO goals or objectives are set please go to question 25

Q22 How are the goals/objectives monitored (i.e. their progress is noted) from one review/IPP/appraisal to the next ?
(circle as many as apply)

1 There is no monitoring
2 It is done during staff meetings
3 It is done during keyworker meetings
4 It is done during my supervision
5 I keep an eye on things through the resident records
6 Any other ways (please state)_____

_____

Q23 How many of the goals/objectives reviewed at the beginning of the last review/IPP/client appraisal were achieved?
(circle only one)

1 The objectives from the previous review were not looked at
2 All were achieved
3 Most were achieved
4 Some were achieved
5 None were achieved

Q24 Were there any particular reasons why some or all of the goals/objectives were not achieved?

_____

_____

Care plans

Q25 Are care plans which cover daily activities drawn up? (circle only one)

1 Yes 2 No

If no, please go to Question 30

Q26 Are these care plans different to the plans drawn up at the review/IPP/client appraisal?

1 Yes 2 No

If no, please go to Question 30

Q27 If yes, could you describe how the care plans are different?

_____

_____

_____

Q28 Who writes the care plan?
(circle only one)

1 The keyworker on their own
2 The keyworker in consultation with others
3 The home manager
4 Someone else (please state) _____

Q29 Please state the areas the care plan covers

_____

_____

_____

Meeting needs and quality of life

Q30 Does this resident usually need help to maintain relationships with friends and/or relatives?
(circle only one)

1 Yes 2 No

If no, go to question 32

Q31 If yes, how do you help this resident maintain these relationships? (circle as many as apply)

1 Write letters for them
2 Help them make telephone calls
3 Arrange visits
4 Speak to their relatives How often (a) weekly
(b) monthly
(c) when they contact me
5 Any other (please state) _____

Q32 How often does this resident usually take part in leisure or social activities **away from the home**? (circle only one)

1 More than once a week
2 Once a week
3 2 or 3 times a month
4 Once a month
5 Less than once a month

Q33 Does this resident attend a separate day centre and/or attend college? (circle only one)

1 Yes 2 No

If no, please go to question 36

Q34 If yes, which day centre and/or college?

_____

_____

and how many days a week? (circle only one)

1 One
2 Two
3 Three
4 Four
5 Five

Q35 How often do you contact the keyworker at the day centre? (circle as many as apply)

1 Once a week
2 Once a month
3 Before the review/IPP/client appraisal
4 Never
5 Other times (please state)

_____

Q36 Who is responsible for organising the residents' **week-day** activities when they are not at the centre or college (**excluding any days they may have at the centre**)?
(circle as many as apply)

1 The keyworker at the home
2 The day care co-ordinator at the home
3 The client in discussion with the keyworker at review time to give an overall framework
4 The client in discussion with staff on duty the day they are based at home
5 Someone else (please state) _____

Q37 Who is responsible for organising the resident's **week-end** activities or programme?

1 The keyworker at the home
2 The day care co-ordinator at the home
3 The client in discussion with the keyworker at review time to give an overall framework
4 The client in discussion with staff on duty on the week-end
5 Someone else (please state)

_____

Q38 How do you promote advocacy? (circle as many as apply)

1 This resident is able to say what he or she wants without help
2 This resident is able to say what he or she wants with help. Please state what sort of help and who gives the help

_____

3 The resident says what they want through residents' meetings
4 The resident has an outside advocate e.g. WEBCAS

5 Someone else is the advocate e.g. parent or social worker (care manager)
6 Other ways (please state) _____

Q39 How are this resident's health needs met?
(circle as many as apply)

1 Routine check-up with doctor
2 Taken to the doctor when required
3 Routine check-up with dentist
4 Routine check-up with optician
5 Regular check-ups with GP or clinic
Please state which and for what condition

_____

6 Resident tells staff if they are unwell
7 Staff can tell when the resident is unwell
8 The resident does not need any help
9 Any other ways (please state) _____

Q40 Is the keyworker at this home responsible for ensuring that this resident's health needs are met? (circle only one)

1 Yes 2 No

If YES go to question 42

Q41 If no, who is responsible? (please state)

_____

Q42 Does your home do any health promotion activities e.g. healthy eating, no smoking for staff or clients?

1 Yes 2 No

If no, please go to question 44

Q43 If yes, which do you pursue?

1 Healthy eating
2 Weight reduction under medical supervision
3 No smoking policy for residents
4 No smoking policy for staff
5 Give-up smoking policy for residents
6 Give-up smoking policy for staff
7 Any others (please state)

_____

For these last few questions please think about the home in general and not just about the resident to whom you are keyworker.

Contract Monitoring

Q44 Who do you think oversees the quality of care in this home? (circle as many as apply)

1 The proprietor
2 The officer in charge (registered manager)
3 The senior person on duty
4 The inspectors at Shire hall
5 The area manager or the Care Services Manager
6 The keyworker
7 The care manager(social worker)
8 Monitoring officer for Social Services (Purchasing)
9 Anyone else (please state) _____

Q45 Does this home have any way to review the overall service offered or check the quality of the service?

1 Yes 2 No

If no, go to question 47

Q46 If yes, please state which. (circle as many as apply)

1 The Inspector's visits from Shire Hall
2 My employer has its own system (e.g. QUALSAT review)
3 Annual establishment or annual service review
4 Staff meetings, supervision
5 Residents' meetings
6 Formal consultation with the residents
7 Any other (please state)

_____

Q47 How do you as keyworker put forward your views about the quality of the service provided?

_____

Q48 Have you seen a copy of the care specification?

1 Yes 2 No 3 Not sure

If no, please go to Question 51

Q49 If have seen a copy do you know what the care specification says about the role of the keyworker?

1 Yes 2 No 3 Not sure

If no, please go to question 51

Q50 If yes, how far do you feel you meet the requirements of the specification concerning the keyworker role?

1 All of the requirements
2 Some of the requirements
3 Very few of the requirements
4 None of the requirements

Q51 Have you seen a copy of the placement contract between Berkshire Social Services (purchasers) and the proprietor?

1 Yes 2 No 3 Not sure

Q52 If applicable, have you seen a copy of the care contract between the Consortium and Berkshire Social Services (providers)?

1 Yes 2 No 3 Not sure 4 Not applicable

THANK YOU VERY MUCH FOR YOUR TIME

2. Letter to keyworkers

<fname> <name>
<add1>
<optional><add2>
<optional><add3>
<town> <pcode>, <county>

29 November 1994

Dear <fname>,

You may remember I visited your residential home earlier this year in my role as Placement and Monitoring Officer. Although I have been seconded to work at Shire Hall, I have maintained my interest in monitoring contracts through my research commitment at Southampton University.

I am writing to ask if you could help me by completing the enclosed questionnaire which is about your role as keyworker to <resident>. When answering the questions please think of this person. If you are keyworker to more than one resident please decide on one of them and complete the questionnaire with reference to that person.

The questionnaire will add information to the monitoring visits. It will also help to see how effective the monitoring is and whether it can be improved. The results of the individual questionnaires will remain confidential to me as a part-time research student at Southampton and the overall conclusions will be shared with the purchasing stream of Berkshire Social Services.

The questionnaire should take about 30 minutes to complete. When you have finished please return it to me in the stamped addressed envelope enclosed. If you have any queries, please do not hesitate to contact me on 0734-234896 (direct line). Your help and co-operation is greatly appreciated.

Yours sincerely,

Marilyn Miles.
Joint Commissioning Development Officer

3. Letter to managers of homes

<fname> <name>
<add1>
<optional><add2>
<optional><add3>
<town> <pcode>, <county>

22 November 1994

Dear <fname>,

Re: Monitoring of Contracts

You may recall when I competed my monitoring visit in June, I explained that I would still be continuing my research interest in contract monitoring despite my secondment to Shire Hall. I am a part time research student in the Department of Social Work Studies at the University of Southampton.

My replacement in Bracknell is Jane Wood who was Senior Care Manager (Adults and Disability) in the Slough Central Locality. She started in the second week of November.

Please find enclosed letters to all the keyworkers of residents who are part of the block contract for residential care with your organisation. If the keyworker has changed since my visit in June, please pass the envelope on to the relevant person. If you have any queries, please do not hesitate to contact me on 0734-234896 (direct line).

Your help and co-operation is greatly appreciated.

Yours sincerely,

Marilyn Miles
Joint Commissioning Development Officer

APPENDIX 7

References to keyworkers in contract documentaion

A. References to the keyworker within the care specification

Section 3. STAFFING

3.1.
Staffing will be provided of such nature as to ensure the safety, health and support of residents in accordance with the principles set out in Section 1 above

(these relate to O'Brien's 5 service accomplishments - presence in the community, participation in the community, choice, respect for the individual and competence)

3.3
Each resident will have a **keyworker**, whose responsibilities include:

- ensuring that the resident has an appropriate care plan and helping to implement it

- helping the resident to maintain or establish relationships with family and friends and keeping such people informed of the resident's situation where permitted by the resident

- ensuring that the resident's health needs are monitored and addressed. Health needs will include dental health, eyesight and hearing requirements and requirements covered by any specialist profession covered by the Professions Supplementary to Medicine Act 1960

- helping the resident to make appropriate choices in his/her life

3.4
Every member of staff will receive a minimum of one hour's individual professional supervision per month from his/her line manager. An induction programme will be available to every new member of staff; this programme will be written down and signed by the staff member to confirm it has been given. Every staff member will have the opportunity of identifying strengths and weaknesses in skills and having a training programme to meet these needs; it is recommended that this be carried out through an annual appraisal.

