Nottinghamshire County Council

Policy Committee

Wednesday, 17 July 2019 at 10:30

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Keith Ford (Tel. 0115 977 2590) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting POLICY COMMITTEE

Date Wednesday 19 June 2019 (commencing at 10.30 am)

membership
Persons absent are marked with `A'

COUNCILLORS

Mrs Kay Cutts MBE (Chairman)
Reg Adair (Vice-Chairman)

Chris Barnfather
Richard Butler
John Cottee
Kate Foale
Tony Harper
Tom Hollis
Richard Jackson
Bruce Laughton
David Martin (Item 4 onwards)
Diana Meale
Philip Owen
John Peck JP
Liz Plant
Mike Pringle
Alan Rhodes
Andy Sissons
Muriel Weisz

OTHER COUNCILLORS IN ATTENDANCE

Nicki Brooks
John Longdon

OFFICERS IN ATTENDANCE

Anthony May	Chief Executives Department
Luke Barrett	
Angie Dilley	
Keith Ford	
Nigel Stevenson	
Marjorie Toward	
James Ward	
Colin Pettigrew	Children, Families and Cultural Services Department
Marion Clay	
Adrian Smith	Place Department
Andy Evans	
David Hughes	
Ainsley Macdonnell	Adult Social Care and Public Health Department

1 MINUTES

The Minutes of the last meeting held on 22 May 2019, having been previously circulated, were confirmed and signed by the Chairman.

2 APOLOGIES FOR ABSENCE

There were no apologies for absence received.

The following temporary changes of membership for this meeting only were reported:-

- Councillor Tom Hollis had replaced Councillor Jason Zadrozny
- Councillor David Martin had replaced Councillor Samantha Deakin
- Councillor Diana Meale had replaced Councillor Glynn Gilfoyle
- Councillor Liz Plant had replaced Councillor Joyce Bosnjak
- Councillor Andy Sissons had replaced Councillor Stephen Garner.

3 DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS.

Councillor John Cottee declared a private and non-pecuniary interest in agenda item 11 – Platt Lane Playing Field, Keyworth as the Chairman of Keyworth Sports Association, which did not preclude him from participating or voting on that item.

Councillor Chris Barnfather declared a private and non-pecuniary interest in agenda item 12 – Proposed Disposal of Linby Meadow and Heritage Centre, Main Street, Linby as he had held several discussions with Nottinghamshire County Council officers on this issue on behalf of Linby Parish Council, which did not preclude him from participating or voting on that item.

Councillor Bruce Laughton declared a private and non-pecuniary interest in agenda item 9 – Investing in Nottinghamshire: Delivering the Top Wighay Farm Sustainable Urban Extension, as his cousin owned part of the land in question, which did not preclude him from participating or voting on that item.

4 HOUSING WITH SUPPORT STRATEGY FOR ADULTS (18-64 YEARS)

RESOLVED: 2019/056

That the Housing with Support Strategy for Adults 18-64 years be approved.

5 SPECIAL PROVISION FUND CAPITAL PLAN – FUNDING ALLOCATION

During discussions it was underlined that the proposed annual update reports would be submitted to Children and Young People's Committee rather than Policy Committee.

RESOLVED: 2019/057

1) That the investment of £253,000 to fund Special Educational Needs & Disability adaptations in mainstream academies.

2) That the investment of £930,000 to establish three enhanced provisions in mainstream settings and two special school hubs be approved.

3) That update reports on the outcomes of this investment be submitted to Children and Young People's Committee on an annual basis.

6 NOTTINGHAMSHIRE TOURISM SUMMIT AND VISITOR ECONOMY STRATEGY YEAR ONE ACTION PLAN FRAMEWORK

RESOLVED: 2019/058

1) That up to £10,000 from the 2019/20 Growth and Economic Development base budget be allocated towards the cost of hosting the Nottinghamshire Tourism Summit.

2) That the Year 1 Visitor Economy Strategy Action Plan Framework be approved.

3) That officers explore the potential for establishing a Pilgrim Fathers commemorative installation.

7 RESPONSE TO PETITION REF: 2019/0349 SAVE OUR GREEN SPACES & PLAYING FIELDS ON FORMER GEDLING SCHOOL SITE

RESOLVED: 2019/059

1) That the ongoing demolition be noted.

2) That a report on the future of the site be submitted to a future meeting of Policy Committee.

3) That the lead petitioner be informed as appropriate and the outcome of the Committee's consideration be reported back to Full Council, in line with the requirements of the Petitions Scheme.

8 MIDLANDS ENGINE DEVELOPMENT CORPORATION – FUNDING AND DELIVERY TEAM

RESOLVED: 2019/060

1) That the process be approved for accessing the £2 million Development Corporation funding from the D2N2 Local Enterprise Partnership, in relation to elements of the work for which Nottinghamshire County Council had been authorised to lead.

2) That 1 Full Time Equivalent (FTE) Midlands Engine Development Corporation Programme Director post, 1 FTE Programme Manager post and 1 FTE Business Support Assistant post be established on a fixed term basis until 31 March 2021.

9 INVESTING IN NOTTINGHAMSHIRE: DELIVERING THE TOP WIGHAY FARM SUSTAINABLE URBAN EXTENSION

In moving the recommendations, the Chairman amended the first recommendation to include a requirement for consultation with the Chairman and Vice-Chairman of Policy Committee.

RESOLVED: 2019/061

1) That the proposed funding offer from Homes England for the Top Wighay site be accepted and authority be delegated to the Corporate Director, Place and the Group Manager, Legal, Democratic and Complaints, in consultation with the Chairman and Vice-Chairman of Policy Committee, to finalise the completion of the funding agreement.

2) That the capital programme be varied by up to £10.3m, including £5.8m external funding from Homes England, to enable detailed design and construction of highway infrastructure and related works associated with the Top Wighay Farm project.

10 OPERATIONAL DECISIONS QUARTERLY UPDATE JANUARY – MARCH 2019

RESOLVED: 2019/062

That, following consideration by Members, no further actions were required in relation to the issues contained within the report.

11 PLATT LANE PLAYING FIELD, KEYWORTH – PROPOSED LEASE TO KEYWORTH SPORTS ASSOCIATION

RESOLVED: 2019/063

1) That a new lease be made to Keyworth Sports Association on the terms outlined within the report in order that external funding be accessed to improve sporting facilities at the site and to ensure its long term future.

2) That authority be delegated to the Corporate Director for Place in consultation with the Chair or Vice-Chair of the Committee, to approve any amendments required to the proposed transaction arising from the Section 77 application and state aid advice, if necessary.

12 PROPOSED DISPOSAL OF LINBY MEADOW AND HERITAGE CENTRE, MAIN STREET, LINBY

RESOLVED: 2019/064

1) That the disposal of Linby Meadow and Heritage Centre to Linby Parish Council be approved in principle, on the terms detailed in the report, subject to resolution 2 and 3 below.

2) That if no representations were made to the public consultation, authority be delegated to the Corporate Director of Place, in consultation with the Chairman or Vice-Chairman of the Committee, to approve the disposal.

3) That if any representations were received to the public consultation then a further report be brought back to Policy Committee.

13 DISPOSAL OF LAND AT DENEWOOD CRESCENT, BILBOROUGH - REVISION

RESOLVED: 2019/065

1) That approval be given to a capped deduction to the bid price from the preferred bidder, as detailed in the exempt appendix.

2) That authority be delegated to the Corporate Director, Place in consultation with the Service Director for Finance, Infrastructure & Improvement and the Group Manager for Legal, Democratic and Complaints to approve any further amendment to the bid to reflect the costs of disposing of Japanese Knotweed subject to the conditions outlined in the report.

14 'SHOWCASING NOTTINGHAMSHIRE' EVENT

RESOLVED: 2019/066

That approval be given to the 'Showcasing Nottinghamshire' event at County Hall on 14 September 2019 at County Hall.

15 COUNTY COUNCILS NETWORK ANNUAL CONFERENCE 2019

RESOLVED: 2019/067

That, subject to the costs of this year's event not significantly increasing, approval be given for the Leader, Deputy Leader and Leader of the Main Opposition Group and one Chief Officer to attend the County Councils Network's Annual Conference in Guildford, Surrey from 17-19 November 2019, together with any necessary travel and accommodation arrangements.

16 WORK PROGRAMME

During discussions, officers clarified that the next Safer Nottinghamshire Board Update would be submitted to the Committee on 18 September 2019 rather than 17 July 2019.

RESOLVED: 2019/068

That the Work Programme, as updated at Committee, be agreed.

17 EXCLUSION OF THE PUBLIC

RESOLVED: 2019/069

That the public be excluded for the remainder of the meeting on the grounds that the discussions were likely to involve disclosure of exempt information described in paragraph 3 of the Local Government (Access to Information) (Variation) Order 2006 and the public interest in maintaining the exemption outweighed the public interest in disclosing the information.

16 DISPOSAL OF LAND AT DENEWOOD CRESCENT, BILBOROUGH REVISION – EXEMPT APPENDIX

RESOLVED: 2019/070

That the contents of the exempt appendix be noted.

17 INVESTING IN NOTTINGHAMSHIRE: DELIVERING THE TOP WIGHAY FARM SUSTAINABLE URBAN EXTENSION – EXEMPT APPENDIX

RESOLVED: 2019/071

That the contents of the exempt appendix be noted.

The meeting closed at 11.48 am.

CHAIRMAN

Nottinghamshire County Council

Report to Policy Committee

17th July 2019

Agenda Item: 4

REPORT OF THE LEADER OF THE COUNCIL

FEASIBILITY COSTS FOR THE CARLTON LE WILLOWS ACADEMY (GREATER NOTTINGHAMSHIRE EDUCATION TRUST) BASIC NEED EXPANSION

Purpose of the Report

1. To seek Member approval for the investment up to £27,500 to fund the initial feasibility study to secure the expansion of Carlton le Willows Academy to accommodate additional forms of entry into Year 7 from 2020.

2. To update Members on the emerging proposal to secure a medium to long term plan to ensure a sufficiency of secondary school places in the planning area in partnership with the Greater Nottinghamshire Education Trust (GNET).

Information

3. The quality of schools and education provision is a key priority in the Council Plan and in investing in Nottinghamshire. Nottinghamshire County Council (NCC) has continued to invest significantly in the provision of schools across the County. Between 2013 and 2019, approximately 5,500 primary school places were created at a cost of £65m. The County Council continues to invest in school places provision and new schools are currently being built in Bestwood, Hawthorne Primary School at a cost of £6.3m; in Rushcliffe, Sharphill Primary School, the cost is pending approval; and Hucknall, the Flying High Academy at a cost of £4.2m. The County Council is making significant progress in the rebuilding of The Orchard Special School in Newark alongside a new Day Service at a cost of £15.5m. In addition to these investments in Nottinghamshire, the Council has also committed to the rebuilding of The Bramcote School.

4. Across the County 84.8% of schools are rated Good or Outstanding by Ofsted, which means children and young people are well served by education providers. This is particularly the case in Gedling. On 1 March 2019, which was national secondary offer day, there were 1,305 applications processed from residents within the Gedling area. 1,195 (91.6%) received their first preference with 1,275 (97.7%) receiving one of their four preferences. In this district only 30 alternative offers had to be made where NCC Admissions could not meet a parental preference. Of these 30, 16 made only one preference. This was delivered through a strong partnership with six secondary schools in the Gedling district which have remained committed to working positively with the County Council to secure a long term plan for this planning area.

5. The Carlton le Willows Academy sits in the Carlton area of Gedling alongside Carlton Academy which is part of the Redhill Trust. These are high performing popular secondary academies in a densely populated area. There are two large housing developments in progress in the area at: Teal Close in Netherfield and Chase Farm in Carlton. At completion it is expected that these developments will contribute an additional four forms of entry (600 secondary students) over the next five academic years (by 2025) between Carlton le Willows (300 permanent places) and Carlton Academy (300 permanent places) in this planning area.

6. A report was taken to Children and Young People's Committee in February 2019 and approval was given to pursue plans that would result in the expansion of The Carlton Academy to meet the need for school places. Negotiations have successfully concluded and a further report was taken to Policy Committee in May 2019 securing the release of £2.9m to The Carlton Academy to fund the development of 300 permanent school places by 2023 at the latest.

7. Officers have continued to negotiate with Carlton le Willows to ensure that a further 300 permanent secondary school places are created. GNET has now established the feasibility costs to develop the plan further and has requested £27,500 to undertake the relevant planning.

8. The academy has been formally requested to create 300 additional permanent school places and the feasibility exercise will confirm a two phase plan with the ultimate objective of the academy formalising a PAN (Published Admission Number) of 360 by 2023 at the latest. The Trust has advised that the feasibility exercise should be completed by 31 August 2019 which will inform the final negotiations with the Council in September 2019.

Other Options Considered

9. There are no other options at this time that would provide the additional places for September 2019.

Reason/s for Recommendation/s

10. The County Council has a statutory duty to ensure a sufficiency of school places across the County. Gedling planning area is an area that will require additional school places.

Statutory and Policy Implications

11. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public-sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

12. The £27,500 capital investment required to fund the feasibility at Carlton le Willows Academy will be funded from within the School Places Programme which is already approved in the Council's capital programme to provide up to 300 additional secondary places by 2027. Therefore, this funding will be drawn down from Nottinghamshire County Council's Basic Need funding.

RECOMMENDATION/S

That the Committee:

1) approves the investment of £27,500 to fund the initial feasibility study to secure a phased plan to create 300 permanent additional secondary school places at Carlton le Willows Academy by 2023 at the latest.

2) requests a further report outlining the costs to create the additional school places once the feasibility exercise has been completed.

Councillor Mrs Kay Cutts MBE
Leader of the Council

For any enquiries about this report please contact:

David Hughes
Service Director - Investment & Growth
T: 0115 9773825
E: david.hughes@nottscc.gov.uk

Constitutional Comments (KK 25/06/19)

13. The proposals in this report are within the remit of the Policy Committee.

Financial Comments (GB 04/07/19)

14. The investment required to fund a feasibility study to secure the expansion of Carlton le Willows Academy is expected to cost £27,500. These costs will be funded from the 2019/20 School Places Programme which totals £18.0m and is already approved within the capital programme. If the feasibility study does not result in a capital project the costs will become abortive and will need to be funded from the revenue budget.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Proposed Basic Need Programme of School Expansions 2019/20 – report to Children and Young People's Committee on 11th February 2019

Basic Need Allocation for the Carlton Academy (The Redhill Academy Trust) - report to Policy Committee on 22nd May 2019

Electoral Division(s) and Member(s) Affected

All.

C1273

Nottinghamshire County Council

Report to Policy Committee

17 July 2019

Agenda Item:

REPORT OF THE LEADER OF THE COUNTY COUNCIL

NEW SCHOOL AT THE SHARPHILL DEVELOPMENT, EDWALTON

Purpose of the Report

1. To seek approval to vary the Council's capital programme for the provision of a new primary school at the Sharphill development in Edwalton, Rushcliffe.

Information

2. A site within the Sharphill housing development has been identified as a new primary school which is required as a result of related housing development and population growth in the West Bridgford area and the new school is required to be open by September 2020.

3. Rushcliffe Borough Council (RBC) entered into a Section 106 (S106) agreement for the wider development, and allocated a £5.3m (indexed from 2016) developer contribution to fund the construction of the school. As part of that S106 agreement between the Borough Council and the developer, a 2 hectare site was allocated for the school which has to be transferred to the County Council by the landowner/developer.

4. The County Council is however not party to the S106 agreement. Unfortunately the site allocated for the new school creates a number of engineering difficulties for the County Council in constructing the buildings, and particularly in the provision of level playing fields as it is located on one of the steeper parts of the overall development area.

5. As result of the site conditions, a more complex site design is required which increases the basic build cost, as well as extensive and costly groundworks to make the site usable. The developer contribution is therefore insufficient to cover off the cost of the new school and the County Council, as the statutory authority responsible for school places, is required to meet the funding gap.

6. Negotiations continue with the developer to seek their support in undertaking regrading of the site prior to it's transfer to the County Council to mitigate some of the cost increases identified.

7. The school has been designed to meet the Education Skills Funding Agency (ESFA) output specification for primary schools and Building Bulletins 99 & 103. The school will be built as a 315 place school with sufficient space to expand to 420, with a 39 place nursery. There will also be associated playing fields and outdoor play areas.

8. Following a tender process Morgan Sindall have been appointed as the main contractor for the build, and the County Council's Planning and Licensing Committee considered the planning application for the new school at its meeting on 16 July.

9. The Spencer Academy Trust will operate the new school as a free school, and will be responsible for identifying and managing any potential community use within safeguarding requirements.

10. The land identified for the school should be transferred to the Council before construction can commence. Property and Legal Services Departments are pursuing the land transfer to facilitate the build.

11. In order to be available by September 2020 construction of the school needs to commence in August 2019. Any delays to completion of the land transfer with the developer, and the relevant site remediation to deal with the level concerns currently present a significant risk to the project in terms of both delivery time and cost.

12. The County Council has a significant school build programme to meet the needs of our population and has a strong track record of delivery. Nationally Government statistics demonstrate that Nottinghamshire outperforms the national average in ensuring children go to the primary school of their choice – 98.4% in Nottinghamshire compared to 97.7%. In order to continue to meet the needs of children and families in the County, it is important that the Council is engaged with local planning authorities. Dialogue is ongoing with Rushcliffe Borough Council about County Council engagement in S106 negotiations to secure the best possible outcome for children, families and communities in future.