The induction programme will include

- A statement of the need for confidentiality
- Health and safety policies and information, including First Aid information
- Instruction in fire procedures
- Instruction in methods of lifting and handling residents

Section 5. CARE PLANNING

5.1
The Care Provider will ensure that there is a structured programme of meaningful activity available for everyone living in the property. (...)

5.2
Such activity will usually include activities away from the property where the resident lives, and may include use of day centres, open or sheltered employment, continuing education (...)

5.3.
Where residents receive a programme of activities within their own home, such a programme will involve the active participation of staff with the resident for at least 50% of the time

5.4.
Any programme available for each resident will be in accordance with a care plan for that resident. This care plan may be described as an Individual Programme Plan or Review. Essential elements of any care plan will be:

- a care plan meeting must occur at lease once a year. Present at this meeting will be the resident if he/she chooses, any relative or advocate of the resident if the resident so chooses, the resident's **keyworker**, and other people as appropriate.

- The care plan will be based on an analysis of the resident's strengths, needs and wishes.

- The care plan will be written and will include objectives agreed with the resident. A copy of this care plan will be available for the resident.

- The care plan will embrace all aspects of the resident's life, though objectives will focus on a limited number of these aspects.

Section 6. LEISURE, SOCIAL AND RELIGIOUS ACTIVITIES

6.2
(...) In addition, there shall be at least one leisure activity provided per week for a group of residents: such activities will be discussed and agreed with residents in advance

[Later care specifications make reference to residents rights not to participate e.g. Type 2 contracts]

Section 14. MONITORING

14.3
The Care Provider shall set in place arrangements which ensure that the residents are consulted about the service they receive. (...)

14.4.
At least once a year, users will be formally consulted about the service they receive. (...) A action plan will be drawn up to address any relevant issues: this action plan shall be written and include time scales. Families and carers of residents using this service should also be formally consulted.

14.5
The Care Provider shall ensure that managers and **staff** within the property are encouraged and enabled to evaluate the service they are delivering

Section 15. ADVOCACY
(this only appears in some contracts e.g. Type 2)

15.
Advocacy for all residents will be promoted as a matter of principle, this being the joint responsibility of the resident's care manager and the **keyworker**.

B. References to the keyworker within the placement agreement.

Clause 5. THE CARE PROVIDER'S STAFF

5.1
The Care provider shall at all times during the Term employ or contract for the employment of sufficient **staff** with sufficient abilities to ensure that the Services are provided at all times to the standard required in the Specification. (....)

5.2
The Care Provider shall ensure that **every person employed by him** in the provision of the Services is at all times properly and sufficiently trained and instructed with regard to:-

i the task or tasks that the person has to perform; and
ii health and safety at work; and
iii fire risks and fire precautions; and
iv the need to observe the highest standards of courtesy and consideration.

Appendix 8

Frequency counts of keyworker questionnaire

Frequency county tables from keyworker questionniare

1. Number of keyworkers with each provider. N = 58

Provider	Frequency
A1	4
A2	3
A3	5
A4	3
B1	22
B2	21

2. Number of keyworkers within each contract. N = 58

Cno	Frequency
[1]	4
[2]	3
[3]	5
[4]	3
[5]	5
[6]	3
[7]	5
[8]	5
[10]	2
[11]	3
[12]	6
[13]	4
[14]	5
[15]	5

3. Number of keyworkers in each category of contract. N = 58
   a = staff employed by provider directly (Type A cojntract)
   b = staff provided through care contract from SS providing stream (Type B)
   c = staff provided in kind from SS providing stream (Type C)

cat	Frequency
a	15
b	32
c	11

4. Gender of Keyworkers. N = 58

Gender	Frequency
Male	15
Female	43

5. Age of keyworkers. N = 58

Age	Frequency
1. Under 20	1
2. 20 - 29	27
3. 30 - 39	16
4. 40 - 49	8
5. 50+	6

6. Length of time keyworker has worked in home. N = 58

work	Frequency
1. less than 6 months	3
2. 6 to 12 months	7
3. between 1 and 2 years	37
4. between 3 and 5 years	6
5. more than 5 years	4

7. Length of time respondent has been keyworker. N =58

kwleng	Frequency
NV	1
[0 - 4]	14
[5 - 9]	12
[10 - 14]	10
[15 - 19]	6
[20 - 24]	10
[30 - 34]	2
[35 - 39]	1
[40 - 44]	1
[45 - 49]	1

8. Who is the line manager of the keyworker. N = 58

manager	Frequency
registered home manager	54
team leader	1
other	2

9. Frequency of supervision of keyworker. N = 58

supervis.	Frequency
every week	1
every month	45
less than every month	12
no supervision	0
other	0

10. Whether keyworker has received training in last year. N = 58

training	Frequency
none	5
some courses	42
other training	41

11. Raw counts of training inputs received by keyworker. N = 58

raw count	Frequency
NV	7
1	11
2	10
3	10
4	6
5	3
6	6
7	3
8	1
9	1

12. Frequency of different types of "formal training". N = 58

train. formal	Frequency
F1 - fire precautions	11
F2. Health and safety	25
F3. Risk taking	2
F4. personal relationships	12
F5. sanctions	1
F6. manag. agression	10
F7. internal organiz.	20
F8. General course	4
F9 pwld courses	25
F10. induction	4

13. Frequency of different types of "informal training". N = 58

informal	Frequency
I1. general	9
I2. fire, health + safety	3
I3. relate to policies	3
I4. internal organization	5

14. How training needs are identified.

how train.	Frequency
1.know what need, keep eye on courses	32
2.discuss in supervision &keep eye open	43
3.through supervision	9
4.like more but not offered	3
5.like more but courses full	8
6.courses I like are too expensive	7
7.courses offered and we wait our turn	9
8.other	4

15. Are any other training needs identified (text answers)

idenot	Frequency
waiting to attend NVQ level 3	1
would like more training but currently waiting for further suitable courses	1
(Not answered)	49
would like more training to do job better	1
we have training list, everyone priorotised own needs + one for gorup as whole	1
works part-time, so difficult to attend courses	1
discussion with Consortium training and personnel manager	1
is sessional worker	1
discussed what like to do by told courses unlikely to be available	1
staff training profiles ensure staff gain skills/knowledge required	1

16. Whether keyworker had received a formal induction. N = 58

induct	Frequency
yes	45
no	12
other	1

17. When formal induction ends (for those who received one). N = 43

indend	Frequency
within 1 week of starting	14
within 1 months of starting	7
within 3 months of starting	21
it is not finished yet	0
within 6 months	1

18. Whether an induction checklist is used (for those who had induction). N = 43

indchk	Frequency
yes	43
no	0
other	0

19. Whether provider has staff appraisal system. N = 58

appra	Frequency
1. yes	42
2. no	12
3. no, but will soon	3
4. don't know	1
5. other	0

20. Whether keyworker has had a staff appraisal this year. N = 58

thisyr	Frequency
yes	34
no	21
other	0

21. Keyworker pay. N = 58

kwpay	Frequency
less than £8K	0
£8K to £9K	4
£9K to £10K	1
£10K to £11K	15
more than £11K	33

22. Whether keyworker pay is related to positive staff appraisals. N = 58

pyrise	Frequency
yes	4
no	38
not sure	15

23. Who does NOT act as a keyworker. N 58

notkw	Frequency
registered manager	40
deputy manager	3
team leaders or unit managers	13
some care workers	34
night staff	15
any other staff	4
some people are associate keyworkers	18
no reply - everyone is keyworker	0

24. Frequency of Individual Programme Plan/ Review/Client Appraisal. N = 58

ipp	Frequency
every year	45
every 6 months	12
other time gap	1
does not have review	0

25. Who attends the IPP/Review. N = 54

Attends	Frequency
Client	54
Keyworker	53
Home manager	53
Relatives	50
Care manager/social worker	37
Other agencies eg kwat day centre	43
Others	28

26. Categories of "other" people who attended IPP/Review. N = 28

Others	Frequency
IPP secretary/co-ordinator	5
WEO or work opportunities	6
Other professional (OT, psy., physio)	10
Senior manager	6
Other	4

27. IPP/ Review alternatives. Taken from information on dates of last and previous reviews

ippalt	Frequency
1. only had one review (recent adm.)	2
2. only had one review	7
3. not yet had review	4

28. Whether someone was responsible for ensuring objectives set at IPPs happen. N = 54

goals	Frequency
yes, though it depended on the goal	33
no one person, all responsible	16
no goals/objectives set	2

29. How goals/objectives are monitored between IPPs/reviews. N = 58?

goalmo	Frequency
1. there is no monitoring	1
2. done in staff meetings	28
3. done during keyworker meetings	23
4. done in my supervision	32
5. I keep an eye on things thr' resident records	39
6. any other ways	21

30. Other ways of monitoring goals/objectives (categories from text answers)

goalcat	Frequency
1. monthly charts	5
2. daily records	4
3. weekly records	2
4. liaison other agencies	5
5. review care plans	4
6. liaison parents/sw	4

31. Number of goals reviewed at last review that had been achieved.

achiev	Frequency
goals not looked at	1
all were achieved	5
most were achieved	22
some were achieved	12
none were achieved	2

32. Reasons why goals not achieved - categories from text answers.

whycat	Frequency
1. client factors	4
2. external 1	1
3. external 2	2
4. organizational 1	8
5. organizational 2	5
6. client factors 2	6
7. not applicable	12

33. Whether care plan to cover daily activities are written. N = 58

carepl	Frequency
yes	52
no	6
other	0

34. Whether care plans are different to IPPs/Reviews/Client Appraisals

cpdiff	Frequency
yes	26
no	23
other	0

35. Who writes the care plan

cpwho	Frequency
keyworker on own	6
keyworker in consultation with others	38
home manager	0
someone else	1