Capital Budget implications

13. Arc Partnership has undertaken a full feasibility costing on the proposed scheme, which is currently in the detailed design development stage. The current costings set out in the table below include risk items which have been identified in relation to the site including additional earthworks, increases in utility connection costs and mitigations for delay in acquiring the land which knock on to the construction programme.

Sharphill Primary School – Preliminary Cost	**£**
Building cost	6,100,000
Highway works beyond site boundary	150,000
Fees, Surveys etc	672,250
Furniture & equipment	300,000
Total Cost	**7,222,250**
Estimated risk costs associated with the site	**1,328.486**
Total	**8,550,736**

14. The budget approval for the purposes of this report is therefore £8.6m. Every effort is being taken to reduce the County Council's exposure to cost given the build cost already exceeds the amount of S106 funding secured by the local planning authority. Latest Estimate Cost

reports will be presented to Finance and Major Contracts Management Committee as the project progresses and costs become more certain.

Other Options Considered

15. None. The development of the new school is vital to providing school places in the local area.

Reason/s for Recommendation/s

16. The Council has a statutory duty to ensure sufficient school places are available for all school age children.

Statutory and Policy Implications

17. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

18. As noted above the budget approval for the purposes of this report is £8.6m to reflect the full value of any construction costs and potential project risks currently identified.

19. The £5.3m (indexed from 2016) S106 monies to be recovered from Rushcliffe Borough Council will be drawn down at stages during the project.

20. Funding in excess of the £5.3m will need to be met by the Council's capital funding allocation for Basic Need pupil provision from the Department for Education/Education and Skills Funding Agency.

21. As noted above negotiations continue with the developer to seek their support in undertaking regrading of the site prior to its transfer to the County Council.

22. Further discussions will be required with Rushcliffe Borough Council to identify potential increases in the S106 contribution to cover the additional costs incurred in developing the school as the County Council considers that the site provided does not meet the requirements of the S106 agreement in that it is not developable without significant additional cost.

23. An updated Latest Estimated Cost (LEC) report based on the tender package provided to the contractor will be presented to Finance and Major Contracts Management Committee in September 2019 when the risks outlined above have been clarified. Further updated LEC reports will be produced as necessary thereafter as the project progresses.

Public Sector Equality Duty implications

24. In accordance with County Council policy the design of the buildings will incorporate access and facilities for people with disabilities.

Implications for Sustainability and the Environment

25. Environmental and Sustainability requirements will be incorporated into the detailed design process for each of the individual buildings

RECOMMENDATION/S

1. That the capital programme be varied by £8.6m to establish a project for the provision of a new school at the Sharphill development in Edwalton.

Councillor Mrs Kay Cutts MBE
Leader of the County Council

For any enquiries about this report please contact: Phil Berrill, Team Manager, Property Commissioning Tel: 0115 9774641

Constitutional Comments (CEH 28.06.19)

26. The recommendation falls within the remit of Policy Committee under the Council's Constitution.

Financial Comments (GB 03.07.19)

27. The financial implications of this project are set out in paragraphs 13 to 14 and 18 to 23. It is proposed that the Children and Young People's capital programme is varied by £8.6m with £5.3m (plus indexation) funded from section 106 contributions and up to £3.3m from Basic Need grant. This element of the funding will be transferred from the 2019/20 Basic Need allocation which totals £18.0m and is already in the approved capital programme.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Report to Planning and Licencing Committee, 16 July 2019

Electoral Division(s) and Member(s) Affected

- Division: West Bridgford South
- County Councillor Jonathan Wheeler

Nottinghamshire County Council

Report to Policy Committee

17th July 2019

Agenda Item: 6

REPORT OF THE LEADER OF THE COUNCIL

INCREASING RESIDENTIAL CAPACITY FOR LOOKED AFTER CHILDREN

Purpose(s) of the Report

1. To seek approval from Policy Committee to buy a house within Nottinghamshire in which to establish a new children's home and to delegate authorisation for the purchase.

2. To seek approval from Policy Committee for the addition to the capital programme of £550,000 for the purchase and refurbishment of a house to make it suitable to be used as a children's home.

Information and Advice

Background

3. Excluding the 3 homes for children with disabilities, NCC has 3 children's homes with a combined capacity of 11 places. NCC has circa 86 children in residential homes provided by other organisations. [1]

4. When a child for whom Nottinghamshire County Council (NCC) is the corporate parent needs to be placed into residential care and there is no appropriate space in one of NCC's own children's homes then a place has to be sought in the external market.

5. Whilst NCC has contracts with two providers which provide placements at standard rates, where a child's needs are perceived as being complex or challenging it can be hard to find an alternative placement and places when found are often far more expensive than NCC provision, with demand outstripping supply. The last few years have seen significant rises in the cost of such placements with external providers[2].

6. Local Authorities have a 'Sufficiency Duty' under the Children's Act 1989 (Section 22G). This requires they ensure there are sufficient placements within their geographical area to meet the needs of children and young people in care and take steps to develop provision to meet the needs of all children and young people in care

[1] NCC BI Hub, L12 – Looked After Children Today, 20th June 2019

[2] The average cost of cat1.2 LAC increased by 10% 2016-17 compared to 2018-19 whereas cat1.1, the lower level of complexity, increased by 2%.

locally, as far as is possible. Many of the external placements NCC uses are outside of Nottinghamshire.

7. Placements outside of Nottinghamshire make it harder for children to maintain links with their families, friends, communities and schools. Whilst there are occasions on which it is in the best interest of a Looked After Child (LAC) to be distant from these aspects of their lives, it is more usual that some link be maintained and built upon to achieve good outcomes for the children, including a return to the family home.

8. Placements outside of Nottinghamshire also make it more difficult to ensure children get the services they need from professionals within and beyond the council. Those professionals will tend to have stronger relationships with and better access to other services within the county than with those outside of the county, e.g. with Nottinghamshire Police and with Child and Adolescent Mental Health Services (CAMHS).

9. The recognition of the potential for cost avoidance, the increased control over placements and the better services to children through creating in-county capacity led to an investigation into the requirements for a new home within Nottinghamshire and a review of the property options.

Options

10. It was determined that a 4-bed children's home would be optimal. This size balances the need to create a homely feel with cost-effectiveness. NCC is experienced in managing this size of home: the current 3 NCC homes have 3, 4 and 4 beds respectively. The national trend has been toward this size of home; whilst larger homes can be successful they are more likely to provide an institutionalised experience rather than a homely environment. Furthermore, larger numbers of children make it harder to maintain a high occupancy as it becomes increasingly difficult to safely accommodate a wider mix of needs and challenges.

11. The portfolio of council property assets, either buildings or land, was assessed to determine whether any were suitable to be used to establish a new home. One site was identified but was withdrawn from the process when another department declared a need for the larger site of which it was part.

12. Initial searches have identified houses of the right size within the budget set that have the potential to be used to establish a children's home. Following committee approval, potential properties will be reviewed against criteria determined by residential services colleagues and their location assessed for risk.

13. The search for suitable houses will concentrate on the Mansfield and Ashfield areas. These areas have higher numbers of Looked After Children than others in the county and are close to the existing homes, allowing for support from colleagues.

Reason/s for Recommendation/s

14. Buying a house and making it suitable to be used in the establishment of a new children's home will quickly increase the children's residential care capacity within

Nottinghamshire and deliver the benefits of lower placement charges and increased availability of places.

15. This proposal is one of a number of initiatives NCC are pursuing in order to improve access to a greater volume and mix of residential placements which collectively provide better financial and social value to the Council.[3] It will serve as a low-risk test of the benefits of Nottinghamshire expanding its children's residential care estate.

Statutory and Policy Implications

16. This report has been compiled after consideration of implications in respect of finance, human resources, human rights, the public sector equality duty, safeguarding of children and vulnerable adults, service users, crime and disorder, sustainability and the environment and ways of working. Where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

17. The purchase and refurbishment of the new home will be funded through a £550,000 capital investment. This was agreed in principle by NCC's Capital Asset Management Group (CAMG) on 8th October 2018, pending the property options appraisal and Policy Committee Approval.

18. A subsequent paper, which will evaluate the options for different operating models for the new home, will be taken to Children & Young People's Committee. There may be advantages in having an external partner play a part in its management. However, in order to determine its viability and budget implications, a financial model has been developed as if NCC were to operate it alongside its existing homes.

19. There will be some revenue implementation costs in advance of the home opening for recruiting and training staff (2019/20) and running costs before the home is up to full capacity (2020/21). The timescale is only indicative and will depend on when the home purchase is completed. These costs are estimated at £250,000 and £73,000 respectively which will be met by a request from contingency of up to £323,000. These costs will be considered as part of establishing the budget for future years.

20. The annual revenue cost of running the new home, including the above, is estimated at £699,000 and will be funded from the existing external placements budget which is £26.6m.

[3] External Placements Budget for Looked After Children, Report to Children & Young People's Committee, 15th October 2018.

21. The table below shows the financial model for the new home if it were to be run by NCC.

	Annual Running Cost £	Estimated cost of avoided external placements £	Net Annual Cost/Saving (-) £
Year 1	250,000	0	250,000
Year 2	698,700	626,080	72,620
Year 3	698,700	804,960	-106,260
Year 4	698,700	804,960	-106,260
Year 5	698,700	804,960	-106,260

Notes on financial model:

a. Staff recruitment & training will be phased and will start prior to opening (Year 1).

b. Occupancy in the first full year of operation (Year 2) will be 70% due to phased introduction of children. The new home will phase the entry of its initial residents to properly manage the mix of children and stabilise group dynamics.

c. Occupancy is estimated to rise to 90% after the first year (Year 3). This is an average of the occupancy of the 3 existing homes in the 12 months to Nov 2018.

d. The estimate of the costs of external placements is based on a projection drawn from 3 years of data relating to placements for children with complex needs.

e. The table may under-estimate the savings that will be made in future years; analysis has shown that the costs of external placements are rising faster than the costs of running a home.

f. Corporate Overheads are excluded from the annual running costs of the home.

HR Implications

22. The HR implications of the new home will be determined following the evaluation of options for its operating model.

RECOMMENDATIONS

23. That Policy Committee approve the addition to the capital programme agreed in principle by the Capital Asset Management Group to assign £550,000 for the project to buy a house and make it suitable to be used as a new children's home.

24. That authorisation of the acquisition of a suitable house is delegated to the Corporate Director for Place, in consultation with the s151 officer and the Chairman of Policy Committee.

25. That options for the new home's operating model be developed and evaluated for approval by NCC's Children & Young People's Committee.

Councillor Mrs Kay Cutts MBE
Leader of the Council

For any enquiries about this report please contact:

Adrian Smith

Corporate Director, Place

0115 977 3680

Constitutional Comments (EP 20/06/2019)

26. The recommendations fall within the remit of the Policy Committee by virtue of its terms of reference. The terms of the purchase must be approved by the Corporate Director for Place in consultation with s151 Officer and the contract for the purchase must be in a form approved by the Group Manager for Legal, Democratic and Complaints.

Financial Comments

27. The purchase and refurbishment cost associated with the establishment of the new children's home is expected to be £550,000. Subject to approval, the capital programme will be varied to include this project in the Children and Young People's capital programme, funded from borrowing. **(GB 04/07/2019)**

28. There will be some revenue implementation costs in advance of the home opening for recruiting and training staff (2019/20) and running costs before the home is up to full capacity (2020/21). The timescale is only indicative and will depend on when the home purchase and refurbishment is completed. These costs are estimated at £250,000 and £73,000 respectively which will be met by a request from contingency of up to £323,000. These costs will be considered as part of establishing the budget for future years. **(SAS 08/07/2019)**

29. The annual revenue cost of running the new home, including the above, is estimated at £699,000 and will be funded from the existing external placements budget which is £26.6m. **(SAS 08/07/2019)**

Electoral Division(s) and Member(s) Affected
All

Nottinghamshire County Council

Report to Policy Committee

17 July 2019

Agenda Item: 7

REPORT OF THE CHAIRMAN OF THE ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE

MANAGEMENT OF MEDICATION AND HEALTH AND SOCIAL CARE TASKS POLICIES FOR START REABLEMENT TEAM AND HOMEBASED CARE AND SUPPORT PROVIDERS

Purpose of the Report

1. To seek Policy Committee's approval of the policies listed below:

   a. Delivering health and social care tasks: policy for homebased care and support providers (attached as **Appendix 1**)

   b. an update to the Assisting with Medication policy for Short Term Assessment & Reablement Team (START) – Reablement Support Workers operating in a service user's home (attached as **Appendix 2**).

Information

2. The current policy "Responsibilities for Care in the Home" was written in 2010. It describes the responsibilities of community nursing services and domiciliary services in delivering health and social care tasks in an individual's own home.

3. "Assisting with Medication Policy for Short Term Assessment & Reablement Team (START)" was written in 2010 and was last updated in December 2015. The policy describes the responsibilities of the Countywide Reablement Teams around the safe and secure handling of medicines.

4. Since 2010, there have been major technological advances and updates to legislation and national guidance which warrant a review of the documents. Key points include:

   a. The introduction of the Care Act 2014 which focusses on prevention, person centred approaches and the promotion of an individual's wellbeing. Low level healthcare tasks being delivered by a homebased care and support or Reablement provider in line with the 'prevention of longer-term care and support needs' agenda which will offer a consistent service intervention where self-medication can be monitored and reviewed.

b. Advances in medications including administration and protocols encourages service users to self-manage or be supported by a non-healthcare worker to promote their independence.

c. Advances in assistive technology including aids can enable individuals to self-care or for a non-healthcare worker or family member to support with healthcare tasks.

d. The national driver to integrate health and social care validates the development of social care workers to take on low level healthcare and medication tasks.

e. A questionnaire was completed by local home care providers. The findings showed that they are carrying out healthcare tasks for privately funded packages of care. The new policies will therefore reflect current practices.

f. A Senior Prescribing and Governance Adviser who works for Clinical Commissioning Groups (CCGs), and has been the clinical expert for Nottinghamshire County Council for the last 10 years, contacted local authorities to find out what healthcare tasks they commission from home care providers. Her research has shown that in comparison with Nottinghamshire County Council more healthcare tasks are being undertaken by home care providers in other councils.

g. National guidance is published by organisations such as National Institute for Care and Health Excellence "Managing medicines for people receiving social care in the community" (NG67 & QS171) which recommend best practice. The Care Quality Commission has also recently published a report on Medicines in Health and Adult Social Care which support the actions in the implementation plan.

h. The inability to support service users with low level healthcare and medication tasks could decrease the number of referrals made to the START service or a homebased care provider, unnecessarily prolong an individual's stay in hospital, have a longer-term financial implication for the Council around the prevention of ongoing support needs and lead to an inequity of medication support being offered.

i. The policies do not circumvent any standards set by a Healthcare Professionals regulatory body such as the Nursing & Midwifery Council (NMC) or the Health and Care Professions Council (HCPC).

5. A multidisciplinary steering group including CCGs and community health providers was set up to review both policies. It was agreed that the policies would:

a. reflect the principles of the Care Act

b. give a clear rationale as to reasoning behind the changes

c. reflect current modern health and social care practices

d. follow current National Institute for Care and Health Excellence and Social Care Institute for Excellence guidance around delivering medication and health care tasks

e. address any funding or financial issues raised

f. clearly establish the tasks that social care can undertake with healthcare support

g. clearly establish the tasks that only healthcare professionals can deliver

h. ensure that social care workers delivering healthcare/medication tasks are appropriately supported e.g. ongoing learning and development provided by healthcare professionals

i. make the best use of financial and staffing health and social care resources.

6. The new documents have undergone a number of revisions to incorporate the extensive consultation with operational and strategic County Council teams, nursing staff working for Clinical Commissioning Groups, clinicians, District Nurses, hospital discharge team, Nottinghamshire Integrated Care Systems staff, Nottinghamshire Healthcare Trust staff (who are working on the delegating healthcare tasks to Personal Assistants project) and homebased care and support providers.

7. START is a short term reablement service whereas homebased care and support provide a longer term service; consequently there are differences in the two policies and the tasks that the workforce can undertake.

8. There are synergies between the workforce who deliver the START service, homebased care and support providers and the Home First team (a short term service which can help people to get home from hospital quickly and/or support someone at home if they have a short term crisis and are at risk of unnecessary readmission to hospital or urgent short term care in a care home). Therefore, the contents of the two documents are closely aligned. Independent homebased care and support providers who are contracted by Nottinghamshire County Council can adopt/adapt the START medication policy to reflect their local service.

9. A high level action plan has been developed to support the communication and implementation of the two policies and this is available as a background paper.

10. In the future, adult social care may be expected to support the NHS self-care agenda, where more products would be expected to be purchased by patients themselves as opposed to being prescribed by their GP.

11. A local project is seeking to support the delegation of healthcare tasks to Personal Assistants. A list of tasks has been drawn up. The proposal is that health care professionals will be responsible for the clinical oversight, accountability and governance of the scheme. They will train Personal Assistants to carry out delegated healthcare tasks.

12. The proposed policies were considered by Adult Social Care and Public Health Committee on 8th July and recommended to Policy Committee for approval.

Other Options Considered

13. The Council could continue to support the current documents but this has been discounted as it does not reflect current local and national practice, and trends. It also hinders continuity of care, decreases choice and control for the service user and could lead to duplication of services which is not cost effective.