36. Way in which care plans are different to IPPs (categories from text answers).

cpcat	Frequency
1. more detailed	12
2. relate to stay back day	4
3. include risk assess.	1
4. personal hygiene	4
5. guidelines for staff on behav.	2
6. IPPs longer term	12
7. daily activities	10
8. new plans drawn up bet. IPPs	7
9. other eg social skills	4

37. Areas covered by care plans (categories from text answers)

cpcata	Frequency
1. same as Q27	2
2. partial overlap	0
3. personal hygiene	17
4. risk areas	6
5. behaviour	7
6. social relat./network	9
7. communication	8
8. work or day care	14
9.other areas- leisure, travel	17
10. health	16
11. choice, decision making	5
12. general eg indep. living	7
13. supervision needs, staff support	9
14. gave list of areas	18

38. Number of residents needing help to maintain social relationships.
N = 58

relat	Frequency
yes	35
no	22
other	0

39. Ways of helping residents maintain social relationships. Includes those who need help to maintain relationships. N = 35

helpre	Frequency
write letters for them	19
help make telephone calls	25
arrange visits	27
speak to relatives weekly	18
speak to relatives monthly	7
speak to relatives when contact me	9
any other stated	7

40. Whether resident attends day care outside of home

dcare	Frequency
yes	45
no	13
other	0

41. Number of days attending day centre and or college

frequencydaycentre	Frequency
1 day	3
2 days	4
3 days	6
4 days	21
5 days	11
other	0

42. Names of day care establishments (some residents attend more than one in given week)

Day centre attended	Frequency
Social Services 1	4
Social Services 2	15
Social Services 3	4
Joint health/SSD	2
Social Services 4	14
College 1	2
College 2	7
College 3	4
other	5
College 4	4
Private	1

43. Frequency of contact between keyworker at residential home and keyworker at day care centre

contkw	Frequency
1. once a week	7
2. once a month	8
3. before the review	24
4. never	1
5. other times	27

44. Other times of contact with keyworker at day centre (categories from text answers). N = 27

contact by k/w @ other times	Frequency
1. k/w does relief at home	1
2. when passing on information	7
3. discussion when necessary	18
4. through daily diary	6
5. not often required	1
6. regular - < once a month	5

45. Number of time residents partakes in social activities outside of home (excluding day care)

socia	Frequency
more than once a week	36
once a week	12
2 or 3 times a month	6
once a month	1
less than once a month	3
other	0

46. Person who organises week-day activities when not at college or day centre.

week	Frequency
1.keyworker at home	34
2.day care co-ordinator	11
3.client + keyworker at review to give framework	21
4.client + staff on duty	45
5.someone else (stated)	13

47. Other people who organise week-day activities. N = 13

wdacat	Frequency
1. Parents	5
2. client + staff before stay-back day	1
3. friends	1
4. resident	3
5. other	4

48. Person who organises week-end activities for resident. N = 58

wend	Frequency
1.keyworker at home	31
2.day care co-ordinator	8
3.client + k/w at review to give framework	14
4.client + staff on duty	48
5.someone else (stated)	15

49. Other people who organise week-end activities for resident. N = 15

wendca	Frequency
1 Parents	8
2. friend	2
3. resident	8
4. other	2

50. Ways keyworker promotes advocacy. N = 58

howadvocacy	Frequency
1. able to speak for self	33
2. able to say what wants with help	30
3. through resident's meetings	27
4. has outside advocate	1
5. someone else is the advocate	8
6. other ways	9
7. no advocate yet	2
8. answers both 1 and 2	10

51. Types of help given to resident to promote advocacy (categories from text answers)

advcat	Frequency
1 Staff support	4
2. makaton	1
3. other help with communication	0
4. family support	1
5	0

52. How resident's health care needs are met.

health	Frequency
1.routine check-up with doctor	13
2.taken to doctor when required	50
3.routine check-up with dentist	43
4.routine check-up with optician	29
5.regular check-up with GP or clinic (stated)	12
6.resident tells staff if unwell	40
7.staff can tell when resident is unwell	37
8.resident does not need any help	0
9.any other ways (stated)	5

53. Categories for regular health care check-ups (categories from text answers)

heacat	Frequency
1. psychiatrist	1
2. epilepsy	4
3. diabetes	1
4. skin	1
5. chiropody	4
6. menopause	1
7, serious weight loss	0
8.	0
9	0

54. Whether keyworker is responsible for meeting health care needs of residents. N = 58

kwheal	Frequency
yes	43
no	15
other	0

55. Responsible person for meeting health care needs, if not keyworker. N = 15

whocat	Frequency
1. all staff/staff team	3
2. resident	1
3. other e.g with UM and parent	1

56. Whether health promotion activities are pursued in the home. N = 58

heprom	Frequency
yes	44
no	14
other	0

57. Which health promotion activities are pursued. N = 44

whathe	Frequency
1 healthy eating	40
2. weight reduction under doctor	9
3. no smoking for residents	5
4. no smoking for staff	26
5. give-up smoking for residnets	4
6 give-up smoking for staff	7
7 any others	11

58. Who the keyworker thinks is responsible for overseeing quality of care in home

whoqua	Frequency
1. proprietor	33
2. registered manager	58
3. senior person on duty	31
4. Inspectors at Shire Hall	45
5. Area manager or care services manager	43
6 the keyworker	40
7. the care manager (social worker)	19
8 Monitoring officer of SSD (purchasing)	21
9. anyone else (stated)	16

59. Who else oversees quality of care. Categories from text answers. N = 16

qualct	Frequency
1. Team as whole	13
2. resident	3
3. parents/relatives	6
4. advocates	1

60. Whether the provider reviews the service. N = 58

servic	Frequency
1. yes	57
2. no	0
3 other	0

61. Ways that service is reviewed. N = 58

wharev	Frequency
1.. Inspector's visits from Shire Hall	54
2. employer has own system	17
3. annual establishment review	27
4. staff meetings, supervision	52
5. residents' meetings	44
6. formal consultation with residents	22
7. any other (stated)	8

62. Ways keyworker puts forward their views about the quality of service. N = 58

qualca	Frequency
1. staff meetings	43
2. supervision	33
3. clients meetings	2
4. senior staff meetings	3
5. other	23
6. keyworker meetings	8

63. Whether keyworker has seen the care specification. N = 58

spec	Frequency
1. yes	40
2 no	1
3 not sure	16

64. Whether keyworker has seen the placement agreement.

place	Frequency
1 yes	11
2 no	19
3 not sure	27

65. Check against whether there is a care contract in place in the contract. N = 58

careyes	Frequency
1. There is a care contract in this placement agreement	33
2. There is no care contract in this placement agreement	25

66. Whether the keyworker has seen the care contract, if applicable.

carecon	Frequency
1 yes	14
2. no	20
3 not sure	17
4 not applicable	1

67. Whether key workers had seen the care contract

Care contract not in existence. N = 25

Seen contract	Frequency
Not answered	3
yes	1
no	12
not sure	8
not applicable	1
Total	25

Care contract in exisitence. N = 33

Seen contract	Frequency
Not answered	3
yes	13
no	8
not sure	9
not applicable	0
Total	33

Appendix 9

Tables of results not included in the text of Chapter 9 & 10

Legend for identifying contracts

Number of contract	Name in text
1	Mendip Way
2	Allenby
3	Pencolm
4	Valley House
5	Hawker Lodge
6	Sheridan Way
7	Rose Cottage
8	Main Road
9	Brookside
10	2 Green Close
11	1 Green Close
12	3 Green Road
13	Langley House
14	Blossom Cottage
15	Warley Green

Provider	Name in text
A1	Peter Brown
A2	Basildon Trust
A3	Community Homes Ltd.
B1	Loddon Consortium
B2	Thames Consortium

Appendix 9 - Tables not included in text of Chapter 9 and 10

Table 1 Whether the keyworker has seen the care contract (analysed by contract). **N = 58**

Whether seen care specification	Contract number														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
yes	2	1	5	3	3	2	3	3	2	3	6	4	3	0	40
no	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
not sure	2	1	0	0	2	1	2	2	0	0	0	0	1	5	16
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 2 Keyworkers who have seen the care specification (or not sure if they have seen it) and whether they know what is the role of the keyworker. **N = 56**

Contract	Know role of keyworker				
	Not answered	yes	no	not sure	Total
1	1	2	0	1	4
2	0	1	0	1	2
3	0	4	0	1	5
4	0	3	0	0	3
5	2	3	0	0	5
6	1	2	0	0	3
7	1	3	0	1	5
8	2	2	0	1	5
10	0	2	0	0	2
11	0	3	0	0	3
12	0	6	0	0	6
13	0	4	0	0	4
14	0	4	0	0	4
15	2	0	1	2	5
Total	9	39	1	7	56

Table 3 How far keyworkers in Provider A contracts felt they met the specification. **N = 15**

Contract	Has seen specification			How far meets specification			
	yes	no	not sure	Not answered	all	some	Total
1	2	0	2	2	2	0	4
2	1	1	1	2	0	1	3
3	5	0	0	1	3	1	5
4	3	0	0	0	3	0	3
Total	11	1	3	5	8	2	15

Table 4 How far keyworkers in Provider B1 contracts met the specification. **N = 23**

Contract	seen specif.		How far meets specification			
	yes	not sure	Not answered	all	some	Total
5	3	2	2	0	3	5
6	2	1	1	2	0	3
7	3	2	2	0	3	5
8	3	2	3	0	2	5
15	0	5	5	0	0	5
Total	11	12	13	2	8	23

Table 5 How far keyworkers in Provider B2 contracts met the specification. **N = 20**

Contract	seen care specification			How far meets specification			
	Not answered	yes	not sure	Not answered	all	some	Total
10	0	2	0	0	2	0	2
11	0	3	0	0	3	0	3
12	0	6	0	0	4	2	6
13	0	4	0	1	2	1	4
14	1	3	1	2	3	0	5
Total	1	18	1	3	14	3	20

Table 6 How far the keyworker felt they met the care specification. By contract (Includes those who have seen specification and know what it says). **N = 37**

Contract	How far meets specification			
	Not answered	all	some	Total
1	0	2	0	2
2	0	0	1	1
3	0	3	1	4
4	0	3	0	3
5	0	0	3	3
6	0	2	0	2
7	0	0	2	2
8	0	0	2	2
10	0	2	0	2
11	0	3	0	3
12	0	4	2	6
13	1	2	1	4
14	1	2	0	3
Total	2	23	12	37

Table 7 Keyworker pay in different contracts (excluding temporary keyworkers). **N = 55**

Keyworker pay	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	1	0	0	0	0	0	2	0	0	0	1	1	0	0	5
£8K to £9K	0	3	1	0	0	0	0	0	0	0	0	0	0	0	4
£9K to £10K	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
£10K to £11K	3	0	1	1	3	0	1	3	0	1	1	0	0	1	15
more than £11K	0	0	1	2	2	3	2	2	2	1	4	2	5	4	30
Total	4	3	3	3	5	3	5	5	2	2	6	4	5	5	55

Table 8 Length of time as keyworker against length of time worked (excluding temporary keyworkers). **N = 55**

keyworker length	Time worked as keyworker					
	no response	less than 6 months	6 to 12 months	between 1 & 2 years	more than 3 years	Total
No value	0	1	0	0	0	1
0..5 mths	1	1	3	5	2	12
6..11 mths	0	0	3	11	1	15
12..23 mths	0	0	0	19	1	20
24..49 mths	0	0	0	2	5	7
Total	1	2	6	37	9	55

Table 9 Occurrence of induction against age of keyworker. **N = 58**

Age	Induction occurs			
	yes	no	other	Total
Under 20 yrs	1	0	0	1
20 - 29 yrs	21	6	0	27
30 - 39 yrs	11	4	1	16
40 - 49 yrs	6	2	0	8
50+ yrs	6	0	0	6
Total	45	12	1	58

Table 10 When induction ends by contract. **N = 58**

When induction ends	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	0	1	0	1	1	1	1	1	0	2	0	2	4	1	15
within 1 week of starting	0	0	4	1	1	1	1	2	0	0	0	0	1	3	14
within 1 months of starting	0	2	0	0	1	1	0	0	0	0	1	2	0	0	7
within 3 months of starting	4	0	1	1	2	0	3	2	2	1	4	0	0	1	21
within 6 months	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 11 Frequency of supervision by contract. **N = 58**

Contract	Supervision. at least once a month	less than once a month	Total
1	3	1	4
2	2	1	3
3	3	2	5
4	3	0	3
5	5	0	5
6	3	0	3
7	5	0	5
8	5	0	5
10	1	1	2
11	2	1	3
12	4	2	6
13	2	2	4
14	5	0	5
15	3	2	5
Total	46	12	58

Table 12 Frequency of supervision for those who had an induction. **N = 45**

Provider	Supervision every month	less than every month	Total
A1	3	1	4
A2	2	0	2
A3	3	2	5
A4	2	0	2
B1	17	2	19
B2	9	4	13
Total	36	9	45

Table 13 Frequency of Supervision for those who had no induction. **N = 12**

Provider	Supervision			
	every week	every month	less than every month	Total
A2	0	0	1	1
A4	0	1	0	1
B1	1	3	0	4
B2	0	4	2	6
Total	1	8	3	12

Table 14 Frequency of supervision by length of time worked. **N = 58**

Time worked in home	Supervision		
	at least once a month	less than once a month	Total
no response	1	0	1
less than 6 months	3	0	3
6 to 12 months	5	2	7
between 1 & 2 years	27	10	37
more than 3 years	10	0	10
Total	46	12	58

Table 15 Frequency of supervision according to age. **N = 58**

Age	Supervision		
	at least once a month	less than once a month	Total
Under 20	1	0	1
20 - 29	21	6	27
30 - 39	12	4	16
40 - 49	6	2	8
50+	6	0	6
Total	46	12	58

Table 16 Frequency of supervision (excluding temporary keyworkers) by contract. **N = 55**

Frequency of supervision	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
every week	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
every month	3	2	1	3	5	2	5	5	1	1	4	2	5	3	42
less than every month	1	1	2	0	0	0	0	0	1	1	2	2	0	2	12
Total	4	3	3	3	5	3	5	5	2	2	6	4	5	5	55

Table 17 Keyworker training in last year by gender (excludes those who did not answer). **N = 55**

Keyworker training in last year	Gender		
	Male	Female	Total
none	1	4	5
some courses	12	30	42
other training	10	31	41
Total	14	41	55

Table 19 Keyworker training in last year by contract. **N = 58**

Contract	Keyworker training received				
	Not answered	none	some courses	other training	Total
1	0	0	4	3	4
2	0	0	2	2	3
3	1	1	2	3	5
4	0	0	3	2	3
5	0	1	4	4	5
6	0	0	3	3	3
7	0	1	4	4	5
8	0	0	5	4	5
10	0	0	2	2	2
11	0	0	2	3	3
12	0	0	2	5	6
13	0	1	3	0	4
14	2	0	2	2	5
15	0	1	4	4	5
Total	3	5	42	41	58

Table 20 Raw counts of training inputs Vs length of time worked. **N = 58**

Raw counts	Time worked as keyworker				
	No response	< 1 year	between 1 & 2 years	> 3 years	Total
NV	0	1	3	3	7
1	1	2	8	0	11
2	0	2	7	1	10
3	0	1	11	0	12
4	0	0	2	2	4
5	0	1	1	1	3
6	0	3	0	2	5
7	0	0	4	1	5
9	0	0	1	0	1
Total	1	10	37	10	58

Raw count score is multiplied by number of keyworkers to give training inputs. In Table 20 this is 145 for 41 keyworkers who answered giving a mean score of 3.5

Table 23 Training (as measured by raw counts) for those who had induction. **N = 45**

Raw counts	Provider						
	A1	A2	A3	A4	B1	B2	Total
NV	0	0	1	0	2	1	4
1	0	1	1	0	0	5	7
2	2	0	1	1	4	1	9
3	1	1	1	0	6	1	10
4	0	0	0	0	3	0	3
5	1	0	0	0	1	0	2
6	0	0	1	1	1	1	4
7	0	0	0	0	2	3	5
9	0	0	0	0	0	1	1
Total	4	2	5	2	19	13	45

Table 24 Raw counts of training by contract. **N = 58**

Raw counts	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
NV	0	0	1	0	1	0	1	0	0	0	0	1	2	1	7
1	0	2	1	0	0	0	0	0	0	1	3	2	2	0	11
2	2	0	1	1	1	1	0	2	0	0	1	0	0	1	10
3	1	1	1	1	2	1	2	1	0	0	1	0	0	1	12
4	0	0	0	0	1	0	1	1	0	0	0	0	0	1	4
5	1	0	0	0	0	0	0	1	0	0	0	0	1	0	3
6	0	0	1	1	0	0	1	0	1	1	0	0	0	0	5
7	0	0	0	0	0	1	0	0	1	0	1	1	0	1	5
9	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 25 Raw counts of training inputs by provider. **N = 58**

Raw count	Provider						
	A1	A2	A3	A4	B1	B2	Total
NV	0	0	1	0	3	3	7
1	0	2	1	0	0	8	11
2	2	0	1	1	5	1	10
3	1	1	1	1	7	1	12
4	0	0	0	0	4	0	4
5	1	0	0	0	1	1	3
6	0	0	1	1	1	2	5
7	0	0	0	0	2	3	5
9	0	0	0	0	0	1	1
Total	4	3	5	3	23	20	58

Table 26 Formal training given in different areas (by provider). **N = 58**

Formal Training	Provider						
	A1	A2	A3	A4	B1	B2	Total
Not answered	0	1	2	0	3	4	10
1. Fire precautions	0	0	1	1	4	5	11
2. Health and safety	1	1	1	1	11	9	24
3. Risk taking	1	0	0	0	0	1	2
4. Personal relationships	0	0	0	1	4	7	12
5. Sanctions	0	0	1	0	0	0	1
6. Manag. agression	2	0	0	0	6	2	10
7. Internal organiz.	0	0	1	0	12	5	18
8. General course	0	0	0	0	1	3	4
9 Pwld courses	4	1	2	2	12	7	28
10. Induction	0	0	2	0	2	0	4
Total	4	3	5	3	23	20	58

Table 27 Informal training received in last year by keyworkers by provider. **N = 58**

Informal training	Provider						
	A1	A2	A3	A4	B1	B2	Total
Not answered	3	1	3	1	15	18	41
1. General	0	2	2	1	3	1	9
2. Fire, health + safety	0	0	0	2	1	0	3
3. Relate to policies	1	0	0	0	1	1	3
4. Internal organization	0	0	0	0	5	0	5
Total	4	3	5	3	23	20	58