Reason/s for Recommendation/s

14. Recent research and new working practices support the implementation of the new guidance.

15. Updating the guidance and providing robust protocols and procedures, a learning and development programme, competency assessments and clinical oversight will have a major impact on health and social care workers in all organisations.

Statutory and Policy Implications

16. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

17. The focus of the policies is to ensure that the right support is provided at the right time in the most cost effective way. It is anticipated that the policies will result in cost efficiencies through better use of resources.

Human Resources Implications

18. Social care staff working in the START team will be expected to undertake learning and development in medication tasks. The CCG prescribing team will deliver training to the START medication champions and other key staff who will cascade the training to all START staff. Regular supervision will ensure that staff are competent to deliver these tasks.

19. Health care resources will be realigned to provide clinical oversight and learning and development opportunities for social care staff.

20. Staff working in homebased care and support organisations already undertake some of the low level health care tasks. The Council will work with Training Officers in these organisations to ensure that this workforce is trained and competent to deliver the health and social care tasks policy. This will be monitored at contract review meetings.

Public Sector Equality Duty Implications

21. In compiling this report, the effects that these policies may have on people with protected characteristics have been considered. It has been concluded that there will be a positive effect because the policies will increase flexibility for the service user as the interdependencies between those involved in their care will be reduced and there will be a quicker, seamless service.

Implications for Service Users

22. The new policies will support continuity of care and a service user's choice over who is best placed to deliver their care whether that be their START or homebased care and support provider or a health care individual. This will increase flexibility for the service user as the interdependencies between those involved in their care will be reduced

RECOMMENDATION/S

That Committee:

1) approves the Delivering health and social care tasks: policy for homebased care and support providers, attached as **Appendix 1**

2) approves the changes made to the Assisting with Medication policy for Short Term Assessment & Reablement Team (START), attached as **Appendix 2**.

Councillor Tony Harper
Chairman of the Adult Social Care and Public Health Committee

For any enquiries about this report please contact:

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Constitutional Comments (EP 01/07/19)

23. The recommendations fall within the remit of Policy Committee by virtue of its terms of reference.

Financial Comments (DG 01/07/19)

24. There are no specific financial implications arising from this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Management of medication and health and social care tasks policies implementation plan

Supporting quality in care homes and domiciliary care medicines management annual report 2018/19

Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

"Managing medicines for people receiving social care in the community" (NG67 & QS171)
https://www.nice.org.uk/guidance/ng67

Personalisation for home care providers
https://www.scie.org.uk/personalisation/practice/home-care-providers

Medicines in Health and Social care
https://www.cqc.org.uk/sites/default/files/20190605_medicines_in_health_and_adult_social_care_report.pdf

Management of medication and health and social care tasks policies for START Reablement Team and Home Based Care and Support providers – report to Adult Social Care and public Health Committee on 8th July 2019.

Electoral Division(s) and Member(s) Affected

All.

ASCPH668 final

APPENDIX 1

Delivering Health and Social Care Tasks: Policy for homebased care and support providers

Introduction

The Care Act (2014) requires Health and Social care to work in partnership to ensure good quality support, that focuses on a person's wellbeing, is provided to service users and their families.

This policy applies to homebased care and support providers also known as domiciliary agencies and to community health teams.

In Nottinghamshire, homebased care providers are commissioned to undertake social care and healthcare tasks on behalf of Nottinghamshire County Council and Clinical Commissioning Groups. These organisations must have clear policies, protocols, insurance and learning and development in place to allow and support staff to undertake any appropriate task.

Extensive consultation has been undertaken with operational and strategic County Council teams, nursing staff working for Clinical Commissioning Groups, clinicians, District Nurses, hospital discharge teams, Nottinghamshire Integrated Care Systems staff, Nottinghamshire Healthcare Trust staff (who are working on the delegation of healthcare tasks to Personal Assistants project) and homebased care and support providers to produce this policy.

This policy does not circumvent any standards set by a Healthcare Professionals regulatory body, which they are required to meet (e.g. Nursing & Midwifery Council (NMC) or Health and Care Professions Council (HCPC)).

The Purpose of the Policy

The policy has been developed to:

a. Articulate current and future service requirements
b. Reflect the principles of the Care Act
c. Give a clear rationale as to reasoning behind the changes
d. Reflect current health and social care practices
e. Follow current NICE and SCIE guidance around delivering health care tasks
f. Clearly establish the tasks that social care can undertake with healthcare support
g. Clearly set out the tasks that only healthcare professionals can deliver
h. Ensure that social care workers delivering healthcare tasks are appropriately supported e.g. ongoing learning and development provided by healthcare professionals

General Principles of the Policy

The following principles apply when deciding who is best placed to undertake a particular task with an individual service user in their own home. We must:

- Promote the wellbeing of the individual as defined in the Care Act
- Support people to manage their own conditions wherever appropriate
- Provide continuity of care for individuals

- Prevent an individual's condition from deteriorating
- Support an individual's choice over who is best placed to deliver their care
- Consider the skills, knowledge and risks required to undertake such tasks
- Provide opportunities for social care staff to develop their knowledge and skills which will help their career development
- Ensure staff follow formal, consistent, person centred, safe working practices led by a relevant health professional
- Ensure the homebased care and support providers have the appropriate insurance in place to cover the tasks described in this document.

Health and Social care Tasks

The list of tasks which have been agreed jointly with Nottinghamshire County Council, Health/CCGs, homebased care providers and partners have been divided into two sections.

- Section 1 describes the tasks routinely undertaken by Social care staff, those which can be undertaken by Social care on behalf of Healthcare Professionals and tasks which remain the responsibility of Healthcare Professionals. Additional information and notes for consideration by providers and Social care staff are included regarding some of the tasks listed.

- Section 2 describes the medication tasks for homebased care and support providers.

The role of healthcare professionals and social care staff in completing particular tasks as described in this document will be reviewed regularly; to reflect technological advances, legislative changes and the progress of health and social care integration.

This list of tasks is neither prescriptive, exhaustive nor needed in all cases, and will depend on which tasks are identified as most likely to meet agreed outcomes, as identified in the person's care and support plan. It should not preclude alternative solutions which may better suit a person (for example telecare). Where the person requires support in decision making or lacks the mental capacity to make specific decisions for themselves, the Principles of the Mental Capacity Act 2005 must be applied.

If "medication only" tasks or single "health" care needs tasks need to be carried out for a service user then this will be looked at on an individual case by case basis and liaison will occur between Health & Social care.

It should be noted that many of the activities are routinely performed by relatives and that adults should be encouraged to perform some of the health care tasks for themselves where appropriate.

A range of equipment is available to support individual service users receiving homebased care & support.

Service users may be able to access benefits such as the attendance allowance to pay for any their social care or health care needs. https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/benefits-for-over-65s/

Funding of social care and healthcare tasks

The tasks that need to be undertaken to meet an individual service user's needs and circumstances will be reviewed jointly by commissioners from Health/CCGs and social care to ensure the appropriate funding is in place (Local Authority funded, Continuing Health Care funded or Joint funded) and where appropriate for delegated tasks, this includes the provision to cover costs for any necessary training and competence assessment

Intermediate level tasks can be undertaken by social care staff providing their organisation has trained them and appropriate insurance is in place. Continuing Health Care or Joint Funding should be agreed prior to social care staff undertaking these tasks. This is to secure the appropriate funding and ensure robust processes are implemented regarding the specific roles & responsibilities of all involved.

Section 1

This is a description of the tasks routinely undertaken by social care staff, those which can be undertaken by social care on behalf of Healthcare Professionals and tasks which remain the responsibility of Healthcare Professionals. Additional information and notes for consideration by providers and social care staff are included regarding some of the tasks listed.

Definitions of low, intermediate and advanced levels of health & social care tasks

Low Level – As outlined in the Care Act, if a service user has an eligible need these activities can be routinely undertaken by all social care staff.

Intermediate Level – As outlined in the Care Act, if a service user has an eligible need, providers can also support with intermediate level tasks.

- The decision to allocate a healthcare task to social care should be made by a registered practitioner who is occupationally competent in the task, delegation of tasks must be in the best interest of the person receiving care and support.
- Where tasks are delegated, the Healthcare Professional must provide written procedures for social care staff to follow, as well as how ongoing clinical reviews of the persons' needs is maintained and by whom.
- The Healthcare Professional delegating to social care staff must identify and inform the provider of the type of training required for the type of task being delegated.
- Intermediate tasks must only be completed by staff who have completed the appropriate training followed by assessment and confirmation of competence. The training will give social care staff the knowledge, confidence and competence to undertake the task.
- The provision of appropriate training and competency assessment will vary depending upon the task, training can be delivered by a Healthcare Professional or competent person (either within the provider organisation or sourced from external organisations)
- The training could be generic and applicable to any service user or specific and particular to an individual service user, this would need to be proportionate to the specific tasks and individuals needs and circumstances.
- Training and competence to perform these tasks must be re-assessed on a regular basis. It is advisable to refresh knowledge and reassess competence annually.
- Social care staff may not assess an individual or make clinical decisions based on their own assessment; therefore Healthcare Professionals need to make arrangements for ongoing oversight and contact arrangements for advice and reassessment and ensure these are communicated as part of the procedures produced for social care staff.
- Social care staff responsible for completing risk assessments for undertaking Intermediate tasks must have completed specific risk assessment training.

Advanced Level – tasks which can only be carried out by Healthcare Professionals.

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Assistance with mobility	**Transfers** (e.g. Getting up/going to bed, transferring from a chair/wheelchair to a commode) Utilisation of all appropriate moving and handling equipment an individual service user has been assessed as needing e.g. hoists, stand aids, turners, glide sheets, handling belts etc.			
Personal Care	**Washing, bathing & hair care** Using appropriate equipment if needed			Social care staff must respect the personal religious beliefs and customs of the people they are supporting with regards to cleansing as long as it is within Health and Safety guidelines. If staff should notice any changes in an individual service user's appearance that may require attention e.g. rashes, blisters, sores etc. report to appropriate Healthcare Professional/manager and support the individual service user to seek medical attention.
	Dressing Using appropriate equipment if needed			
	Support with spectacles, hearing aids etc. May assist people to clean and put on glasses. May assist people to insert and adjust hearing aids.		Insert contact lenses not permitted by health or social care	

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Personal Care	**Apply sun creams, sun blocks, simple body moisturisers without prescription from a doctor or non-medical prescriber** If the service user has used these before. These preparations can be used as part of a personal care routine.			Products containing paraffin should be documented on the MAR chart e.g. Emulsifying ointment, Zinc ointment BP, Zinc and Salicylic Acid Paste BP, Diprobase® ointment, Hydromol® ointment, White Soft Paraffin, Liquid paraffin 50% WSP 50% ointment, Dihranol ointment, Epaderm and Imuderm liquid due to the flammability risk when applying to large areas.
	Shaving with an electric shaver			
	Wet Shaving Following consultation with Healthcare Professionals regarding known infections, diseases, skin conditions or other medical conditions that may make wet shaving inappropriate for the individual service user or when an they are prescribed anticoagulants (Blood thinning agents e.g. Warfarin/Aspirin)			Where information about blood borne infection/diseases (e.g. Hepatitis/HIV/AIDS) is not sourced Risk Assessments should include risks associated with possible blood borne infections/diseases and any appropriate incidents reported to RIDDOR due to the absence of such information.
	Routine nail care Care of finger nails may be undertaken where a risk assessment indicates there are no contra-indications. Nails should be filed with an emery board.		Podiatry services provided on the basis of assessed need and in accordance with eligibility criteria.	

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Personal Care	**Dental Care & Oral hygiene** May assist individual service users to clean and insert false teeth. May assist individual service users to cleanse their natural teeth and perform mouth care tasks.			
	Support with menstruation care Support to apply, change, dispose of pads		Health or social care are not allowed to insert tampons	
Household	**General tidying** Including emptying bins, bed making, general tidying after carrying out tasks within the home			
	Cleaning Including cleaning things such as, floor areas (sweeping ,mopping and vacuuming), baths, toilets, commodes (emptying and cleaning of), microwaves, ovens, work surfaces, crockery and cutlery			
	Ironing & Laundry			
	Shopping & Collecting Including shopping (May include shopping on-line) collecting, prescriptions, paying bills etc.			
	Fire Lighting As part of a Care Plan			
	Pet care Feeding/providing water/essential care			

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Care	**Care at night** (i.e. between 10 pm and 7 am)		If active health interventions are required e.g. specialist palliative nursing services i.e. through fast track or continuing health care. DN team also provide care through the night for catheter issues, and End of Life Care drug administration.	
	Respite for Carers On a regular and planned basis as part of the Service User's package of care			
General Health & Wellbeing	**Support with the organisation of essential day to day living activities** including household management and maintaining health and well-being e.g. assisting to make appointments, where the Service User has no other suitable person to offer support. Some of the time may be non-direct contact			
	Support with putting on appliances After having read the instructions (e.g. leg callipers, special boots, artificial limbs, trusses)	Social care staff could be trained in the application of specialist devices.	Social care staff will not: Adjust appliances or change the application without direction from healthcare professional.	Social care staff should always ensure that the individual service user is comfortable with the appliance after putting on. Report and record any difficulties experienced by the individual service user or staff member with putting on the appliance

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
General Health & Wellbeing	**Promote good health**	**Observation and monitoring of physical or mental health condition** where the Service User is under the supervision of a Healthcare Professional and specific guidance has been given as to the observations/monitoring required e.g. monitoring fluid charts	Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
Eating, Drinking, Nutrition & Hydration	**Basic food & drink preparation** Including associated kitchen cleaning and hygiene as appropriate	**Prepare modified liquids and food** Following a GP/SALT assessment **Use of drink thickeners** is covered in the "medication tasks" section of this policy	Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
	Assisting to eat and drink Where there is no identified risk of choking			

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Eating, Drinking, Nutrition & Hydration		**Assisting with feeds & fluids via a PEG (percutaneous endoscopic gastrostomy)** is covered in the "medication tasks" section of this policy	**Naso-gastric tube feeding** Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
Wound Care			**Wound care** including both simple and complex dressings (excluding application of Holding Dressings to pressure areas upon the advice of a healthcare professional see "Tissues Viability & Pressure Area Care)	
Tissue Viability & Pressure area care	**Supporting the maintenance and improvement of pressure areas** Through basic tissue viability advice/care and planned interventions such as positioning the person supported by the Tissue Viability Team Report and access appropriate health services as required upon identifying possible pressure ulcers	**Applying a "holding dressing"** without otherwise cleaning or treating the site Only with direction from a relevant Healthcare Professional as an interim measure until relevant Healthcare Professional can carry out required care. Not be completed on a regular basis, only when leaving a wound uncovered would increase risks. Agree	Social care staff will not: Make any judgements on the care required Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Social care staff should document who requested "holding dressings" are applied, when this advice was given and when the dressing was applied.

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Tissue Viability & Pressure area care		**Clean & apply prescribed creams to pressure areas where the skin is not broken** (e.g. Grade 1 pressure sore)	Social care staff will not: Make any judgements on the care required Apply creams purchased by the service user to pressure areas Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
Continence	**Signpost** any issues to relevant services/agencies regarding continence		Manual evacuation of the bowel	
	Support to gain allocated or prescribed provision of incontinence materials (e.g. requesting deliveries/ringing regarding prescription)			
	Applying incontinence pads			
	Disposal of used incontinence materials			

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Catheter Care	**Catheter Bags** Empty day, night & leg bags Attach night bags to day bags Detach night bags from day bags For both urethral and supra-pubic catheters.	**Catheter Bags** Change day and night bags Keep the area clean where the catheter enters the body.	**Changing, inserting or removing catheters** Social care staff will not: Provide personal care where there is evidence of infection or soreness to the entry site. Make judgements on a person's health. Apply leg bags where there is broken skin	Social care staff should report any change in appearance of condition/bodily fluids, no matter how small to appropriate Healthcare Professional/manager and support the individual service user to seek medical attention. Risk assessments should be carried out regarding the application of leg bags.
		Intermittent self-catheterisation The individual service user does this themselves, Social care staff can be trained/briefed to help the individual	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Risk assessments & care plans should outline what the individual service user does themselves and what help Social care staff can provide
Male sheath (Conveen)	**Catheter Bags** Empty day, night & leg bags Attach night bags to day bags Detach night bags from day bags	**Change the sheath**	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Stoma Care colostomy/ ileostomy/urostomy	Empty the bags if the flange connection to the user does not have to be disturbed but NOT where "closed" systems are in use.	Empty the bags if "closed" systems are in use Support with the removal of the bag, cleaning the area and applying the new bag.	Social care staff will not: Provide assistance where there is evidence of infection or soreness to the site. Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Social care staff should report any change in appearance of condition/bodily fluids, no matter how small to appropriate Healthcare Professional/manager and support the individual service user to seek medical attention.
Post-Operative Care		**Post-Operative Care** Discharge reports and post-operative care guidance should be received by Social care staff. Specific support plans to be implemented for post-operative care needs as per Healthcare Professionals guidance. Information should be included about who to contact if there are any changes in a person's presentation/health & wellbeing following post-operative discharge	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	Where Social care staff are involved in post-operative care and specific Healthcare Professional input has not been allocated to review following discharge from hospital, Social care staff should support the individual service user to seek a review from the GP to assess the post-operative care being delivered and the individual service users health and wellbeing

	Social Care	Health Care responsibility but can be carried out by Social Care	Health Care/ Not permitted	Notes for providers & Social Care staff
Area	**Low Level**	**Intermediate Level**	**Advanced Level**	
Other		The taking of a **capillary blood test** - finger prick test (e.g. to test blood glucose levels)	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.	
			Bladder compression	
			Taking pulse or blood pressure readings	
			Assisting with the dialysis process	
			Fitting of prescribed supports for the control of hernias	
			Assisting with the cleaning and replacement of tracheostomy tubes	
			Oral suction	

Section 2 Medication Tasks for Homebased Care and Support Providers

This is guidance for **homebased care and support providers only**.

All homebased care and support providers must have a comprehensive medication policy (or may adopt /adapt the "Nottinghamshire County Council Assistance with Medication Policy") in order to support with medication tasks. If providers are using their own policy this must follow the principles and guidance included in the NCC policy.

Definition and requirements of levels of medication tasks

Level 1
Following induction, social care staff may carry out Level 1 support tasks.

Level 2
Following enhanced training and competency sign off, social care staff may also carry out level 2 support tasks.

Competency assessment and appropriate training should be delivered by a Healthcare Professional or competent person (either in their own organisation or an external organisation). Refresher medication training and competency will take place at least annually.

Level 3 (support tasks associated with a higher level of risk)

The following tasks are associated with a higher level of risk and must only be undertaken by social care staff who have also been signed off as competent to support with level 2 tasks.

Those marked with an **asterisk *** also require specific training and competency sign off before social care staff can carry out the specific task.

Competency assessment and appropriate training for specific medication tasks should be delivered by a Healthcare Professional or competent person (either in their own organisation or an external organisation). Refresher medication training and competency will take place at least annually.

All level 3 tasks should have the following:

- A specific risk assessment must be carried out by a competent person (someone who has received Risk Assessment training) for all level 3 tasks, this should be in conjunction with staff from applicable healthcare professions e.g. community nursing service, GP practice etc.
- A specific support plan for that area of need/task should be completed for those tasks marked with an **asterisk *** Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs and will provide Social care staff with information of contact arrangements for advice and reassessment.
- Input required should be negotiated on a case by case basis
- Responsibility will be retained by healthcare professionals with clear documentation, detailing roles and responsibilities.

Health Care only/Not permitted to be carried out by social care staff
Tasks which can only be carried out by health staff

	Level 1	Health Care only/Not permitted by Social Care Staff
Preparation of medication/ Non Administration	**Collect prescriptions from surgery or medicines from the pharmacy** when there is no alternative means of collection and delivery. Ensuring the name on the medicines matches the name on the MAR chart and that of the service user when delivered to their home.	Social care staff will not: Accept any change to medication unless it is clearly identified on the Medication Label.
	Make sure medicines are stored safely and securely in the individual service users own home	
	Note and record any change in the individual service user's ability to manage their medication. Notifying their line manager if there are any concerns.	

	Level 2	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Support to take oral medication**	
	Take tablets/ capsules out of pharmacy labelled containers, remove tablets/capsules from foil strips contained within an original pharmacy labelled pack. (NB assistance with medication may not be given for medicines that are not in their original pharmacy labelled containers).	Transferring medication from their original containers
	Shake bottles of liquid medicines and remove the bottle cap so that the individual service user can take the required dose.	
	Pour liquid into measuring cups, spoons	
	Draw up liquid into an oral syringe	
	Mix or dissolve soluble medicines	
	Insert an eye drop bottle into a compliance aid So that the individual service user can self-administer their eye drops. Assistance may only be provided for eye drops that have been prescribed by a doctor or non-medical prescriber.	

	Level 2	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Administer eye drops/ointment that** have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed. Prior to administration of eye drops the use of an aid to assist with instillation of eye drops should be tried (opticare available via prescription) and deemed to be unsuitable.	Provide assistance with any drops that are over the counter.
	Administer ear drops that have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed.	Provide assistance with any drops that are over the counter
	Administer nasal drops, nasal creams or nasal sprays that have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed.	Provide assistance with any drops that are over the counter
	Assist with the use of inhaler devices By passing the device to the individual service user, inserting a capsule into the device or, where necessary, press down the aerosol canister when the inhaler is used in conjunction with a spacer device. Prior to assisting with inhaler devices, the use of a compliance aid should be tried.	Make decisions on when required inhalers
	Application and removal of transdermal patches With appropriate documentation to include body maps regarding application sites & where applicable, monitoring charts for rotation of application.	
	Apply creams and ointments To clean skin and only to the area it has been prescribed for by a doctor or non-medical prescriber. Only apply to skin that is **not** broken or inflamed (unless documented as the reason it is being applied). Any concerns on the skins condition should be reported to line manager.	
	Use of drink thickeners That have been prescribed by the individual service user's GP or non-medical prescriber. The prescriber's instructions should always be followed. There needs to be a regular review from the prescriber.	Supplement drinks on advice from anyone other than a relevant medical professional which must be recorded.
	Compression stockings Provided they have been prescribed by a doctor or non-medical prescriber and a shared care agreement is in place with the community nursing team. The agreement details the reasons for use, responsibilities of healthcare staff and social care staff, including how often stockings need to be changed. The Nottinghamshire Community Health nursing team and prescribing advisor have developed a 'working in partnership agreement' for assistance with application of compression hosiery (Information can be found within the START Medication Policy – Appendix 3 regarding agreements for application of compression hosiery)	Apply stockings where there are areas of broken skin

	Level 3	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Administration of Controlled drugs** Administered in the same way as all other forms of medication, however, their documenting and storage may be different for some individual service users. (Examples include morphine tablets and solution; buprenorphine sublingual tablets; oxycodone tablets, capsules and solution.)	
	Cytotoxic oral medicines Administered in the same way as all other forms of medication, however, their documenting and storage may be different for some individual service users. These preparations are usually supplied from a hospital pharmacy. (Examples include methotrexate tablets, hydroxycarbamide capsules, fluorouracil cream, mercaptopurine tablets and fludarabine phosphate tablets)	
	Administration of Warfarin Under no circumstances should social care employees remind/ assist/administer with warfarin that is not in the original container. The dose should always be checked against written instructions provided by the anticoagulant clinic or GP practice.	
	PRN Medication Some medication will only be required to be taken when needed e.g. painkillers A clear protocol must be in place which includes the following: • Why it is needed (e.g. for pain) • When should it be taken/dose interval (e.g. four hourly, when required) • Time needed between doses • Maximum dose/quantity to be given in any 24 hour period • Clear information about what would indicate that the medication should be administered ('for pain' or 'for agitation' is not adequate) Where an individual service user lacks the capacity to identify when PRN medication is required the protocol must include the behavioural indicators that the individual service may display when they need the medication. Advice and guidance should be sought the doctor or non-medical prescriber to inform the assessment. The following should be recorded on the MAR chart: • Actual dose given (where this is variable) The effect of the medication (if known); usually recorded on the back of the MAR chart.	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.

	Level 3	Health Care only/Not permitted by Social Care staff
Medication & prescription only	**Administration of Buccal midazolam** * (Examples include Buccolam and Epistatus)	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.
	Support with TED (Thrombo-Embolic-Deterrent)/ compression stockings * Provided they have been prescribed by a doctor or non-medical prescriber and a shared care agreement is in place with the community nursing team.	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment. <u>Social care staff will not:</u> Remove or apply TED stockings.
	Assisting with the use of oxygen at home * via a pre-set facility **ONLY** Report and access appropriate health services as required upon if concerned regarding oxygen intake. • Assist the individual service user to fit the mask/tube. • Switch the machine on or off as required. • Notify appropriate Healthcare Professional/manager when pressure gauge indicates the contents of the cylinder are running low.	<u>Social care staff will not:</u> • Make any decision as to when the oxygen is or is not required. • Set any controls to regulate the flow of oxygen. • Change oxygen cylinders. Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.
	Support with use of nebulisers & medication via a nebuliser* Provided they are routine and have been prescribed by a doctor or non-medical prescriber. Medications should preferably be pre measured	The administration of medicines through a nebuliser for acute/emergency conditions
	Support with use of a PEG (percutaneous endoscopic gastrostomy) * Only using feeds, fluids and medications prescribed by a doctor or non-medical prescriber. Ensure tubes are clean and running free - Inserting water through the tube before and after the feed. Clean PEG site area when required and attaching the pump Attaching feeds, inserting fluids into the tube using the correct utensils provided. Insert medication into the tube as per MAR chart using the utensils provided.	<u>Social care staff will not:</u> • Make decisions about the quantity, content and speed of the feed provided. • Rectify any faults identified with the feed apparatus. • Flushing to unblock the tube Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.

	Level 3	Health Care only/Not permitted by Social Care Staff
Medication & prescription only	**Administering laxative suppositories*** Must be linked to a review by a Healthcare Professional	Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.
	Administration of Adrenaline auto-injectors * Brands include EpiPen, Jext and Emerade. These devices are prescribed to people with allergies who are at risk of having a severe allergic reaction (anaphylaxis). The devices and dose administered can differ between brands, therefore the risk assessment & support/care plan should be reviewed following each prescription/pharmacy dispense.	Social care staff will not: Make any judgements on the dose required by the individual service user Health retains responsibility for management, monitoring, oversight and ongoing clinical review/support of the person's needs. They will provide Social care staff with information of contact arrangements for advice and reassessment.

	Health Care only/Not permitted to be carried out by Social Care staff
Medication & prescription only	Social care staff will not carry out any invasive procedure including:
	Rectal administration of creams or enemas Vaginal administration of creams or pessaries
	Injection or procedures which break the skin (with the exception of an adrenaline auto injector e.g. EpiPen) including administration of insulin
	Syringe drivers
	Assisting or supporting the individual service user with medication that has not been prescribed by the individual service user's GP
	Any procedure that requires the Social care staff to make medical judgements.

This policy replaces the "Responsibilities for Care in the Home" 2010 document.

GLOSSARY

Carer - A family member or friend of the service user who provides day-to-day support to the service user without which the service user could not manage

Care and Support Plan - A document that explains the type of support an individual needs, how this support will be given & the responsibilities of people involved in care delivery

CCG - Clinical Commissioning Groups

Competency Assessment – The system to measure and document that social care staff are applying the knowledge, skills and behaviours required to perform specific tasks.

Health/CCG – NHS (National Health Service)

Homebased Care & Support Providers - Also known as domiciliary agencies are private, independent organisations which provide staff who support individual service users in their own home.

Healthcare Professional – A person qualified in a healthcare related profession, who is regulated by statute and so is specifically accountable to their regulatory body as well as to their employer. Healthcare Professionals may include; Nurses, GPs, Physiotherapists, Occupational Therapists, dieticians, Speech & Language Therapists and psychiatrists (this list is not exhaustive).

Joint Funding - a package of care which is jointly funded between the local authority and health.

Local Authority – Nottinghamshire County Council

NHS Continuing Health Care Funding – Is funding through the NHS for people who are assessed as having significant ongoing healthcare needs.

PRN – pro re nata – medication as needed

RIDDOR – Reporting of injuries, diseases and dangerous occurrences regulations

Risk Assessment – A document that records what might cause harm to people when carrying out a certain activity and the steps that will be taken to prevent or reduce that harm

SALT – Speech and Language Therapy

Social care staff - Staff employed by Homebased Care & Support providers to support individuals in their own home.

APPENDIX 2

Title:
Assistance with medication policy for Short Term Assessment & Re-ablement Team (START) re-ablement support workers operating in a service users home

Aim / Summary:
To detail the principles that must be followed by re-ablement support workers in relation to medication.

Document type *(please choose one)*			
Policy	*X*	*Guidance*	
Strategy		*Procedure*	

Approved by:	***Version number:*** *3.0*
Date approved:	***Proposed review date:***

Subject Areas *(choose all relevant)*			
About the Council		*Older people*	*X*
Births, Deaths, Marriages		*Parking*	
Business		*Recycling and Waste*	
Children and Families		*Roads*	
Countryside & Environment		*Schools*	
History and Heritage		*Social Care*	*X*
Jobs		*Staff*	
Leisure		*Travel and Transport*	
libraries			

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Please include any supporting documents	
1.	
Review date	***Amendments***
September 2014	*Addition of Bassetlaw CCG GPs and community pharmacists contact details*
December 2015	*Addition of updated Medicine Risk Assessment Form*
January 2019	*Review of policy*

Nottinghamshire County Council

Nottinghamshire County Council Adult Social Care, Health & Public Protection

ASSISTANCE WITH MEDICATION POLICY FOR START RE-ABLEMENT SUPPORT WORKERS OPERATING IN A SERVICE USER'S HOME

Contents:

1. INTRODUCTION

This document details the policy on the safe and secure handling of medicines by the Short Term Assessment and Re-Ablement Team (START) staff of Nottinghamshire County Council (NCC).

Care providers need to ensure they can respond to the Care Quality Commissions (CQC) 5 key questions for services

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

CQC Inspectors will use professional judgement, supported by Key Lines of Enquiry (KLOEs) and evidence, to assess services against these five key questions.

It is important that care providers:

- Handle medicines safely, securely and appropriately
- Ensure that medicines are prescribed and given by people safely
- Follow published guidance about how to use medicines safely

This policy sets out the principles that must be followed throughout the START service of the Council so that the CQC fundamental standards of quality and safety are met. It provides clarity on the medication tasks that can be undertaken by START staff (following training and assessment of competency) and those tasks which should remain the responsibility of healthcare.

All medication is potentially harmful, if not used correctly, and care must be taken with its storage, administration, control and safe disposal. It is important therefore that START employees who provide support are confident about their role in the management of medication.

The responsibilities of health and social care staff in relation to tasks other than medication are set out in the policy on "*Responsibilities for Care in the Home', June 2010,* (the Wavy Line document), available via the re-ablement manager and team managers.

There may be occasions where situations are not covered in this policy. Therefore any concerns must be brought to the attention of the workers line manager or person on call.

Independent home care providers who are contracted by Nottinghamshire County Council to provide medication support as part of a package of care may wish to use/adapt this medication policy to reflect their local service.

1.1. Consultation

Consultation on previous versions of this document occurred widely within Nottinghamshire County Council, Nottinghamshire Clinical Commissioning Groups (CCGs) and Nottinghamshire Health community groups. The groups listed below were involved in the original consultation process and supported the medication policy as set out in this document.

NHS Nottinghamshire County and Bassetlaw

NHS Nottinghamshire County Medicines Operational Group
NHS Nottinghamshire County Community Pharmacy Development Group
Nottinghamshire Local Pharmaceutical Committee - covers Nottinghamshire County, Nottingham City and Bassetlaw CCGs
Nottinghamshire Local Medical Committee, (electronically). Covers Nottinghamshire County, Nottingham City and Bassetlaw CCGs
Nottinghamshire Community Health locality service managers
Bassetlaw PCT Provider Clinical Governance Group
NHS Nottinghamshire County Medicines Management Sub-Committee,
NHS Nottinghamshire County Quality and Risk Sub-Committee
Nottinghamshire Community Health Senior Management Team

Nottinghamshire County Council

START Countywide Operational Managers
Unions
Independent providers of homecare services
Risk Safety Emergency Management Group (RSEMG)
Commissioning Managers (COMMS)
Adult Care Management Team (ACMT)
Safeguarding Adult Mental Capacity Act Team (SAMCAT)

Due to the restructuring of NHS organisations some of the above mentioned groups now cease to exist. The following additional groups/ staff were therefore involved in the consultation and/or the review notification process.

Greater Nottingham CCGs Medicines Optimisation Committee, Mid- Notts CCGs Joint Prescribing Sub group, Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and Nottingham University Hospitals NHS Trust Pharmacy staff.

Feedback was also sought from START and NCC staff on previous policy content and how this translated to patient facing care. Domiciliary care policies were also viewed from councils both locally and nationally to establish that the contents of this policy were in line with local and national thinking.

1.2. Working together and taking risks

All members of staff have an important role to play in risk identification, assessment and management of medication. It is important the service learns from events and situations where things have, or could have gone wrong in order that the reasons for the occurrence of the event or situation can be identified and rectified. This is to encourage a culture of openness and willingness to admit mistakes.

Service users may require social care support and health related input. This will necessitate employees from all agencies to work together in partnership to meet individuals' needs.

Nottinghamshire County Council fully indemnifies START staff against claims for alleged negligence provided they are acting within the scope of their employment and following guidelines set out within this policy.

1.3. Capacity and Consent

The majority of service users take responsibility for taking their own medication and their independence should be supported as much as possible.

This part of the policy should be read in conjunction with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice.

1.3.1. Any professional who prescribes medication has a responsibility to assess that their patient / service user has capacity to consent to treatment with medication at the point of prescribing, or, if the person lacks capacity, that it is in their best interests to take the medication. Any advance decisions to refuse treatment should be taken into account by this professional.

1.3.2. Within the START service a peripatetic (peri)-re-ablement support worker or a re-ablement manager will undertake an assessment of the service user's ability to manage their medication, during their first visit. They will then have a separate responsibility to ensure the person has capacity to consent to medication assistance (if applicable) or, if the person lacks capacity, that it is in their best interests to have medication assistance.

1.3.3. Consent must be given by the service user in writing during the first visit with the peri-re-ablement support worker or re-ablement manager, before re-ablement support workers may support with medication related tasks (whether this is reminding, assisting and or administration tasks). If the service user appears to lack capacity to give consent for medication assistance, the peri-re-ablement support worker or re-ablement manager will undertake a mental capacity assessment.