Table 28 How training needs are identified by contract. N = 58

How training needs are identified	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Know what need, keep eye on courses	3	2	3	1	5	1	4	4	0	3	0	1	1	4	32
Discuss in supervision & keep eye open	3	0	3	2	4	3	5	4	2	3	3	3	5	3	43
Through supervision	0	1	2	0	1	2	1	0	0	1	1	0	0	0	9
Like more but not offered	0	0	0	0	1	0	0	0	0	0	1	1	0	0	3
Lke more but courses full	0	0	0	0	1	0	0	2	0	0	0	2	0	3	8
Courses I like are too expensive	0	2	1	2	0	0	0	0	0	0	1	0	1	0	7
Courses offered and we wait our turn	0	0	1	1	1	0	1	1	0	0	1	2	0	1	9
Other	1	0	0	0	0	0	0	1	0	0	1	0	1	0	4
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 29 How training needs are identified (by provider). **N = 58**

How training is identifed	Provider						
	A1	A2	A3	A4	B1	B2	Total
Know what need, keep eye on courses	3	2	3	1	18	5	32
Discuss in supervision & keep eye open	3	0	3	2	19	16	43
Through supervision	0	1	2	0	4	2	9
Would like more but not offered	0	0	0	0	1	2	3
Like more but courses full	0	0	0	0	6	2	8
Courses I like are too expensive	0	2	1	2	0	2	7
Courses are offered and we wait our turn	0	0	1	1	4	3	9
Other	1	0	0	0	1	2	4
Total	4	3	5	3	23	20	58

Table 30 Use of staff appraisal by contract. **N = 58**

Contract	Occurence of staff appraisal			
	Yes	No	Not sure	Total
1	2	2	0	4
2	0	3	0	3
3	5	0	0	5
4	3	0	0	3
5	5	0	0	5
6	3	0	0	3
7	5	0	0	5
8	5	0	0	5
10	2	0	0	2
11	3	0	0	3
12	5	1	0	6
13	4	0	0	4
14	2	2	1	5
15	1	4	0	5
Total	45	12	1	58

Table 31 Use of staff appraisal systems by provider. **N = 58**

Provider	Appraisal occurs			
	yes	no	unsure	Total
A1	2	2	0	4
A2	0	3	0	3
A3	5	0	0	5
A4	3	0	0	3
B1	19	4	0	23
B2	16	3	1	20
Total	45	12	1	58

Table 32 Keyworkers who have had staff appraisal - whether future training needs are identified. By Provider. **N = 42**

Provider	Training identified			
	Not answered	yes	no	Total
A1	0	0	1	1
A3	0	2	3	5
A4	0	1	0	1
B1	1	15	3	19
B2	2	10	4	16
Total	3	28	11	42

Table 32a Keyworkers who have had staff appraisal - whether future training needs are identified. By contract. **N = 42**

Traning needs for this year identified	Contract													
	1	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	0	0	0	1	0	0	0	0	1	0	0	1	0	3
yes	0	2	1	4	2	3	5	1	2	3	3	1	1	28
no	1	3	0	0	1	2	0	1	0	2	1	0	0	11
Total	1	5	1	5	3	5	5	2	3	5	4	2	1	42

Table 33 Frequency of Individual Programme Plan (client review) by contract. **N = 58**

Cont.	IPP frequency			
	every year	every 6 months	other time gap	Total
1	0	4	0	4
2	0	3	0	3
3	0	5	0	5
4	3	0	0	3
5	5	0	0	5
6	3	0	0	3
7	5	0	0	5
8	5	0	0	5
10	2	0	0	2
11	3	0	0	3
12	6	0	0	6
13	4	0	0	4
14	5	0	0	5
15	4	0	1	5
Total	45	12	1	58

Table 34 Actual gap between IPPs/reviews by provider. includes only those who have had 2 IPPs/reviews **N = 45**

gap in months between IPPs	Provider					
	A1	A2	A3	B1	B2	Total
0..6	3	2	1	2	1	9
7..12	0	1	2	8	12	23
13..18	0	0	0	5	3	8
19..24	0	0	0	3	1	4
25..29	0	0	0	1	0	1
Total	3	3	3	19	17	45

Table 35 Frequency count for those invited to Individual Programme Plan (client review) by contract. **N = 58**

Who invited to IPP	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	0	0	1	3	0	0	0	0	0	0	0	0	0	0	4
Client	4	3	4	0	5	3	5	5	2	3	6	4	5	5	54
Keyworker	4	3	4	0	5	3	4	5	2	3	6	4	5	5	53
Home manager	4	3	4	0	5	3	5	5	2	3	6	4	5	4	53
Relatives	4	1	4	0	5	3	4	5	2	3	6	4	5	4	50
Care manager/ social worker	3	3	4	0	2	3	2	3	1	3	5	1	4	3	37
Other agencies eg kw at day centre	1	0	4	0	4	2	5	2	2	3	6	4	5	5	43
Others	1	1	4	0	2	2	3	3	2	2	3	1	0	4	28
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 36 Others invited to Individual {Programme Pan (client review) by provider. **N = 29**

Categories of others invited to IPPs	Provider					
	A1	A2	A3	B1	B2	Total
IPP secretary/ co-ordinator	0	0	0	3	2	5
WEO or work opportunities	0	1	0	2	3	6
Other professional (OT, psy., physio)	1	0	5	4	1	11
Senior manager	0	0	0	4	1	5
Other	0	0	0	2	2	4
Total	1	1	5	14	8	29

Table 37 Frequency of contact between relevant keyworkers for residents that attend day centres. **N = 45**

Day Centre	Keyworker contact with day centre (frequency)					
	once a week	once a month	before the review	never	other times	Total
Day centre 1	1	0	2	0	3	4
Day centre 2	0	2	10	0	11	15
Day centre 3	1	0	2	1	1	4
Day centre 4	1	1	2	0	0	2
Day centre 5	3	4	6	0	9	14
College 1	0	0	2	0	2	2
College 2	2	1	5	0	5	7
College 3	0	0	4	0	2	4
Other centres	1	2	2	0	2	5
College 4	0	1	3	0	2	4
College 5	0	0	1	0	0	1
Total	7	8	24	1	27	45

Table 38 Other reasons given for contacting keyworkers at day centre. **N = 27**

Reasons for contacting centre at other times	Contract											
	4	5	6	7	8	10	11	12	13	14	15	Total
Keyworker does relief at home	0	0	0	0	0	0	0	0	0	0	1	1
When passing on information	0	1	0	0	0	1	1	2	0	2	0	7
Discussion when necessary	1	4	1	2	2	1	1	3	1	2	0	18
Through daily diary	0	1	0	4	0	0	0	0	0	1	0	6
Not often required	0	0	0	0	0	0	0	1	0	0	0	1
Regular - < once a month	0	0	0	0	0	0	2	1	1	1	0	5
Total	1	4	1	4	2	1	3	5	2	3	1	27

Table 39 Whether goals set at IPPs/reviews (by contract). Excludes those where no IPP/review held. **N = 54**

Goals set at IPP	Contract													
	1	2	3	5	6	7	8	10	11	12	13	14	15	Total
Not answered	1	0	0	1	0	1	0	0	0	0	0	0	0	3
yes, though it depended on the goal	0	1	3	2	0	3	5	2	2	5	2	3	5	33
no one person, all responsible	2	2	1	2	2	1	0	0	1	1	2	2	0	16
no goals/objectives set	1	0	0	0	1	0	0	0	0	0	0	0	0	2
Total	4	3	4	5	3	5	5	2	3	6	4	5	5	54

Table 40a Ways of monitoring goals set by provider. Excludes those who had not had IPP/review. **N = 54**

Goal monitoring	Provider					
	A1	A2	A3	B1	B2	Total
Not answered	1	0	0	1	0	2
1. there is no monitoring	0	0	0	1	0	1
2. done in staff meetings	1	2	1	5	19	28
3. done during keyworker meetings	1	1	1	15	5	23
4. done in my supervision	1	1	2	11	17	32
5. I keep an eye on things thr' resident records	2	2	2	17	15	38
6. any other ways	2	0	3	6	9	20
Total	4	3	4	23	20	54

Table 40b Ways of monitoring goals set by contract. **N = 54**

Ways of goal monitoring	Contract													
	1	2	3	5	6	7	8	10	11	12	13	14	15	Total
Not answered	1	0	0	0	1	0	0	0	0	0	0	0	0	2
There is no monitoring	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Done in staff meetings	1	2	1	2	0	0	2	2	3	6	4	4	1	28
Done during keyworker meetings	1	1	1	2	1	5	4	1	3	1	0	0	3	23
Done in my supervision	1	1	2	1	0	4	4	2	3	6	3	3	2	32
I keep an eye on things thr' resident records	2	2	2	5	1	5	2	1	3	5	4	2	4	38
Any other ways	2	0	3	0	2	1	1	1	3	2	0	3	2	20
Total	4	3	4	5	3	5	5	2	3	6	4	5	5	54

Table 41 Methods of goal monitoring - by contract. Excludes those who have not had IP/review. **N = 54**

Goal monitoring methods	Contract													
	1	2	3	5	6	7	8	10	11	12	13	14	15	Total
Not answered	1	0	0	0	1	0	0	0	0	0	0	0	0	2
There is no monitoring	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Any other ways	2	0	3	0	2	1	1	1	3	2	0	3	2	20
Formal/collective	2	3	2	4	1	5	6	3	6	7	4	4	4	51
Formal/individual	1	1	2	1	0	4	4	2	3	6	3	3	2	32
Informal	2	2	2	5	1	5	2	1	3	5	4	2	4	38
Total	4	3	4	5	3	5	5	2	3	6	4	5	5	54

Table 42 Other ways of monitoring goals for residents who have had IPP/review. **N = 54**

Other ways of goal monitoring	Provider					
	A1	A2	A3	B1	B2	Total
Not answered	2	3	1	17	11	34
Monthly charts	0	0	3	0	1	4
Daily records	1	0	1	1	1	4
Weekly records	1	0	1	1	0	3
Liaison other agencies	0	0	1	0	5	6
Review care plans	0	0	0	3	1	4
Liaison parents/sw	0	0	0	1	3	4
Total	4	3	4	23	20	54

Table 43 Methods of goal monitoring by main provider. Excludes those who have not had IP/review. **N = 54**

Goal monitoring	Provider			
	A	B1	B2	Total
Not answered	1 9%	1 4%	0 0%	2 4%
There is no monitoring	0 0%	1 4%	0 0%	1 2%
Formal/collective	7 64%	20 87%	24 120%	51 94%
Formal/individual	4 36%	11 48%	17 85%	32 59%
Informal	6 55%	17 74%	15 75%	38 70%
Any other ways	5 45%	6 26%	9 45%	20 37%
Total	11	23	20	54

Percentages by column.

Table 44 Degree to which goals were achieved. Excludes those where no goals set, no response or where no review yet held. **N = 49**

Degree to which goals achieved	Contract													
	1	2	3	5	6	7	8	10	11	12	13	14	15	Total
Not answered	1	0	1	2	0	0	1	0	0	3	0	1	0	9
Goals not looked at	0	0	0	0	0	1	0	0	0	0	0	0	0	1
All achieved	0	0	0	0	0	2	1	0	0	0	0	0	2	5
Most achieved	0	0	1	2	0	1	3	0	3	3	0	4	3	20
Some achieved	1	2	2	0	1	0	0	2	0	0	4	0	0	12
None were achieved	0	1	0	0	1	0	0	0	0	0	0	0	0	2
Total	2	3	4	4	2	4	5	2	3	6	4	5	5	49

Table 45 Reasons given for why goals not achieved. By contract. **N = 58**

Contract	Reasons why goals not achieved								
	Not answered	1. client factors	2. external 1	3. external 2	4. organizational 1	5. organizational 2	6.client factors 2	7. not applicable	Total
1	2	1	1	0	0	0	0	0	4
2	0	0	0	0	1	1	1	0	3
3	1	0	0	0	0	2	0	2	5
4	3	0	0	0	0	0	0	0	3
5	2	0	0	1	0	0	0	2	5
6	0	1	0	0	1	0	0	1	3
7	3	0	0	0	0	0	0	2	5
8	1	0	0	0	2	0	1	2	5
10	1	0	0	0	1	0	0	0	2
11	1	1	0	0	1	0	0	0	3
12	2	0	0	0	1	0	1	2	6
13	1	0	0	0	1	0	3	0	4
14	3	0	0	0	0	2	0	0	5
15	2	1	0	1	0	0	0	1	5
Total	22	4	1	2	8	5	6	12	58

Table 46 Whether care plans are drawn up for daily activities (by contract). **N = 58**

Care plans are drawn up	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
yes	4	2	3	3	5	3	5	4	2	3	4	4	5	5	52
no	0	1	2	0	0	0	0	1	0	0	2	0	0	0	6
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 47 Whether care plans are different to IPP/review (where written). **N = 52**

Provider	Care plans differ from IPP			
	Not answered	yes	no	Total
A1	1	1	2	4
A2	0	1	1	2
A3	0	2	1	3
A4	1	2	0	3
B1	0	13	9	22
B2	0	8	10	18
Total	2	27	23	52

Table 48a Whether care plans are different to IPP/review (where written) when annual IPPs are held. By provider. **N = 42**

Care plans differ from IPP	Provider			
	A4	B1	B2	Total
Not answered	1	0	0	1
yes	2	13	8	23
no	0	8	10	18
Total	3	21	18	42

Table 48b Whether care plans are different to IPP/review (where written) when annual IPPs are held by contract. **N = 42**

Care plans differ from IPPs	Contract											
	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	1	0	0	0	0	0	0	0	0	0	0	1
yes	2	2	2	4	1	0	1	3	2	2	4	23
no	0	3	1	1	3	2	2	1	2	3	0	18
Total	3	5	3	5	4	2	3	4	4	5	4	42

Table 49 Care plans (when written) for those where IPPs more frequent than annually. **N = 10**

Care plans differ from IPPs	Provider				
	A1	A2	A3	B1	Total
Not answered	1	0	0	0	1
yes	1	1	2	0	4
no	2	1	1	1	5
Total	4	2	3	1	10

Table 50 How care plans are different for keyworkers who say there is a difference. **N = 27**

How care plans differ	Provider						
	A1	A2	A3	A4	B1	B2	Total
Not answered	0	0	1	0	0	0	1
More detailed	1	1	0	1	6	3	12
Relate to stay back day	0	0	0	0	3	1	4
Includes risk assess.	0	0	0	1	0	0	1
Personal hygiene	0	0	1	0	0	3	4
Guidelines for staff on behav.	1	0	0	0	0	1	2
IPPs longer term	0	0	0	1	7	4	12
Daily activities	1	0	1	0	7	1	10
New plans drawn up between IPPs	0	0	0	1	2	4	7
Other eg social skills	0	0	1	0	1	2	4
Total	1	1	2	2	13	8	27

Table 51 Internal consistency for Provider B1 contracts (excludes NR). **N = 22**

Contract (B1 provid.)	Care plans differ from IPP		
	yes	no	Total
5	2	3	5
6	2	1	3
7	4	1	5
8	1	3	4
15	4	1	5
Total	13	9	22

Table 52 Internal consistency for Provider B2 contracts (excludes NR). **N = 18**

Contract (B2 provid.)	Care plans differ from IPP		
	yes	no	Total
10	0	2	2
11	1	2	3
12	3	1	4
13	2	2	4
14	2	3	5
Total	8	10	18

Table 53 Comparison of how care plans are different from IPPs/reviews (provider B1 and B2 only). Note high non-response rate (51%). **N = 43**

How care plans differ from IPPs	Provider		
	B1	B2	Total
Not answered	10	12	22
More detailed	6	3	9
Relate to stay back day	3	1	4
Personal hygiene	0	3	3
Guidelines for staff on behav.	0	1	1
IPPs longer term	7	4	11
Daily activities	7	1	8
New plans drawn up bet. IPPs	2	4	6
Other eg social skills	1	2	3
Total	23	20	43

Table 54 Help with relationships by contract. **N = 58**

Whether need help with relationships	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
yes	3	2	2	1	3	1	3	2	1	3	3	2	4	5	35
no	1	1	3	2	2	2	1	3	1	0	3	2	1	0	22
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 55 For those that needed help, ways of helping residents maintain relationships by provider type. **N = 35**

How help with relationships	Provider type			
	A	B1	B2	Total
write letters for them	4	6	9	19
help make telephone calls	4	11	10	25
arrange visits	6	10	11	27
speak to relatives weekly	6	5	7	18
speak to relatives monthly	1	2	4	7
speak to relatives when contact me	1	5	3	9
any other stated	1	2	4	7
Total	8	14	13	35

Table 56 Where resident attends day centres. **N = 58**

Day centre or college attended	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	3	3	2	0	0	1	0	3	0	0	0	0	1	0	13
Social Services 1	0	0	0	0	0	0	0	0	0	0	0	0	4	0	4
Social Services 2	0	0	0	0	0	0	0	0	2	3	6	4	0	0	15
Social Services 3	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4
Joint Health/SS	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Social Services 4	0	0	0	2	3	2	5	2	0	0	0	0	0	0	14
College 1	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
College2	0	0	0	2	4	0	0	1	0	0	0	0	0	0	7
College 3	0	0	0	0	0	0	0	0	0	1	0	1	0	2	4
other	1	0	2	0	2	0	0	0	0	0	0	0	0	0	5
College 4	0	0	0	0	0	0	0	0	0	0	2	2	0	0	4
Private	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 57 For those residents that attend a separate day centre, frequency of attendance at centre. **N = 45**

Day centre or college	Frequency of attendence (days per week) 1 day	2 days	3 days	4 days	5 days	Total
Social Services 1	0	0	0	4	0	4
Social Services 2	0	3	1	3	8	15
Social Services 3	0	0	2	2	0	4
Joint Health/SS	0	1	0	0	1	2
Social Services 4	0	0	3	10	1	14
College 1	0	0	0	0	2	2
College 2	0	0	2	4	1	7
College 3	0	0	0	4	0	4
other	2	1	0	2	0	5
College 4	0	1	0	0	3	4
Private	1	0	0	0	0	1
Total	3	4	6	21	11	45

Table 58 Who organises week-day activities (by provider). **N = 58**

Who organises weekday activities	Provider A1	A2	A3	A4	B1	B2	Total
Keyworker at home	0	3	5	1	9	16	34
Day care co-ordinator	4	0	2	1	1	3	11
Client + keyworker at review to give framework	0	2	3	2	4	10	21
Client + staff on duty	0	2	4	2	19	18	45
Someone else (stated)	0	0	3	0	6	4	13
Total	4	3	5	3	23	20	58

Table 59 Who organises week-day activities (by contract). **N = 58**

Who orgainises weekday activities	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Keyworker at home	0	3	5	1	2	1	0	3	2	3	3	3	5	3	34
Day care co-ordinator	4	0	2	1	1	0	0	0	0	0	1	0	2	0	11
Client + keyworker at review to give framework	0	2	3	2	1	1	0	1	2	3	2	2	1	1	21
Client + staff on duty	0	2	4	2	4	2	5	3	1	3	5	4	5	5	45
Someone else (stated)	0	0	3	0	1	1	0	4	0	1	2	0	1	0	13
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 60 Who is responsible for organising the day time activities of residents (when not at centre) for week-days and week-ends. **N = 58**