1.3.4. If the service user lacks capacity, the peri-re-ablement support worker or re-ablement manager must check if there is a Lasting Power of Attorney (for health and welfare) who may have authority to make the decision about assistance with medication. If not, when a service user is assessed as lacking capacity a best interests decision must be made by the peri- re-ablement support worker or re-ablement manager on their behalf consulting relevant people based on the best interests checklist and local guidance taking into account any advance statements. A record must be made in the health section of the service users support plan of the reasons and circumstances of the best interest's decision and who was involved in the process.

1.3.5. Confirmation of consent for support with medication will be noted on the service user's support plan. Unless it has been concluded that the service user lacks capacity to provide authorisation, the service user should sign to confirm authorisation on the support plan.

1.4. Authorisation

1.4.1. Re-ablement support workers and peri re-ablement support workers must only support with medication related tasks following authorisation by their line manager, and where the authorisation of the service user has been obtained or where a record has been made in the health section of the support plan identifying it is in the best interests of the service user to receive assistance (see 1.3).

1.4.2. All re-ablement support workers and peri re-ablement support workers can undertake Level 1 support tasks once they have received induction training and provided conditions described in sections 1.3 and 1.4 apply. Level 2 tasks may only be undertaken following enhanced training and once confirmation of competency has been signed off by their line manager and provided conditions described in section 1.3 and 1.4 apply.

1.5. Reporting concerns

1.5.1. Re-ablement support workers and peri re-ablement support workers must report any concerns relating to a service user's medication to their line manager (or if out of hours the person on call).

1.5.2. Where a service user has responsibility for their own medicines and the re-ablement support worker is concerned about the service user's ability to continue to manage their own treatment, the re-ablement or peri re-ablement support worker must report this to their line manager (or if out of hours the person on call). It is the responsibility of the line manager to arrange a further assessment of the service user's need for assistance with their medication.

1.5.3. If the peri or re-ablement support worker has any concerns about any aspects of medication assistance in relation to a service user who lacks capacity, this must be notified at once to the re-ablement manager.

2. AIMS AND PRINCIPLES

The aim of this policy is to provide clear guidance to the re-ablement support worker, service user, and their relatives as to the nature of support that may be given with medication administration by paid carers in the domiciliary setting.

The result of using this policy must be that service users have the,

- **Right medicine**
- **Right dose**
- **Right time**
- **Right route**

and medication is assisted/administered to the **Right person.**

The recent NICE guideline 67 “Managing medicines for adults receiving social care in the community” also states service users have a **Right to decline.**

The following **principles** will also apply:-

- Independence will be promoted, encouraging service users to manage their own medicines as far as they are able, and for as long as possible
- The service user’s independence at home will be maintained
- If the person is assessed as lacking capacity, the principles in the Mental Capacity Act must be applied.
- Where there is no carer or other responsible adult willing and able to assist service users to take their medicines at home, or where the service user requests that informal carers are not to be involved in administration of their medication, START staff will undertake this task as part of the agreed personal care.
- Where START staff assist service users to take their medication there must be a formal agreement with the service user and their relatives as to which tasks are the responsibilities of START.
- Any assistance provided with medication will be by trained competent employees.
- The START service will not be provided solely for the purpose of administering/assisting with medication however, this may be considered as an interim arrangement on a case by case basis. At point of discharge, where there are medication only needs, ASCH will be unable to provide an ongoing service”.

3. ROLES AND RESPONSIBILITIES

There are three main roles of START staff involved with supporting a service user with their medication, these are a re-ablement support worker, peri re-ablement support worker and the re-ablement manager:-

3.1. Responsibilities of the re-ablement support worker

The re-ablement support worker must,

- Adhere to procedures set out in this policy.
- **Not** undertake Level 1 medication support tasks until induction training has been completed
- **Not** undertake Level 2 medication support tasks until they have received training and been signed off as competent.
- Concentrate on support with medication tasks to the exclusion of all other duties and distractions.
- Talk to the service user about the support they are providing with their medication. The views of the service user should be taken into account and acted upon as appropriate.
- Ensure the service user's name and the name of the medication on the container match with the Medication and Administration Record (MAR) chart.
- Record all provision of support with medication as detailed in section 12 on the MAR chart including any refusal/omission of medication along with reason for the refusal occurring.
- Ensure they complete the authorised signature sheet in order to identify their signature. The signature sheet will be kept in the office bases.
- Notify the re-ablement manager (or person on-call) of any changes to a service user's medication regime so that the support plan can be updated by the peri re-ablement support worker or the re-ablement manager.
- Refer any observations/concerns about a service user's condition back to the re-ablement manager (or person on-call).
- Inform the re-ablement manager (or person on-call) of any risks and potential for error associated with medication in order that risk assessments can be undertaken and safe systems and processes can be implemented. In addition any occurrence of errors should be reported immediately (see section 14).
- Inform the re-ablement manager (or person on-call) immediately should they become aware of discrepancies in quantities of medicines. Whether the discrepancy is due to medicines being mislaid, stolen or the incorrect quantity being supplied by the pharmacy, a medication incident form should be completed in conjunction with their line manager.
- Ensure any reported medication changes are updated promptly in the support plan, and ensure arrangements have been made to update the MAR chart in line with procedure by the peri- re-ablement support worker or re-ablement manager. The support plan must be signed and dated by the service user and appropriate social care staff.

3.2. Responsibilities of the peri re-ablement support worker

As for the re-ablement support worker above with the addition of

- Undertakes the first visit to service users to introduce the service.
- Completes the service users support plan
- Carries out all risk assessments needed and mental capacity assessment, if required.
- Ensures details of current medicines are obtained (including any over-the-counter medicines and creams for personal care) and produces a MAR chart for the service user, which is then checked on a regular basis.
- Ensures the required medication is available in the service user's home
- Provides an on-call function out of hours.

3.3. Responsibilities of the re-ablement manager

It is the responsibility of the re-ablement manager to,

- Ensure that all peripatetic (peri) re-ablement support workers and re-ablement support workers can access/view a copy of this policy along with the summary of tasks that can be undertaken by each group.
- Provide information to all re-ablement support workers, as part of their induction training, as to what tasks they can and cannot undertake prior to receiving enhanced training and being signed off as competent to assist with Level 2 medication tasks.
- Ensure that re-ablement support workers and peri re-ablement support workers receive training on assistance with level 2 medication tasks and competency sign off in a timely manner. Records should be kept of the date training is undertaken and the date of competency sign off.
- Establish that the re-ablement support worker and peri re-ablement support worker is competent in the EPDR each year.
- Undertake a new competency on each re-ablement support worker and peri re-ablement support worker every year.
- Ensure a MAR chart and the required medication is available in the service user's home.
- Line manage peri re-ablement support workers and re-ablement support workers

Managers must,

- **Not** request any staff to undertake Level 2 medication tasks prior to them receiving training and subsequently being signed off as competent.
- Ensure any reported medication changes are updated promptly on the support plan and ensure arrangements have been made to update the MAR chart in line with procedure. The support plan should be signed and dated by the service user and appropriate START staff.
- Ensure an up to date authorised signatories list is maintained in order that signatories on the MAR chart can be easily identified by staff.
- Provide support to employees who report errors and facilitate a culture of "Fair Blame". Implement a fair blame culture in which staff are not blamed, criticised or disciplined as a result of a genuine slip or mistake that leads to an incident. Disciplinary action under Nottinghamshire County Council's

Disciplinary Procedure may still follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm.

- Ensure where an error has been reported, or the re-ablement manager is made aware of potential for an error to occur, a review of systems and processes is undertaken, in conjunction with the team manager to determine appropriate actions.

3.4. Responsibilities of the Occupational Therapist & Community Care Officer (Occupational Therapy)

It is the responsibility of the Occupational therapist and Community Care Officer (Occupational Therapy) to:-

- Participate in appropriate training on the medication policy in order to become familiar with it.
- Keep up to date with any memos, amendments or changes to the policy.
- Abide by the procedures set out in the Medication policy
- Ensure that any START Goal Plans or Support Plans comply with the procedures set out in the Medication Policy.
- Notify the Re-ablement Manager of any changes to a service users medication regime that they become aware of.
- Notify the Re-ablement Manager immediately if they become aware of any concerns.

4. ACCOUNTABILITY

All START staff are accountable for ensuring they comply with the Council's START medication policy. They should only undertake actions for which they have been trained and have been deemed competent to do so. In cases of uncertainty they should refer to their line manager.

5. ASSESSING LEVELS OF SUPPORT

This is key to the whole process to identify what assistance is required. It will also highlight service user's whose medication needs are beyond the knowledge and competence of the Re-ablement Support Workers.

5.1. First visit

Following referral the first visit must be undertaken by a peri re-ablement support worker or a re-ablement manager.

As part of the visit the peri-re-ablement support worker or the re-ablement manager will speak to the potential service user and complete:-

A Support with Medication Risk Assessment form (START/AMP/7)
This will determine the level of support, if required, by the service user.

A support plan
This will detail the level of support to be provided to the service user. It must include an up to date list of prescribed medicines from the service users GP or a hospital discharge letter. Information should also be clarified as to any medicines the service user is taking which they have bought themselves and any creams used for personal care. The service user must sign the relevant sections of the support plan, including the statement of permission to identify that they consent to a level of service support. A first contact form must also be completed, if applicable.

Where START staff support service users to take their medication there must be a formal agreement with the service user and their relatives as to which tasks are the responsibilities of the START staff. This must be clearly documented in the support plan and form START/AMP/1 completed where there may be a necessity to clarify in more detail. For example, where relatives are in dispute over what is provided and by whom or where there is shared responsibility

Even when staff do not routinely give medicines, it is important to document whether the service user has any medicines, what the medicines are and the dosage instructions on the dispensing label.

Warfarin Risk assessment form
This must be completed if it is identified that the service user is prescribed warfarin.

Mental capacity assessment
If the support with medication assessment form identifies a possible issue with capacity then a mental capacity assessment (MCA) must be undertaken and the results documented. The MCA will be completed by the peri re-ablement support worker or re-ablement manager. See section 1.3 for additional information.

Production of a MAR chart
If the assessment form identifies that the service user requires support with their medication by the START team the peri-re-ablement support worker or re-ablement manager will produce a MAR chart for the service user. See section 9. The MAR chart will then be checked by the peri- re-ablement support worker on the first day of their subsequent shifts.

5.2. First visit outcomes:

At the end of the first visit the outcomes will be one of the following:-

- The service user is able to self-medicate **all** their prescribed medication. Therefore no further action required with medication from the START service
- A family member or informal carer assists them with **all** their prescribed medication.
  Therefore no further action required with medication from the START service
- A family member or informal carer assists with some of the service user's medication e.g. they may assist with a tea-time dose of medication. Hence support required from START service at other administration times.
- Service user requires support from the START service. The support can include verbal reminders, the use of compliance aids, preparation, assistance and administration. For example a service user may be able to self-medicate some of their medication but not others, or a service user may require administration support with all their medication.

In all cases where support (including verbal reminders) is to be provided by the START service a MAR chart must be completed and kept at the service user's home. This will be checked on a regular basis to ensure medication has been documented correctly e.g. no missing administration signatures.

As per above if family members or informal carers assist with a service user's medication this must be clearly documented in the support plan and a START/AMP/1 form completed. This ensures that family members or informal carers understand their responsibilities, including signing the MAR chart to document that they have assisted with a dose of medication.

Joint working between health and social care is important to ensure service users receive integrated person-centred support. The START service should notify the service users GP and supplying pharmacy when starting to provide medicines support.

A range of compliance aids are available to help service users administer their medicines independently. START staff should contact the service user's community pharmacist for advice. (See appendix 7 and 8)

Service users who may need support with medication would include those with:

- No sight/partial sight
- Severe mental health problems
- Complex medicine regimes
- Dementia
- Learning difficulties
- Poor mobility or manual dexterity
- Stroke
- Arthritis

- Multiple Sclerosis /Parkinson's disease
- Poor literacy
- Inability to read or interpret
- Language barriers

It should be noted that if any START staff notices a change in the service user's condition, they must contact their line manager to arrange a review of the service user's support with medication risk assessment.

6. TRAINING AND COMPETENCY ASSESSMENTS

Following induction training all re-ablement support workers will be able to assist with Level 1 medication tasks.

On induction all staff will be expected to successfully complete the following:

- Attend a medication training session specified by Nottinghamshire County Council
- Work through the Supporting with Medication workbook
- Answer a selection of short questions and scenarios as part of the knowledge assessment
- Demonstrate competency to undertake tasks as specified in this policy by observation or simulation.

Competency will be assessed and signed off by the Re-ablement Manager.

Only trained certificated re-ablement staff who have demonstrated competency are able to undertake Level 2 assistance with medication tasks.

All staff will have refresher medication training and undertake a competency assessment every year.

7. ORDERING, COLLECTION AND STORAGE OF MEDICATION

7.1. Appropriate arrangements must be taken to ensure there is a continuous supply of medication for the service user.

7.2. It must be clearly documented how the service user orders their medication how it is obtained (collected) and who is responsible for this.

7.3. Requests for a supply of medication i.e. ordering from the service user's GP, should wherever possible remain the responsibility of the service user, or their relatives. In exceptional circumstances where this is not possible a re-ablement support worker may undertake this task following authorisation from their line manager, and this must be documented in the support plan.

7.4. Re-ablement staff may collect prescriptions from the surgery and or medicines from a community pharmacy.

7.5. If re-ablement staff assist with the collection of medication from a community pharmacy or dispensing doctors, this must be collected and returned directly to the service user's home. Staff should transport medication out of direct view.

7.6. Re-ablement staff should ensure that all ordered medication has been received from the community pharmacy. They must check that the name on the medications matches that of the service user and the MAR chart. Staff must contact their line manager (or person on-call) for advice if an item is missing or is owed by the pharmacy. If an item is owed it must be documented in the support plan who and when it will be collected for the service user.

7.7. Re-ablement staff that collect schedule 2 or 3 controlled drugs from the community pharmacy or dispensing doctor, will be required to show proof of identity and sign the back of the service user's prescription.

7.8. Medicines should be stored appropriately in the home environment, e.g. out of reach of children and animals. Medicines should not be exposed to extreme temperatures (hot or cold) or to excessive moisture. As part of the risk assessment process, any specific issues for the safety and storage of medication will be identified in the support plan.

7.9. Medication should be left in a safe place that is known and accessible to the service user. Where, following risk assessment and in line with the Mental Capacity Act, it has been determined that the service user is unable to take safe control of their medication and re-ablement support staff are responsible for the administration of medicines, medication should be stored safely and appropriately in accordance with instruction documented in the support plan. Other relatives, carers and health professionals should be told where it is stored.

7.10. When medication is stored away from the service user (as per 7.9) it may be more appropriate for a family member or re-ablement staff to collect the service user's medication rather than arrange for it to be delivered to the service user's home by their community pharmacy.

7.11. Medication safes are available for relatives to purchase for safe storage. Staff should contact their line manager for further details.

7.12. Medication that has to be stored in the refrigerator should be held in a separate re-sealable container to avoid cross contamination with food. These medicines should not be stored in or adjacent to the ice box/freezer compartment.

7.13. Whenever new medication is received into the service user's home expiry dates should be checked and medication stored in such a way that those medicines that expire first are used first.

8. MEDICATION SUPPORT TASKS

START peri and re-ablement support workers may assist a service user to take medication that has been prescribed by the service user's general practitioner, dental practitioner, non-medical prescriber or hospital doctor responsible for aspects of the service user's medical care.

8.1. Level 1 & 2 medication support tasks for START staff

Following induction training peri and re-ablement support workers may carry out **level 1 support tasks**. This means they can,

- Collect prescriptions from surgery or medicines from the pharmacy when there is no alternative means of collection and delivery. Ensuring the name on the medicines matches the name on the MAR chart and that of the service user when delivered to their home.
- Make sure medicines are stored safely and securely in the service user's own home
- Note and record any change in the service user's ability to manage their medication. Notifying their line manager if there are any concerns.

Following enhanced training and competency sign off, peri and re-ablement support workers may also carry out **level 2 support tasks**. This means they can,

- Take tablets/capsules out of pharmacy labelled containers, remove tablets/capsules from foil strips contained within an original pharmacy labelled pack. (NB assistance with medication may not be given for medicines that are not in their original pharmacy labelled containers).
- Shake bottles of liquid medicines and remove the bottle cap so that the service user can take the required dose.
- Pour liquid into measuring cups, spoons.
- Draw up liquid into an oral syringe
- Mix or dissolve soluble medicines or thickening agents.
- Insert an eye drop bottle into a compliance aid so that the service user can self-administer their eye drops. Assistance may only be provided for eye drops that have been prescribed by a doctor or non-medical prescriber.
- Administer eye drops/ointment that have been prescribed by a doctor or non-medical prescriber.
- Administer ear drops that have been prescribed by the service user's GP or non-medical prescriber.
- Administer nasal drops, nasal creams or nasal sprays
- Apply creams and ointments to clean skin and only to the area it has been prescribed for by a doctor or non-medical prescriber. Only apply to skin that is **not** broken or inflamed (unless documented as the reason it is being applied). This should only be undertaken when a service user is unable to do this for him or herself and there is no other appropriate person to assist

them. Any concerns on the skins condition should be reported to line manager.