Organisation of weekday	Frequency
Keyworker at home	34
Day care co-ordinator	11
Client + keyworker at review to give framework	21
Client + staff on duty	45
Someone else (stated)	13

Organisation of weekend	Frequency
Keyworker at home	31
Day care co-ordinator	8
Client + keyworker at review to give framework	14
Client + staff on duty	48
Someone else (stated)	15

Table 61 Who else is responsible for organising the day time activities of residents (when not at centre) for week-days and week-ends. **N = 58**

Weekday (others)	Frequency
Parents	5
Client + staff before stay-back day	1
Friends	1
Resident	3
Other	4

W/end (others)	Frequency
Parents	8
Friend	2
Resident	8
Other	2

Table 62a How health needs are met (by provider). **N = 58**

How health needs are met	Provider						
	A1	A2	A3	A4	B1	B2	Total
Not answered	0	0	0	0	1	0	1
Routine check-up with doctor	2	1	2	1	5	2	13
Taken to doctor when required	4	2	5	2	18	19	50
Routine check-up with dentist	4	3	3	3	12	18	43
Routine check-up with optician	4	2	3	3	5	12	29
Regular check-up with GP or clinic (stated)	0	0	0	2	5	5	12
Resident tells staff if unwell	1	3	0	1	19	16	40
Staff can tell when resident is unwell	3	2	5	1	12	14	37
Any other ways (stated)	0	0	0	0	2	3	5
Total	4	3	5	3	23	20	58

Table 62b How health needs are met (by contract). **N = 58**

How health needs are met	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Not answered	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Routine check-up with doctor	2	1	2	1	0	0	3	2	0	0	0	2	0	0	13
Taken to doctor when required	4	2	5	2	5	2	4	2	2	3	6	3	5	5	50
Routine check-up with dentist	4	3	3	3	2	2	4	2	2	3	6	3	4	2	43
Routine check-up with optician	4	2	3	3	0	1	1	2	2	1	3	3	3	1	29
Regular check-up with GP or clinic (stated)	0	0	0	2	1	0	1	0	2	2	0	0	1	3	12
Resident tells staff if unwell	1	3	0	1	3	2	5	4	2	3	5	4	2	5	40
Staff can tell when resident is unwell	3	2	5	1	3	1	2	3	2	3	4	2	3	3	37
Any other ways (stated)	0	0	0	0	0	0	0	1	0	1	1	0	1	1	5
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 63 Reasons for routine health checks. **N = 58**

Health category	Frequency
Psychiatrist	1
Epilepsy	4
Diabetes	1
Skin	1
Chiropody	4
Menopause	1

Table 64 Who is responsible for meeting health needs (by contract). **N = 58**

Whether keyworker responsible for meeting health needs	Contract														Total
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	
yes	4	3	5	3	3	0	4	2	2	1	3	4	5	4	43
no	0	0	0	0	2	3	1	3	0	2	3	0	0	1	15
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 65 How the homes varied in who the keyworker thought was responsible for meeting health needs (Provider B1 and B2 only). **N = 43**

Contract	Keyworker responsible for health needs		Total
	yes	no	
5 (B1)	3	2	5
6 (B1)	0	3	3
7 (B1)	4	1	5
8 (B1)	2	3	5
10 (B2)	2	0	2
11 (B2)	1	2	3
12 (B2)	3	3	6
13 (B2)	4	0	4
14 (B2)	5	0	5
15 (B1)	4	1	5
Total	28	15	43

Table 66 Who is responsible for meeting health needs if not the keyworker. **N = 15**

Who else looks after health needs	Provider (Social Services staff)		
	B1	B2	Total
Not answered	7	3	10
All staff/staff team	3	0	3
Resident	0	1	1
Other e.g with UM and parent	0	1	1
Total	10	5	15

Table 67 Which health promotion policies are pursued, by provider. **N = 44**

Which health promotion ways	Provider type			
	A	B1	B2	Total
Healthy eating	8	13	19	40
Weight reduction under doctor	3	1	5	9
No smoking for residents	1	1	3	5
No smoking for staff	6	8	12	26
Give-up smoking for residents	0	0	4	4
Give-up smoking for staff	0	0	7	7
Any others	3	4	4	11
Total	10	15	19	44

Table 68 Which health promotion policies are pursued, by contract. **N = 44**

Which health promotion ways	Contract													
	1	2	3	4	5	6	7	10	11	12	13	14	15	Total
Healthy eating	2	1	2	3	3	2	4	2	3	5	4	5	4	40
Weight reduction under doctor	0	0	0	3	0	1	0	0	1	3	0	1	0	9
No smoking for residents	1	0	0	0	0	1	0	2	0	1	0	0	0	5
No smoking for staff	1	1	4	0	4	2	1	2	3	4	0	3	1	26
Give-up smoking for residents	0	0	0	0	0	0	0	2	1	0	1	0	0	4
Give-up smoking for staff	0	0	0	0	0	0	0	2	3	1	0	1	0	7
Any others	1	1	1	0	1	0	0	0	1	2	0	1	3	11
Total	2	1	4	3	5	2	4	2	3	5	4	5	4	44

Table 69 How advocacy is promoted (frequency table). **N = 58**

How promote advocacy	Frequency
Able to speak for self	33
Able to say what wants with help	30
Through resident's meetings	27
Has outside advocate	1
Someone else is the advocate	8
Other ways	9
No advocate yet	2
Answers both 1 and 2	10

Table 70 How advocacy is promoted by provider type. **N = 58**

How promote advocacy	Provider type			
	A	B1	B2	Total
Not answered	0	0	1	1
Able to speak for self	6	18	9	33
Able to say what wants with help	10	9	11	30
Through resident's meetings	2	12	13	27
Has outside advocate	0	1	0	1
Someone else is the advocate	5	0	3	8
Other ways	1	3	5	9
No advocate yet	0	1	1	2
Answers both 1 and 2	3	5	2	10
Total	15	23	20	58

Table 71 Who oversees the care by contract. **N = 58**

Who oversees quality of care	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Proprietor	4	1	5	0	1	1	4	2	2	3	3	3	3	1	33
Registered manager	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58
Senior person on duty	4	3	5	0	2	2	4	0	0	1	2	1	3	4	31
Inspectors at Shire Hall	1	2	5	2	4	3	5	4	2	3	4	2	4	4	45
Area manager or care services manager	0	1	5	3	5	3	4	4	2	3	3	4	3	3	43
Keyworker	4	3	2	3	2	1	3	1	2	3	4	4	4	4	40
Care manager (social worker)	1	1	2	0	1	3	0	1	0	2	2	1	2	3	19
Monitoring officer of SSD (purchasing)	2	1	5	1	0	1	0	1	2	3	2	1	1	1	21
Anyone else (stated)	2	0	2	1	1	1	0	3	0	1	3	0	0	2	16
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 72 Comparison of Provider A1 and Provider B2 about who the keyworker thinks oversees the quality of care. **N = 24**

Who oversees the quality of care	Provider		
	A1	B2	Total
Proprietor	4	14	18
Registered manager	4	20	24
Senior person on duty	4	7	11
Inspectors at Shire Hall	1	15	16
Area manager or care services manager	0	15	15
Keyworker	4	17	21
Care manager (social worker)	1	7	8
Monitoring officer of SSD (purchasing)	2	9	11
Anyone else (stated)	2	4	6
Total	4	20	24

Table 71 Who oversees the care by contract. **N = 58**

Who oversees quality of care	Contract														
	1	2	3	4	5	6	7	8	10	11	12	13	14	15	Total
Proprietor	4	1	5	0	1	1	4	2	2	3	3	3	3	1	33
Registered manager	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58
Senior person on duty	4	3	5	0	2	2	4	0	0	1	2	1	3	4	31
Inspectors at Shire Hall	1	2	5	2	4	3	5	4	2	3	4	2	4	4	45
Area manager or care services manager	0	1	5	3	5	3	4	4	2	3	3	4	3	3	43
Keyworker	4	3	2	3	2	1	3	1	2	3	4	4	4	4	40
Care manager (social worker)	1	1	2	0	1	3	0	1	0	2	2	1	2	3	19
Monitoring officer of SSD (purchasing)	2	1	5	1	0	1	0	1	2	3	2	1	1	1	21
Anyone else (stated)	2	0	2	1	1	1	0	3	0	1	3	0	0	2	16
Total	4	3	5	3	5	3	5	5	2	3	6	4	5	5	58

Table 72 Comparison of Provider A1 and Provider B2 about who the keyworker thinks oversees the quality of care. **N = 24**

Who oversees the quality of care	Provider		
	A1	B2	Total
Proprietor	4	14	18
Registered manager	4	20	24
Senior person on duty	4	7	11
Inspectors at Shire Hall	1	15	16
Area manager or care services manager	0	15	15
Keyworker	4	17	21
Care manager (social worker)	1	7	8
Monitoring officer of SSD (purchasing)	2	9	11
Anyone else (stated)	2	4	6
Total	4	20	24

Table 73 Frequency count of who else oversees quality of care. **N = 16**

Others & quality	Frequency
Team as whole	11
Resident	3
Parents/relatives	5
Advocates	1

Table 74 Ways of reviewing quality of care. **N = 58**

Ways of reviewing service	Frequency
Inspector's visits from Shire Hall	54
Employer has own system	17
Annual establishment review	27
Staff meetings, supervision	52
Residents' meetings	44
Formal consultation with residents	22
Any other (stated)	8