- Apply sun creams, sun blocks, simple body moisturisers without prescription from a doctor or non-medical prescriber, if the service user has used these before. These preparations can be used as part of a personal care routine and are recorded in the personal care plan. Staff should not apply products containing paraffin due to the flammability risk when applying to large areas unless these have been prescribed.
- Assist with the use of inhaler devices by passing the device to the service user, inserting a capsule into the device or, where necessary, press down the aerosol canister when the inhaler is used in conjunction with a spacer device. Prior to assisting with inhaler devices, the use of a compliance aid should be tried.
- Apply transdermal patches for the treatment of Parkinson's disease e.g. Rotigotine.
- Support with compression stockings; provided they have been prescribed by a doctor or non-medical prescriber and a shared care agreement is in place with the community nursing team. The agreement (appendix 3) details the reasons for use, responsibilities of healthcare staff and social care staff, including how often stockings need to be changed., in addition form START/AMP/2 should be completed. Compression stockings are generally removed at bedtime and reapplied the following morning, but may be kept on for up to 7 days. Refer to section 9.13 for additional information.
- Support with Thrombo – Embolic Deterrant (TED) stockings; provided the service has been informed of the treatment duration for these. Refer to section 9.13 for additional information.

8.2. Support tasks associated with a higher level of risk

The following tasks are associated with a higher level of risk and must only be undertaken by peri and re-ablement support workers who have been signed off as competent to support with **level 2 tasks**. Wherever possible these tasks should remain the responsibility of the service user and or their relatives. However, where this is not possible the following must be undertaken before support from the START team is provided

- **A risk assessment must be carried out by the re-ablement manager this should be in conjunction with staff from the community nursing service and the service user's GP practice as applicable**.
- Input should be negotiated on a case by case basis in all cases involving support with the medication listed below.
- Responsibility will be retained by healthcare professionals with clear documentation, detailing roles and responsibilities.
- Additional documentation and training may be necessary. This will be agreed by the re-ablement manager and healthcare professionals with input from the NCC prescribing advisor as appropriate.

Tasks include, assisting with the administration (including reminding) of:

- **Warfarin** - under no circumstances should social care employees remind/ assist/administer with warfarin that is not in the original container from a community (or hospital) pharmacy or dispensing doctors. The dose should

always be checked against written instructions provided by the anticoagulant clinic or GP practice and documented clearly on the service users MAR chart.

- **Controlled drugs** – these are administered in exactly the same way as all other forms of medication however their documenting and storage may be different for some service users. This should therefore be determined as part of the service users care plan and a risk assessment completed if applicable. Examples include morphine tablets and solution; buprenorphenine sublingual tablets; oxycodone tablets, capsules and solution. Other controlled drugs may be considered, provided they are not for administration via injection.
- **Cytotoxic oral medicines-** these are administered in exactly the same way as all other forms of medication however their documenting and storage may be different for some service users. This should therefore be determined as part of the service users care plan and a risk assessment completed if applicable. Examples include methotrexate tablets, hydroxycarbamide capsules, fluorouracil cream, mercaptopurine tablets, fludarabine phosphate tablets. These preparations are usually supplied from a hospital pharmacy.
- **Adrenaline auto-injectors-** Brands include Epipen, Jext and Emerade. These devices are prescribed to people with allergies who are at risk of having a severe allergic reaction (anaphylaxis). The devices and dose administered can differ between brands hence an appropriate risk assessment/treatment protocol must be completed and training provided to staff by a healthcare professional prior to support from START being agreed. It must be specified in the assessment that START staff will not make any judgements on the dose required by the service user. Staff are also requested to familiarise themselves with the patient information leaflet for this product, which will be included as part of its packaging.
- **Buccal midazolam**- includes Buccolam and Epistatus. Risk assessment and individual treatment protocol must be completed and training provided to staff by a healthcare professional prior to support from START being agreed. Staff are also requested to familiarise themselves with the patient information leaflet for this product, which will be included as part of its packaging.
- **Transdermal patch medication**- Patches containing controlled drugs or dementia medication should not routinely be supported by the START service. Managers will assess whether a service user prescribed this type of medication satisfies the criteria for re-ablement.

8.3. Tasks that re-ablement staff CAN NOT undertake

These tasks include:

- Any invasive procedure including:
  - Rectal administration of creams, suppositories or enemas
  - Vaginal administration of creams or pessaries
- Wound care: including both simple and complex dressings
- Injection or procedures which break the skin (with the exception of an adrenaline auto injector e.g. epipen)
- Syringe drivers
- Any procedure that requires the re-ablement support worker to make medical judgements.
- Assisting with nebulised medication
- Assisting or supporting the service user with oxygen therapy
- Supporting with medication via a PEG tube
- Assisting or supporting the service user with medication that has not been prescribed by the service user's GP

A summary of these tasks can be found in Appendix 9.

9. ADMINISTRATION OF MEDICATION

Administration of medication for the purposes of this policy means supporting the service user to take medication. The type of support will vary and will be identified from the support with medication risk assessment form completed with the service user at their first visit.

9.1. Types of Support

Support can be:-

Verbal reminder - asking a service user if they have taken their medication or reminding them that it is time that they take it. (except where this occurs on an occasional basis). A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medication. This would be coded as **R** on the MAR chart.

Reminded and service user observed taking the medication -reminding a service user to take their medication and observing them taking their medication. This would be coded as **RO** on the MAR chart.

Prepared and service user observed taking their medication- handling the service user's medication in some way, i.e. preparing the dose required, either by shaking a bottle of liquid medication, mixing soluble medicines, taking tablets out of containers and putting onto a spoon/saucer or pouring liquids into measuring cups or onto a spoon or squeezing a tube of ointment for use. This would be coded as **PO** on the MAR chart.

Assisted e.g. pressing an inhaler device **Applied** e.g. applying a cream to a service user's skin or **Administered-** physically giving a service user their medication by either placing it in their hand or mouth. These would all be coded as **A** on the MAR chart as in all 3 scenarios the support worker is physically ensuring the service user has their medication.

9.2. Containers and monitored dosage systems

Re-ablement staff must only support with medication from containers that have been assembled and supplied by a community pharmacy, hospital pharmacy or dispensing doctor practice.

Medication may only be used if the container is clearly labelled with the service user's name, the name of the drug and the dosage. Most of the containers used today by pharmacists for packaging medication in are the manufacturers foil blister strip packs. Occasionally medication may be placed in brown plastic bottles or brown glass bottles for liquids.

A pharmacy may also supply the medication in a monitored dosage system (sometimes referred to as a blister pack). If so this should be clearly labelled with each medication in it. There should also be a means of identifying each tablet i.e. by description of tablets colour, markings etc.

If a label becomes detached from the container, is illegible, or has been altered, medication must not be used. Advice should be sought through the line manager who should seek further advice where necessary.

Please note: - Re-ablement Staff are trained to support service users from original containers as well as monitored dosage systems.

Community Pharmacists are not obliged to dispense a prescription presented to them in a monitored dosage system and are entitled to charge for this service, if the service user does not satisfy Disability Discrimination Act (DDA) criteria.

9.3. Medication Administration Record (MAR) charts

The standard NCC MAR chart (See appendix 2) must be used and maintained for each service user who is receiving support with medication tasks (level 2). A separate patch chart should be used to record administration of patches (see appendix 10). CQC refer to the guidance 'The handling of medicines in social care' published by the RPSGB which states that

'In every social care service where care workers give medicines, they must have a MAR chart to refer to. The MAR chart **must** detail

- Which medicines are prescribed for the person
- When they must be given
- What the dose is
- Any special information, such as giving the medicines with food'

The legal direction to administer a medication is as per the medication dispensing label. The MAR chart is a record of medication to be given and taken. Both the dispensing label and MAR chart must be an exact match. If this is not the case, the medication must not be supported with and the re-ablement manager must be contacted.

MAR charts must be completed correctly and in full to ensure a service user's safety. Handwritten medication details e.g. name of medication and dosage instructions must be in indelible ink, use capital letters and words used instead of numbers. For example a dosage must be written as "Two to be taken in the morning" not "2 to be taken in the morning". **All** medications must then be signed by that staff member who entered the information. This must then be countersigned by the next staff member who undertakes a visit to that service user to ensure that the MAR chart has been completed correctly. If the staff member has any concerns they must contact their line manager or person on-call immediately.

Any medications which are labelled "as directed" must be referred back to the service users GP for a specific dose to be defined.

Please note: "As per blister pack "must not be written on the MAR chart as it is not accepted by the CQC. This is because it does not satisfy the requirement of "which medications are prescribed for the person" and hence does not support a clear audit trail for the service user's care.

It is the staff member's responsibility who undertakes the first visit to ensure the correct medications are detailed on the MAR chart. This must be done through referring to the service users GP or a hospital discharge letter. On each entry it should be documented if the medication is in a blister pack (MDS) or box.

If the staff member is unsure about the service user's current medication and it is out of hours they should try to determine the current medication from the service user's relatives and notify their line manager. Advice may also be sought from the service user's usual community pharmacy (See appendix 7), NHS 111 telephone service or another community pharmacy, many of whom are now open 100 hours a week. Professionals working in these areas will be able to advise.

The MAR chart must be kept in the service user's home in an agreed location, and must be examined on each occasion that the re-ablement support worker attends the service user's home, in order to make themselves aware of any changes in medication.

Re-ablement staff must always check the MAR chart to ensure that the medication has not already been administered and, in addition, check verbally that the service user has not already taken or been given the medication. Re-ablement staff will also count the tablets in-situ prior to administration to ensure medication has not already been taken and document the number of tablets remaining on the MAR chart after administration. This will be done using gloves (or a counting triangle if available) for those tablets in bottles. For liquids, including oramorph, a visual check (no need to measure) should

be carried out to check that the quantity remaining is approximately what is in the bottle.

Where a service user remains in the service for over six weeks, the MAR chart should be copied and returned at regular intervals to the locality office (at least monthly). A new MAR chart will be written if required by the peri re-ablement support worker. Monitoring and oversight of the MAR chart will be maintained by the re-ablement manager.

Re-ablement support staff must record details of administration on the MAR chart at the time the medication is administered.

Where a service user receives support with medication from re-ablement staff and new medication is received into their home the quantity and date received should be recorded on the MAR chart by the peri-re-ablement manager or re-ablement manager. This also applies if there is discontinuation of medication or a change of dose.

9.4. Administration procedure

Medicines must only be supported with in accordance with the prescriber's specific instructions (Medicines Act 1968). The directions of how the drug must be taken will be detailed on the dispensing label attached to the medication.

Re-ablement staff must adhere to the following administration procedure:-

- Check that they are giving the right medication to the right service user by asking their name or asking an informal carer if unsure.
- Check verbally that the service user has not already taken or been given the medication.
- Check that the service user's name, the name of the medication on the container and the dosage instructions on the label match with the MAR chart. If there is a discrepancy the line manager must be notified.
- Check that there have been no recent changes in medication. If there is a discrepancy the line manager must be notified.
- Check the containers have been assembled by a community/hospital pharmacy or doctors dispensing practice and are clearly labelled.
- Check that the medication has not exceeded its expiry date. Eye drops should not be used if the date of opening exceeds 28 days. The date of opening should be marked on the eye drop bottle.
- Check the dosage instructions and any other specific instructions regarding time of administration e.g. before food.
- Check it is the correct time to administer the medication, paying attention to pain killing medication e.g. paracetamol, that must have at least four hours between doses.
- Check the label to determine if medication should be dissolved / dispersed in water before administration.
- Check the way in which the medication is to be administered e.g. eye drops left or right eye, etc.
- Check that the dose has not already been administered by checking the MAR chart and counting the tablets in-situ (gloves and counting triangle to be used

for tablets in bottles) or if in a pharmacy dispensed monitored dosage system that the tablets are not there. If there is a discrepancy the line manager (or person on-call) must be notified to make contact with the pharmacy/GP to find out if a further dose should be given.

- Measure doses of liquid medication using a 5ml medicine spoon, a graduated medicine measure or an oral syringe supplied by the pharmacist. Where a service user is experiencing difficulties with liquid medicines the re-ablement support worker must contact their line manager.
- Check old patch has been removed before applying a new one. Ensuring old patch is disposed of safely and gloves are worn.
- Ensure that if a thickening agent is prescribed this is mixed to the correct consistency.
- Ensure that compression stockings, if applicable, are applied correctly according to manufacturers instructions.
- Appropriate hand hygiene must occur before and after any direct handling of medication and before and after the wearing of disposable gloves.
- Medication must not be handled; solid dose forms e.g. tablets or capsules should be passed to the service user on a spoon or saucer. Disposable gloves must be worn by re-ablement staff where the dose has to be placed in the service user's mouth.
- Disposable gloves should be worn when applying skin treatments (e.g. creams, ointments, lotions). **Fire Hazard: all paraffin-containing emollients (regardless of paraffin concentration) and paraffin-free emollients, when used in large quantities, pose a fire risk which could result in severe or fatal burns. Service users should be kept away from naked flames, ignited cigarettes or open fires after the use of such preparations.**
- Check the service user has taken their medication and record this on the MAR chart straight away in the correct day and time box, using the appropriate code followed by the support workers initials.
- Ensure that medication is returned to its safe storage place
- Report any concerns about the service user experiencing any side effects from their medication.
- Report any concerns about any aspects of medication support in relation to a service user who lacks capacity at once to the re-ablement manager (or if out of hours the person on call)

When supporting with medication do not:

- Give medications from unlabelled or illegibly labelled bottles, containers or compliance aids.
- Give medications via a PEG line
- Give medications from compliance aids filled by family members
- Make alterations to the dosage directions on the dispensing label
- Force a service user to take their medication
- Transfer medication from their original containers to a different container for later administration by a third party such as a family member. If medication is required to be administered at a different setting e.g. day service or a visit to family – the medication should be sent in its original container and the MAR chart must remain in the service user's home.
- Prepare medicines or drugs in advance of administration. (Except in rare occasions see 9.5) Once prepared they must be used immediately or discarded.
- Handle medication directly when administering, as far as is practicable.
- Give discoloured solutions, disfigured tablets, substances etc. These must be returned to the community pharmacist.
- Give medication from containers that have **not** been assembled by a community pharmacy, hospital pharmacy or dispensing doctor practice.

9.5. Leaving medication out

Generally re-ablement support workers should **not** put medication out for the service user to take themselves at a later (prescribed) time.

There may be rare occasions when leaving medication out to be taken later enables the service user to have greater independence. For example, if Re-ablement staff visit at 7.00pm and the service user is prescribed sleeping tablets, it may be appropriate for these tablets to be put in an agreed accessible place for the service user to take later.

Before medication is put out a risk assessment must be undertaken and agreement obtained from the re-ablement manager. Arrangements agreed must be documented in the support plan and recorded as **O = Other** on the MAR chart.

No more than one dose of medication must be left out.

9.6. Crushing tablets, opening capsules, splitting tablets

Tablets must **not** routinely be crushed or capsules opened. There may be circumstances however where tablets or capsules may need to be crushed or opened to enable the service user to take their medication. This should be carried out with the service user's consent.

In these circumstances the following must apply:-

- Crushing or opening must be authorized with the prescriber and pharmacist using form START/AMP/4, as the efficacy and legal status of the medicine can be altered.
- Guidance on how to prepare the medication for administration by re-ablement support workers must be sought from the supplying pharmacy
- Information and authorisation must be recorded in the support plan.
- The direction to crush/open should be added to the dispensing label by the GP practice/Pharmacy
- The correct equipment should be used to crush tablets e.g. a pill crusher, available from community pharmacies.

Occasionally it may be necessary to split a tablet to achieve the required dose. If this is required this should be done by the service user's community pharmacy or dispensing doctor.

9.7. Imprecise or ambiguous directions

Where medication is labelled with imprecise or ambiguous directions e.g. 'take as directed', 'take as before', 'apply to the affected part' the re-ablement support worker must seek clarification through their line manager and/or service user's GP or community pharmacist. Clarification in writing using form START/AMP/3 may be necessary to gain confirmation of the intended direction of the prescriber and then noted in the support plan and on the MAR chart.

9.8. When required (PRN) medication

Medication with a when required (PRN) dose is usually prescribed to treat short term or intermittent conditions. The service user may not need the medication at every dosage time.

Where medication is to be taken on a when required (PRN) basis sufficient information should be available detailing the condition for which the medicine should be given, the interval between doses and the maximum dose in 24 hour period. Where the label does not provide this information, confirmation should be sought from the service user's GP using form START/AMP/5 and a note of the outcome made in the support plan and on the MAR chart if applicable.

The re-ablement support worker must document the actual dose the service user has received. This should be documented as an O code on the MAR chart with the dose details documented on the RSW medication notes section of the MAR chart.

If the frequency of PRN medication changes by increasing or decreasing then a referral to the service user's prescriber, via the line manager should be considered for a review of the service user's medication. This is because their medical condition may have changed and the treatment required may need altering.

9.9. Variable dosages

If a variable dose is prescribed e.g. one or two tablets or 5-10mls, the decision regarding the dose to take rests with the service user.

The re-ablement support worker must ask the service user how many they wish to take. If the service user is unable to decide or respond the re-ablement support worker must contact their line manager, who will seek advice from the prescriber. The circumstances in which the variable dose is to be taken must then be documented in the support plan. This should also be documented as an O code on the MAR chart with the dose details documented on the RSW medication notes section of the MAR chart.

9.10. Warfarin and new anticoagulants

Warfarin is a high risk drug due to the specific dosing required for each service user. Blood tests (INR) are carried out to determine the dosage of warfarin required. Robust arrangements are required to ensure that re-ablement workers support the administration of warfarin at the correct dose.