Table 75 Comparison of ways service is reviewed in the 2 homes where the proprietor is explicit about the way the service was monitored. **N = 24**

Ways of reviewing service	Provider		
	A1	B2	Total
Not answered	0	2	2
Inspector's visits from Shire Hall	4	18	22
Employer has own system	1	6	7
Annual establishment review	3	11	14
Staff meetings, supervision	4	18	22
Residents' meetings	1	15	16
Formal consultation with residents	1	11	12
Any other (stated)	0	3	3
Total	4	20	24

Table 76 Comparison of ways service is reviewed. Homes where staff are part of care contract with SSD (whether in kind or not). **N = 43**

Ways of reviewing service	Provider		
	B1	B2	Total
Not answered	0	2	2
Inspector's visits from Shire Hall	23	18	41
Employer has own system	1	6	7
Annual establishment review	7	11	18
Staff meetings, supervision	21	18	39
Residents' meetings	22	15	37
Formal consultation with residents	7	11	18
Any other (stated)	3	3	6
Total	23	20	43

Table 77 Ways in which keyworkers can put forward their views about the quality of care. **N = 58**

Ways keyworker puts forward views on quality	Provider type			
	A	B1	B2	Total
Not answered	1	1	3	5
Staff meetings	11	17	15	43
Supervision	8	12	13	33
Clients meetings	0	2	0	2
Senior staff meetings	0	1	2	3
Other	8	8	7	23
Keyworker meetings	0	8	0	8
Total	15	23	20	58

Appendix 10

Guidelines for monitoring and review of Section 28A reducing block contracts

Guidance for monitoring and reviewing reducing block contracts funded by S28A Grant.

1. The Section 28A Agreement between Berkshire Health Authority and Berkshire Social Services is the mechanism by which the two statutory authorities jointly commission services for people with learning disabilities in Berkshire. In particular Berkshire Health Authority has decided to make payments to Berkshire Social Services relating to the provision of care and accommodation for people with learning disabilities who were long stay residents of NHS hospitals and are the responsibility of the Berkshire Health Authority. Examples of such hospitals are (.....). Berkshire Social Services purchases this care and accommodation from the various care providers and establishes a contractual relationship between the two parties. The introduction of joint commissioning in Berkshire means that the ex-residents of long stay hospitals now have access to the care management service within the Community Teams for People with Learning Disabilities.

2. Most of the homes to which the residents were discharged were established especially to accommodate the residents of the hospitals and Berkshire Social Services purchases all or most of the places in these homes. For this reason, reducing block contracts have been established whereby Berkshire Social Services buys a fixed number of places for the period whilst the residents remain in that home. Should a resident named in the contract die or be discharged then the number of places purchased reduces.

3. Berkshire Social Services wishes to ensure that the service purchased meets the needs of the individual, is of high quality and meets the care specification. Monitoring and review of the service is an important element in achieving and monitoring a high quality service. The Section 28A Agreement makes specific reference to "Berkshire County Council co-operating with all contracted providers with the monitoring requirements of Berkshire health Authority including any reasonable access to premises". (Paragraph 12.4 of the Agreement).

4. The standard terms and conditions of contract for the reducing block purchase or residential care makes reference to the "Procedures" and this is one such set of procedures. It should be used to inform the annual contract review in paragraph 17.7 of the terms and conditions of reducing block contracts. It is written for care providers to help them ensure they are meeting their contractual obligations. Berkshire Social Services does not wish to be rigidly prescriptive and hopes that providers will develop their won procedures and policies which fit in with this guidance. This guidance will be revised from time to time and issued to all providers where Berkshire Social Services has a Section 28A funded reducing block contract.

6. It is hoped that for each reducing block contract there will be a "nominated purchaser representative" who will be the main link between Berkshire Social

Services and the care provider. In the absence of a named purchaser representative, reports etc. should be sent in the first instance to the Joint Commissioning Manager based at Berkshire Social Services, Shire Hall, Shinfield Park, Reading RG2 9XH

7. Ways of monitoring residential care services.

7.1 Monitoring is the regular checking of progress against a plan through the routine systematic collection of information. It is essentially value free. Review is looking back at activity and putting monitoring data into a usable form.

7.2 Most providers have built in processes to monitor the service they provide. They also review the service on the basis of that systematic monitoring. In addition there are external mechanisms which add to these internal processes. The following ways are those which Berkshire Social Services would expect to see within each home.

7.2.1 **Client reviews** (sometimes referred to as Individual Programme Plans - IPPs - or client appraisals). These should occur at least annually and are described in more detail in Section 12 of the care specification (October 1995). Paragraph 12.1 makes reference to some definitions which include the Care Management Care Plan, the residential care plan and the day care plan. The residential care plan and the client review is the responsibility of the provider in the block contract. If day services are not provided by a separate supplier then the care plan relating to day opportunities should be included in the residential care plan. Client reviews are usually organised by the residential provider and should involve the input of the client, their family and/or advocate, the care manager, other providers involved with the resident e.g. day service or college courses and/or other members of the Community Teams for People with Learning Disabilities. A system adopted by the care provider that meets the requirements of this section of the specification is acceptable to Berkshire Social Services. Documentation from these client reviews would meet the requirements of clause 17.5 (ref. "the Client Report") of the terms and conditions of reducing block contracts.

7.2.2 **Inspection visits by the registration authority**. The Registered Homes Act 1984 expects that these visits will be twice a year - one unannounced visit and one announced. In Berkshire these reports are available to the public and the joint commissioning team automatically receives a copy of the final report for any home that is registered with Berkshire County Council for people with learning disabilities. If a supplier has a home outside the boundaries of Berkshire county then a copy of the relevant inspection report should be sent to the purchaser.

7.2.3 **Proprietor's monthly visits**. If the registered proprietor is not the manager of the home the Registered Homes Act requires that the proprietor visits monthly to check that all is satisfactory. For large providers, the proprietor may delegate that task down - for example to an area manager. Some providers have established a rolling programme of monitoring so that over the course of the year all aspects of the care and service are checked to a frequency agreed in the programme. These

monthly checks would also be a good opportunity to look at those areas that are indicative of good practice e.g. induction of staff, appropriate training of staff relevant to the needs of the resident group, care planning and reviews, meeting health needs of residents.

7.2.4 **Internal quality assurance systems**, including reports to Management Committees or Boards of Directors. These may well rely on information from the monthly visits, client reviews, staff and resident meetings, inspection reports but should be primarily a method for reviewing the service, particularly outcomes for residents. Measuring outcomes would mean looking to see how far the service provided to the resident measures up to the philosophy of the service and the overall aims and objectives of the home. e.g. how many friendships or relationships were established with non- handicapped people, how many activities were in non-segregated settings, to what extent were the new skills learnt promoting independence, to what extent were residents treated with dignity and respect and whether their views were listened to and acted upon. There are various simple methods of measuring quality outcomes by service providers and research has shown that residents leaving hospital make substantial gains in the first year after discharge but these gains do not continue occurring in subsequent years without the concerted efforts of those providing the care.

7.2.5 **Reviews of care packages by care managers** under Berkshire Social Services care management procedures. These occur 6 weeks after the placement begins, then 6 months after that and subsequently every year. These reviews are often combined with the IPP/client reviews organised by the care provider and would cover the requirements of Clause 17.6 of the Commitment to Purchase with respects to breaches of contract.

7.2.6 It is also important to look at the **views of other stakeholders** e.g. residents, relatives, care managers, service providers who are part of the service users' care package. Within the care specification there is an expectation that meetings of residents are held at least quarterly and that they be consulted formally at least once a year. For users of respite services, the families should be consulted at least once every 2 years. The Community Health Council is expected to visit annually to homes where long stay hospital residents have been discharged.

7.2.7 Berkshire Social Services also operates an accreditation process. Being an accredited provider enables a Berkshire care manager to place resident in a particular home but it does not guarantee business from Berkshire. Placements can only be made with a homes that are accredited or have been awarded transitional accreditation. There are review mechanisms within the accreditation process and reports from these reviews are available to Berkshire purchasers.

7. Annual Contract Review

7.1 The reducing block contract will be reviewed as whole on an annual basis (Clause 17.7 of the standard terms and conditions). The review will be held on a mutually convenient date and follow the standard agenda for the review of contracts as set

out by Berkshire County Council. The review will consider the quality of the care service, its delivery and cost in relation to the individual residents. Many of the results of the regular monitoring described in Section 7 of these guidelines will be incorporated within this annual review.

7.2 The County Council agenda currently in operation covers the following:

- The performance of the contract against the specification in particular the degree to which any monitoring contributes to an evaluation of service outcomes for residents in accordance with O'Brien's Five Accomplishments (Section 1 of the Specification). The views of residents about the care service they receive and the extent to which they can influence the provision of the care service (including complaints and representations made by residents or their relatives/advocates) should be included.
- The care provider's annual service plan review for the home
- Performance indicators - examples are as follows though providers are encouraged to suggest others if they wish
  - Number of residents in places and absences
  - Access to day activities (frequency and type) - whether supplied by the residential care provider or not
  - Staff turnover and staff vacancies
  - Use of agency cover and bank staff to cover staff vacancies and sickness
  - Amount and types of staff training received
  - Summary of information from the various sources of monitoring
- Key issues raised by the purchaser - feedback from the budget holder (Joint Commissioning Manager) and members of the Community Teams for People with Learning Disabilities
- Key issues raised by the provider
- Assessment of resident satisfaction/dissatisfaction
- Finance

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