The level of support required with warfarin will be identified through completion of the support with medication risk assessment form. In addition the warfarin risk assessment algorithm (see appendix 4) must be followed, with completion of a risk assessment form to identify and control any additional risks.

All service users should have an “oral anti-coagulant therapy pack” commonly known as a “yellow book”. The INR results may be recorded in the yellow book or on an INR chart supplied from a GP surgery or hospital anti-coagulant clinic with the current dosage of warfarin to be taken. If START staff are assisting or administering warfarin to a service user they must check the yellow book or INR chart, which must be kept with the MAR chart, to check the dose of warfarin to be given each day.

The re-ablement manager may consider requesting a community pharmacist /GP to label the warfarin “to be taken as per INR chart/yellow book” as an additional reminder for START staff member to check that information.

If the yellow book or INR chart is not available START staff must not support the service user until the correct dose has been clarified. They must contact the re-ablement manager (or person on-call) for advice on who to contact.

If START staff support service users to attend healthcare appointments, dentist, hospital etc. they should take the yellow book to the appointment and inform the relevant healthcare professional that the service user is on warfarin.

It must be documented in the support plan how any communication related to changed doses will be addressed.

Staff should be aware that there are newer anticoagulants e.g. dabigatran, rivaroxaban and apixaban. These do not require regular monitoring of INR

but due to the risk of blood clots it is extremely important that a dose of these medications is not missed.

Due to the risk of bleeding when receiving anticoagulants if a service user suffers a knock or injury carers should inform their line manager and the service users GP as soon as possible for advice on what action to take.

9.11. Food and drink interactions

Some medicines can interact with certain foods and drinks. One of the most common ones is grapefruit juice. Similarly, milk can also affect some medicines by reducing the amount of drug that is absorbed by the body. The pharmacist may add this information onto the label.

Alcohol can interfere with the action of many drugs. Where a known interaction exists between a medicine and alcohol, a warning will appear on the label of the medicine container. If the service user appears to be intoxicated with alcohol or other substances, staff must not administer any medicine until their line manager (or person on-call) has been informed.

Further information on interactions can be found in the patient Information leaflet, in the BNF or by talking to a community pharmacist.

9.12. Food supplements and Thickening agents

Both of these items may be administered by the service providing they are prescribed and documented on the MAR chart.

Staff must ensure that they follow the mixing instructions on the label of thickening agents. This will include using the appropriate measuring spoon provided to ensure that the consistency made up is that specified on the dispensing label. If this is not correct, this must be re done to avoid the risk of choking.

Advice must be sought from the prescriber or speech and language therapy service in relation to the other medication prescribed to the service user to ensure this is not a choking risk also.

9.13 Support with TED and Compression Stockings

TED stockings

Thrombo- Embolic Deterrent (TED) stockings are recommended for patients who have had surgery or are bed ridden to prevent blood clots. The stockings should be worn all the time including through the night and may be worn for up to 3 weeks after which time they lose their elasticity. They are generally white in colour and are not available on prescription so are supplied normally by a hospital or district nurse.

As the TED stockings should remain in place, support with personal care may need to be adapted by START staff e.g. flannel washes instead of a shower or bath. The service should determine before the service user is supported by the START team the duration that the stockings are required to be kept on for. After this time they may be carefully removed taking care not to damage any fragile skin. Staff must contact their line manager if they are in doubt / concerned about their removal and support from the district nursing team may be required.

Compression stockings

Compression stockings are available on prescription they are generally brown in colour and may be below knee or above knee, closed or open toe styles. They have a higher compression than TED stockings, are generally only worn during the day and are removed at night. They are used to treat conditions such as varicose veins and so are worn for long periods of time e.g. years.

A shared care agreement Appendix 3 should be completed with district nursing staff to ensure that necessary checks have been undertaken e.g. ruling out of arterial disease and that any venous leg ulcers have healed. The agreement (appendix 3) details the reasons for use, responsibilities of healthcare staff and social care staff, including how often stockings need to be changed, in addition form START/AMP/2 should be completed. Compression stockings are generally removed at bedtime and reapplied the following morning, but may be kept on for up to 7 days. Staff must follow the manufacturers instructions on how to apply the stockings correctly ensuring that no skin is damaged. If worn incorrectly stockings may cause local pressure on toes leading to skin necrosis. Sometimes it may be recommended that a skin emollient is applied while the stocking is off to reduce skin dryness and irritation. Staff must contact their line manager if they are in doubt / concerned about their removal/ application and support from the district nursing team may be required.

As part of the reablement process a stocking aid may be required in order for the service user to apply stockings themselves. These are available from community pharmacies.

9.14 Application of eye drops and ointment

Staff must ensure that they follow strict hand hygiene rules when applying eye drops or ointment. Drops or ointments may be prescribed to treat dry eye conditions but also eye infections or prevent eye infections following eye surgery. Staff must ensure that dropper bottles or ointment tubes do not come into contact with the eye surface or lid. If staff observe there is a change in appearance of the eye area e.g. redness, weeping or inflammation they should contact their line manager for advice.

9.15 Application of transdermal patches

Patches must be applied to clean, dry, non-irritated skin generally on the torso, upper arm or shoulder area. Staff must record application on the MAR chart as well as the patch application record as per appendix 10, which details where the patch has been applied. Before another patch is applied the old one must be located, carefully removed and disposed of whilst wearing disposable gloves. Staff should refer to the manufacturers leaflet for information on where to apply the patch and any special instructions. The START service will support with those patches that contain medication to treat Parkinson's disease. For patches that contain different medication e.g. controlled drugs this must first be agreed with the START manager as to the service user's suitability to be supported by the START service.

10. OMISSIONS AND REFUSAL TO TAKE MEDICINES

It is a service user's choice not to take medication. Administration cannot be forced but some degree of encouragement may be given.

Medicines must not be administered covertly to anyone who is deemed to have capacity on whether or not they take medication.

If a service user refuses their medication or does not take their medication or a dose is omitted for any reason, an entry on the MAR chart must be made.

The reason for refusal/omission should be documented on the reverse of the MAR chart, for example, "following guidance from a health professional, Lactulose has not been given because the service user has diarrhoea".

If the re-ablement support worker has any concerns about the service user's medical condition and the appropriateness of a medication they should seek advice from a health professional and inform their line manager.

If a service user refuses their medication or does not take their medication the re-ablement staff should inform their line manager. They will make a judgement about whether to seek further advice.

11. COVERT MEDICATION

Medication must always be administered by consent with the full agreement and understanding of the service user, and, where appropriate, their relatives, wherever possible. Every effort must be made to obtain consent.

Where the service user is deemed to have capacity to make an informed decision, refusal of treatment must be respected. The re-ablement staff should endeavour to make enquiries as to why the service user is refusing their medication and report back to their line manager for notification to the service user's GP. Actions undertaken must be documented in the service user's support plan.

All service users must be presumed to have mental capacity to consent to treatment unless proved otherwise. The service user must be able to understand the information relating to the decision, retain and weigh up the information and communicate their decision. If the service user is unable to do any of these they will be classed as lacking capacity to make the decision regarding giving consent.

When a service user is deemed to lack capacity, a best interest decision must be made on their behalf consulting relevant people and taking all relevant circumstances into account. The best interest meeting may include START managers, the service user's GP (or consultant psychiatrist or psychologist), and relatives. This may include considering the administration of medication covertly, although this should only ever be seen as a last resort.

If it is agreed it is in the service user's best interests to receive their medication covertly this must be risk assessed, detailed in the support plan and a date specified for when the decision will be reviewed.

Confirmation should be obtained from a pharmacist and included in the risk assessment that the medication can be administered in this way (i.e. medication is suitable to be mixed with food or liquid).

Only medication which is regarded as essential for the service user's health and well-being, or for the safety of others, should be considered for administration in a covert way.

12. RECORD KEEPING

12.1. Support Plan, Risk Assessments and MAR charts

The support plan will detail the level of support required by the service user from the START team. This will have been assessed through the support with medication risk assessment form and any accompanying specific risk assessments.

All of these must be referred to by START staff prior to supporting with medication. These documents are all confidential records and should only be shared with others on a professional basis and with permission from the service user, referring to the mental capacity act if necessary.

All medication should be recorded on the MAR chart including those prescribed medications that the service user is self-medicating, the latter of which the re-ablement worker should document on the MAR chart.

MAR charts must be retained in the service user's home whilst in use. They should then be transferred to the re-ablement manager's offices and stored for 6 years in line with Nottinghamshire County Councils retention policy.

12.2 MAR chart codes

The re-ablement staff must record details of assistance with medication on the MAR chart in line with the medicine administration codes described below.

R = Verbal reminder-asking a service user if they have taken their medication or reminding them that it is time that they take it. (except where this occurs on an occasional basis). A persistent need for reminders may indicate that a person does not have the ability to take responsibility for their own medication.

RO = Reminded and service user observed taking the medication - reminding a service user to take their medication and observing them taking their medication. No physical help given.

PO = Prepared and service user observed taking their medication- handling the service user's medication in some way, i.e. preparing the dose required, either by shaking a bottle of liquid medication, mixing soluble medicines, taking tablets out of containers and putting onto a spoon/saucer or pouring liquids into measuring cups or onto a spoon or squeezing a tube of ointment for use.

A = Assisted e.g. pressing an inhaler device **Applied** e.g. applying a cream to a service user's skin or Administered**-** physically giving a service user their medication by either placing it in their hand or mouth. These would all be coded as **A** on the MAR chart as in all 3 scenarios the support worker is physically ensuring the service user has their medication.

X = Refused, a service user refuses to take their medication

O = Other, document reason on reverse e.g. in hospital, medication left out, variable dose of medication.

If a service user self-medicates their medication this can be written under the drug and dosage description in the medication label box on the MAR chart

12.3 Recording application of topical products (creams, ointments, patches)

When emollient creams are prescribed as a soap substitute, moisturiser or barrier cream the support plan should record what the cream is and where it is to be used. This should also apply to prescribed medicated creams/ointments.

A MAR chart must document all prescribed creams/ointments and where they are to be applied.

The application of sun creams, sun blocks and simple body moisturisers purchased by the service user and applied as part of their personal care routine do not need to be recorded on the MAR chart as long as the service user has used these before. They should however be documented in the support plan.

Any products containing paraffin cannot be applied unless they are prescribed and documented on the MAR chart due to their flammability risk when applying to large areas.

It is important that the removal and application of patches is documented accurately see Appendix 10 for record chart. The administration of patches containing controlled drug medication or for dementia is not supported by the START service.

12.4. Discharge from the START service

A social worker will discharge a service user from the START service. They will complete a community care assessment and support plan (CCASP) for the service user and commission an on-going package of care if required.

On discharge the re-ablement support worker must collect the support plan and any other service documentation from the service user's home. This must then be brought back to the locality offices, scanned and uploaded onto framework.

13. DISPOSAL OF MEDICATION

13.1. All medication prescribed for the service user is their property and must never be removed by re-ablement support staff from the service user's home without written consent.

13.2. The service user or their relatives should be encouraged to return excessive amounts of unused or unwanted medicines to a pharmacy. They should not be encouraged to add them to their household waste or flush them away via the toilet. Empty bottles of liquid medication may be rinsed out and disposed of in the household waste.

13.3. Return of medication should wherever possible remain the responsibility of the service user and/or their relatives. In exceptional circumstances re-ablement support staff may return medication to a community pharmacy, having obtained written consent from the service user and sought approval from their line manager (START/AMP/8)

13.4. Details of medication returned for disposal by START staff should be recorded on the MAR chart and countersigned by the community pharmacist, the Peri re-ablement support worker or the re-ablement manager on the appropriate form (START/AMP/8). Information recorded should include the quantity removed and the date of return to the pharmacy.

13.5. Any medication that is taken out of its original container but is then not taken by the service user (for instance refusal, or medication is dropped on the floor) should be placed in an envelope with identification that it is waste medication. The service user's family should be requested to return this medication to a community pharmacy for disposal. Dropped tablets can be avoided with good administration technique e.g. preparing doses over a work surface.

13.6. In the event of a service user's death all medication should remain in the service user's home for seven days in case there is a coroner's inquest.

14. ERROR AND NEAR MISS REPORTING

14.1. Any instances of error involving medication **must** be reported to the re-ablement manager immediately (or if out of hours the person on call). Medical advice must be sought via the services user's GP, NHS 111, or out of hours service (GP telephone service will direct you to the out of hours service) as appropriate. This also applies to errors that staff identify, but have not made themselves e.g. errors made by prescribers, pharmacists and other care workers.

14.2. In the event of a serious error outside normal office hours NHS 111 or out of hours service and the Emergency Duty Team (0300 456 45 46) must be contacted immediately for further advice and next steps.

14.3. The re-ablement manager will complete a Medication Incident Report Form (START/AMP/6) with information provided by the re-ablement support worker.

A copy of this form will be sent to the Shared Medicines Management Team. The Re-ablement Manager will enter details of the incident onto the Well-Worker system for monitoring and audit purposes.

14.4. Following report of an error or circumstances where an error could have occurred (a near miss) the Team Manager must investigate systems and processes to identify contributing factors and implement appropriate actions. The re-ablement manager should facilitate shared learning with colleagues to prevent reoccurrence of the error in the START service, and through the appropriate mechanism for independent providers.

14.5. At all times support must be provided to employees who report errors or near misses in order to encourage an environment of openness and shared learning.

15. GIVING ADVICE TO SERVICE USERS ON MEDICAL ISSUES

15.1. Advice on medicines is the responsibility of the service user's GP, pharmacist or clinician who has responsibility for the service user's medical care. Re-ablement support staff must not advise on medication issues (including over the counter medicines). Any question should be referred to the service user's GP or pharmacist.

15.2. It is the responsibility of the prescriber to explain the reason for the treatment and the likely effects (including side effects) of any medication prescribed to the patient.

15.3. Patient information leaflets are included with prescribed medicines dispensed by a community pharmacist, dispensing doctor or hospital pharmacy. Re-ablement support workers may need to assist service users to access this information e.g. by reading the leaflet to them if required.

15.4. Re-ablement workers should refer to appendixes 6 and 7 for contact details for GPs and Community pharmacists, including opening hours.

15.5. Medication advice is available from the CCG medicines management team, via referral through the re-ablement managers and team managers.

16. CONFIDENTIALITY

Re-ablement staff must not discuss or disclose a service user's medical history or treatment to a relative or lay person. Any questions must be re-directed to the service user, the service user's medical practitioner or the re-ablement manager.

17. DEFINITIONS

Assessor: Social care professional authorised by Adult Social Care, Health and Public Protection (ASCHPP) to undertake an assessment of a service users need and eligibility under Fair Access to Care Services (FACS) for on-going services e.g. a social worker or a community care officer (CCO)

Container: The packaging in which medication is supplied by the community (or hospital) pharmacy or dispensing doctor. For example: glass or plastic bottle, foil strip or blister packaging, tube containing ointment or cream for external application. Includes monitored dosage system or other compliance aid

Cytotoxic medicines: used in the therapy of various cancers and other conditions. Their effects are produced by interference with some human cell functions. There is a possibility that prolonged; uncontrolled exposure to cytotoxic drugs could produce some type of adverse effect on people who handle these medications.

Disability Discrimination Act (DDA): Community pharmacists will ask service users a series of questions. If the service user satisfies the DDA criteria, they may be eligible to have their prescription dispensed in a compliance aid.

Emollient: Defined as a preparation listed under section 13.2.1 of the British National Formulary (BNF); does not include barrier preparations.

'Fair Blame' culture: A culture in which staff are not blamed, criticised or disciplined as a result of a genuine slip or mistake that leads to an incident. Disciplinary action under Nottinghamshire County Council's Disciplinary Procedure may still follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm.

Framework: An electronic system for recording contact and relevant information regarding a service user's social care support

Medication Administration Record (MAR) chart: this is a document which gives details of all medicines that a service user is given support to manage. It shows the name of the medicine, the dose to be given, the time it is to be given and the identity of the person supporting with administration

Monitored dosage system/compliance aid: A form of packaging in which all medication required at specific times of the day are grouped together in individual compartments of the container

Non-medical prescriber: A registered healthcare professional, other than a doctor or dentist, who has been accredited as a prescriber by their professional body. At present such professionals include: nurses, midwives, pharmacists, optometrists, physiotherapists or chiropodists/podiatrists who have completed the relevant training programme.

Occupational Therapist: ASCHPP worker who visits all service users to provide equipment or re-ablement goals. May also complete the first visit if needed. Refers to Social Worker for assessment for on-going service.

Perigastric endoscopic tube (PEG): A feeding tube which is surgically inserted directly into the stomach to provide a safe and long term method of obtaining nutrition.

Peripatetic Re-ablement Support Workers: ASCHPP worker who undertakes the first visits to introduce the service and complete the Support Plan. They will also complete a medication risk assessment form as well as other risk assessments. He/she is also responsible for obtaining the consent of the service user for a re-ablement support worker to assist them with their medication.

Re-ablement Manager: the ASCHPP manager who is responsible for the management of the START and line management and day to day supervision of the re-ablement support workers. He/she undertakes the first visit and completes the risk assessment and support plan only when the Peri Re-ablement Support Workers are not available.

Re-ablement support worker: ASCHPP worker who provides support to service users with a range of personal and practical tasks while enhancing independence. He/she carries out the support plan and monitors and provides feedback.

Remind/prepare/assist/apply/administer: Situations where the service user is not able to take full responsibility for their medication and staff are required to provide varying degrees of assistance through to full administration. This includes selection of medicines by staff from a monitored dosage system or compliance aid.

Team Manager: Has overall responsibility for the service as the Registered Manager with CQC. Has line management responsibility for the Re-ablement Managers.

Transdermal patches: A medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream.

18. FORMS TO USE

START/AMP/1 – Information for relatives/friends of service users receiving support with their medication from the START service.

START/AMP/2 – Agreement for assistance with application of compression hosiery.

START/AMP/3 – Fax confirmation of prescriber directions.

START/AMP/4 – Confirmation agreement for crushing tablets or opening of capsules.

START/AMP/5 – GP Instructions – prescribed medication (PRN) when required.

START/AMP/6 – Medication incident report form

START/AMP/7 – Support with medication risk assessment form

Nottinghamshire County Council

Report to Policy Committee

17th July 2019

Agenda Item: 8

REPORT OF THE CHAIRMAN OF PLANNING AND LICENSING COMMITTEE

PROPOSED AMENDMENTS TO THE COUNTY COUNCIL'S CODE OF BEST PRACTICE RELATING TO THE REPORTING OF PLANNING APPLICATIONS TO PLANNING AND LICENSING COMMITTEE

Purpose of Report

1. To seek Members' approval of amendments to the existing Planning and Licensing Committee Code of Best Practice, setting out which planning applications must be reported to Planning and Licensing Committee for determination.

Background information

2. The Planning and Licensing Committee Code of Best Practice sets out how the County Council deals with those matters which come within the remit of the Planning and Licensing Committee, the role of the Committee, how the Committee operates and the respective responsibilities of councillors and officers. Section 2A.2 of the Code confirms that Committee delegates authority to officers to determine planning applications submitted to the authority, apart from those which meet any of the criteria set out below. The current list, setting out which applications must be reported to Planning and Licensing Committee for a decision, was last updated and approved in July 2017. Members will recall that at Policy Committee in January this year the introduction of a Planning Performance Agreement Charter was approved as Council policy and Members resolved to add Planning Performance Agreements to criterion d) below.

Current Code of Best Practice

a) Applications involving a site area greater than 25 hectares or extraction/input in excess of 30,000 tonnes per annum or new development with a floor space in excess of 10,000 square metres;

b) Applications involving a departure from the Development Plan and which meet the criteria for applications being referred to the Secretary of State before granting planning permission, plus development in a Flood Risk Area to which the County Council, as Lead Local Flood Authority, has made an objection. Departure applications which do not meet the criteria for referral to the Secretary of State will only be determined under delegated powers with the prior agreement of the Local Member;

c) Applications accompanied by an Environmental Impact Assessment;

d) Applications which have S106 agreements/Planning obligations/or a Planning Performance Agreement and those which have other financial implications for the County Council;

e) Applications which have received valid planning objections, in writing, from the District/Borough or Parish Council or local Member within the statutory consultation period or within an extended period as agreed by the County Council;

f) Applications which have been referred to Committee by a local Member;

g) Applications which are recommended for refusal unless the refusal is on the grounds of insufficient information;

h) Applications which have received significant* objections, within the statutory consultation period or other such period as agreed with the County Council, from consultees or neighbouring occupiers (* for clarification, 'significant' objections requiring referral must, i) raise material planning considerations, ii) be irresolvable by amendment to the scheme or imposition of planning conditions, iii) involve **four or more** objections from separate properties);

i) Applications which are submitted by Place Department (or any subsequent Department following any future restructuring where the applicant is in the same Department as the Development Management Team) where these are the subject of any objections;

j) Applications which raise issues of regional or national importance or relate to proposals involving emerging technologies;

k) Applications involving the determination of new conditions for mineral sites and those involving the making and serving of orders for revocation, etc where compensation is likely to become payable;

l) Applications for variations (Section 73 applications) to planning permissions which involve the variation or removal of a condition which Members of Planning and Licensing Committee requested be brought back to committee for determination.

Wider review of the Code of Best Practice

3. Following the Policy Committee decision, Members of Planning and Licensing Committee subsequently (in March 2019) approved the inclusion of this amendment to the Code of Best Practice and also approved a recommendation that officers should undertake a wider review of the list of application types which must be referred to Planning and Licensing Committee for a decision.

4. Between July 2017 (the date of the last review) and March 2019 there have been a total of 44 planning applications reported to Planning and Licensing Committee for determination. 38 (86%) of these were for minerals and waste applications and 6 (14%) for Regulation 3 (County Council) development. During the same time period, July 2017 to March 2019, there have been 90 delegated decisions issued.

5. As part of the review officers identified a range of issues and recommended a number of changes to the criteria, these are set out below.

Key issues and changes to the criteria for referral to Committee

6. **Variations (Section 73 applications) relating to 25-hectare sites** – 57% of the total applications reported to Committee related to Section 73 applications to vary conditions attached to existing planning permissions. Many of these Committee decisions have been for relatively minor changes to the extant permission, such as changes to the restoration plans or changing hours of operation. However, because the proposals related to development on a site greater than 25 hectares in size or with a rate of extraction or input of more than 30,000 tonnes per annum, the existing Code of Best Practice required the applications to be referred to Committee for determination, irrespective of whether the applications generated any objections from the local Member, consultees or members of the public. Members are therefore asked to

consider the proposal of removing the 25-hectare threshold for sites which are the subject of variation applications and only applying this threshold to new minerals and waste sites.

7. **Variations relating to 30,000tpa (tonnes per annum)** – The suggested new criterion (b) will require only those variation applications which involve increasing the rate of extraction/input by more than 30,000tpa on existing minerals and waste sites to be reported to Committee. The existing wording requires all variations on sites with existing extraction/input rate of 30,000tpa to be reported to Committee irrespective of the changes proposed.

8. These two changes will ensure that only the most significant and controversial variation applications are brought to Committee for a decision. All other criteria would apply to these proposals, such as objections or Chair/Vice Chair or local member referral. It is estimated that around 8 applications (since the last review in July 2017) would not have been reported to Committee if this had been in place.

9. **New built development** – The current threshold for new built development for both minerals and waste applications and Regulation 3 proposals is 10,000 sqm of floorspace. This is set at such a high level that it has not resulted in any application being referred to Committee for a decision because it met this criterion. Officers consider that a more realistic threshold would be proposals with a floorspace more than 1,000 sqm. Had this criterion been in place two significant County Council proposals would have been brought to Committee for determination. These were the new school on the former Rolls Royce site in Hucknall and the Orchard School and Day Centre in Newark, both which had a proposed floorspace over 1,000sqm. These did not trigger any of the other criteria so were determined under delegated powers. Reducing the threshold of new built development to 1,000sqm will provide the opportunity for Members to be involved in the decision-making process on significant developments and major investments in the County such as these.

10. **Applications which are recommended for refusal unless the refusal is on the grounds of insufficient information** – this criterion was introduced to allow for a quick turnaround of applications where insufficient information has been submitted, despite repeated requests, to enable the Council to make a decision and to enable the Council to meet its targets for determining application within statutory timeframes or an agreed time extension. However, it was intended that this would be irrespective of the other criteria in the list which needed to be made clearer.

11. Other minor changes

- **Financial implications** – it is proposed to consolidate all criteria relating to financial implications.
- **Local members** – all references to local member within the list be amended to local members to reflect divisions where there is more than one member.
- **Significant objections** – the criterion relating to significant objections is reworded for clarity, “non-statutory” consultees added and confirmation that any withdrawn objections must be confirmed in writing.
- **District/Borough or Parish Council or local Member representation** – the word “valid” is amended to “material” planning objections to be consistent with other criterion.
- **Referrals by the Chair/Vice Chair of Planning and Licensing Committee** – a new criterion added to allow such referrals of applications that would otherwise be determined under delegated powers.

12. Based upon the issues above a revised list was reported to Planning and Licensing Committee on 4th June 2019 where these changes were agreed subject to one minor amendment. The endorsed scheme is set out below and is now brought to Policy Committee for approval. The Appendix to this report provides a summary of the existing and proposed criteria and the reasons for the changes.

Approved criteria for referral to Planning and Licensing Committee

13. If approved by this Committee and adopted as Council policy the following types of planning applications will, in future, be reported to Planning and Licensing Committee for a decision:

    a) Applications for new minerals or waste sites involving a site area greater than 25 hectares or extraction/input in excess of 30,000 tonnes per annum.

    b) Section 73 variations on existing minerals or waste sites which involve increasing the rate of extraction/input by more than 30,000 tonnes per annum.

    c) New built development with a floor space in excess of 1,000 square metres.

    d) Applications involving a departure from the Development Plan and which meet the criteria for applications being referred to the Secretary of State before granting planning permission. Departure applications which do not meet the criteria for referral to the Secretary of State will only be determined under delegated powers with the prior agreement of the Local Member(s).

    e) Applications to which a *statutory consultee has made an objection. [*as defined by the Town and County Planning (Development Management Procedure) (England) Order 2015 and any subsequent amendments].

    f) Applications accompanied by an Environmental Impact Assessment.

    g) Applications which have financial implications for the County Council such as:

        - Section 106 agreements/obligations/restoration bonds;
        - Review of minerals permissions (ROMPs) and revocation orders where compensation is likely to be payable;
        - Applications subject to a Planning Performance Agreement.

    h) Applications which have received material planning objections, in writing, from the District/Borough or Parish Council or local County Councillor(s) within the statutory consultation period or within an extended period as agreed by the County Council.

    i) Applications which have been referred to Committee by the Chair and/or Vice Chair of Planning and Licensing Committee and/or by the local County Councillor(s).

    j) Applications which have received 4 or more material planning objections within the statutory consultation/publicity period (or other such period as agreed with the County Council) from non-statutory consultees or members of the public which remain unresolved following amendments to the scheme or through the imposition of planning conditions and where the objections have not been withdrawn in writing.

    k) Applications which are submitted by Place Department (or any subsequent Department following any future restructuring where the applicant is in the same Department as the Development Management Team) where these are the subject of any material planning objections.

l) Applications which raise issues of regional or national importance or relate to proposals involving emerging technologies.

m) Applications for variations (Section 73 applications) to planning permissions which involve the variation or removal of a condition which Members of Planning and Licensing Committee requested be brought back to committee for determination.

n) Irrespective of whether any of the criteria above are met, any application which is recommended for refusal unless the refusal is on the grounds of insufficient information.

Monitoring of the Code of Best Practice

14. Members should be mindful of the need to strike a balance between the transparency of decisions being made at Committee, particularly for those applications where the County Council is also the applicant or those subject to significant local objections, and the recognition that determining applications under delegated powers usually results in decisions being made in a timelier manner. It is not anticipated that the proposed changes to the criteria will make a significant difference to the overall number of applications being reported to committee and therefore it is unlikely that there will be any impact on the workload of officers or Members. The current level of delegated decisions is likely to remain at around 70%, with 30% being reported to Committee for a decision. However, in line with the previous reviews, officers will continue to monitor the scheme and report back annually on how the scheme is working and provide advice to Members should any further amendments be considered appropriate.

Statutory and Policy Implications

15. This report has been compiled after consideration of implications in respect of finance, the public-sector equality duty, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment, and those using the service and where such implications are material they are described below.

Human Rights Implications

16. Relevant issues arising out of consideration of the Human Rights Act have been assessed. Rights under Article 8 (Right to Respect for Private and Family Life), Article 1 of the First Protocol (Protection of Property) and Article 6 (Right to a Fair Trial) are those to be considered. In this case, however, there are no impacts of any substance on individuals and therefore no interference with rights safeguarded under these articles.

RECOMMENDATIONS

It is recommended that:

1. Members approve the amendments to the criteria for referral of planning applications to Planning and Licensing Committee as set out in paragraph 13 above and approve an update to Section 2A.2 of the Planning and Licensing Committee Code of Best Practice to reflect these changes.

Councillor Chris Barnfather
Chairman of Planning and Licensing Committee

For any enquiries about this report please contact:
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Constitutional Comments (RHC 24/06/19)

17. Policy Committee is the appropriate body to consider the contents of this report by virtue of its terms of reference.

Financial Comments (RWK 13/06/19)

18. There are no specific financial implications arising directly from the report

Background Papers Available for Inspection

- None

Electoral Divisions and Members Affected

- All

Appendix - Summary of existing and proposed wording of criteria and reasons for the changes

Existing criteria	**New criteria**	**Reason for change/no change**
Applications involving a site area greater than 25 hectares or extraction/input in excess of 30,000 tonnes per annum or new development with a floor space in excess of 10,000sqm	This criterion has been amended and split to include Section 73 applications (variations) but to distinguish between new sites and variations in term of the site area and throughput. The proposed new criteria and the reasons for them are detailed separately below.	
	a. Applications for new minerals or waste sites involving a site area greater than 25 hectares or extraction/input in excess of 30,000 tonnes per annum;	a. The proposed wording ensures that the 25 hectares criterion **only** relates to new sites and not to proposals to vary conditions attached to existing planning permissions.
	b. Section 73 variations on existing minerals or waste sites which involve increasing the rate of extraction/input by more than 30,000 tonnes per annum;	b. The proposed wording confirms that any variation application which seeks to increase the amount of mineral extraction or waste input by 30,000 tonnes per annum will automatically be referred to committee.
	c. New built development with a floor space in excess of 1,000 square metres	c. Reduce new built floorspace from 10,000sqm to 1,000 sqm to ensure schemes of significant floorspace are brought to members for a decision. 10,000sqm considered to be set too high and has resulted in no applications being brought to Committee on that basis.

Applications involving a departure from the Development Plan and which meet the criteria for applications being referred to the Secretary of State before granting planning permission, plus development in a Flood Risk Area to which the County Council, as Lead Local Flood Authority, has made an objection. Departure applications which do not meet the criteria for referral to the Secretary of State will only be determined under delegated powers with the prior agreement of the Local Member	d. Applications involving a departure from the Development Plan and which meet the criteria for applications being referred to the Secretary of State before granting planning permission. Departure applications which do not meet the criteria for referral to the Secretary of State will only be determined under delegated powers with the prior agreement of the Local Member(s)	Separate this criterion into two separate criteria for clarity and Local Member changed to plural to reflect divisions represented by more than one Member.
As above	e. Applications to which a *statutory consultee has made an objection [*as defined by the Town and County Planning (Development Management Procedure) (England) Order 2015 and any subsequent amendments]	Now a separate criterion and category broadened to include objections from all statutory consultees not just those from the Lead Local Flood Authority. Definition of statutory consultee added for clarity.
Applications accompanied by an Environmental Impact Assessment	f. Applications accompanied by an Environmental Impact Assessment	Criteria to remain the same to enable Committee consideration of large-scale mineral, waste and County Council development and those in sensitive locations.
Applications which have S106 agreements/ Planning obligations or a Planning Performance Agreement and those which	g. Applications which have financial implications for the County Council such as;	Criteria to be amended so Members are made aware of any financial implications for the County Council relating to proposals where restoration bonds are sought.

have other financial implications for the County Council	• Section 106 agreements/ obligations/ restoration bonds, • Review of minerals permissions (ROMPs) and revocation orders where compensation is likely to be payable, • Applications subject to a Planning Performance Agreement.	Financial implications relating to ROMPS included within this criterion in place of previous separate criterion.
Applications which have received valid planning objections, in writing, from the District/Borough or Parish Council or local Member within the statutory consultation period or within an extended period as agreed by the County Council	h. Applications which have received material planning objections, in writing, from the District/Borough or Parish Council or local County Councillor(s) within the statutory consultation period or within an extended period as agreed by the County Council.	"Valid" changed to "material" planning objections to be consistent with wording used in criterion (j). Local Member changed to plural to reflect divisions represented by more than one Member.
Applications which have been referred to committee by a local member	i. Applications which have been referred to Committee by the Chair and/or the Vice Chair of Planning and Licensing Committee and/or the local County Councillor(s).	Chair and Vice Chair referrals added at the request of the Chair/ Vice Chair of Planning and Licensing Committee. Local Member changed to plural to reflect divisions represented by more than one Member.
Applications which have received significant* objections, within the statutory consultation period or other such period as agreed with the County Planning Authority, from consultees or neighbouring occupiers (* for clarification, 'significant' objections requiring referral must i) raise material planning consideration, ii) be irresolvable	j. Applications which have received 4 or more material planning objections within the statutory consultation/publicity period (or other such period as agreed with the County Council) from non-statutory consultees or members of the public which remain unresolved following amendments to the scheme or through	Wording of condition rearranged for clarity. Clarity also provided by stating that objections need to be withdrawn **in writing**, otherwise they remain as valid objections.

by amendment to the scheme or imposition of planning conditions, iii) involve four or more objections from separate properties)	the imposition of planning conditions and where the objections have not been withdrawn in writing.	
Applications which are submitted by Place Department (or any subsequent Department following any future restructuring where the applicant is in the same Department as the Development Management Team) where these are the subject of any objections	k. Applications which are submitted by Place Department (or any subsequent Department following any future restructuring where the applicant is in the same Department as the Development Management Team) where these are the subject of any material planning objections.	The word “material” added for consistency with other criteria.
Applications which raise issues of regional or national importance or relate to proposals involving emerging technologies	l. Applications which raise issues of regional or national importance or relate to proposals involving emerging technologies.	No change.
Applications involving the determination of new conditions for mineral sites and those involving the making and serving of orders for revocation, etc where compensation is likely to become payable	No separate criterion	Delete criterion and include within financial implication category above.
Applications for variations (Section 73 applications) to planning permissions which involve the variation or removal of a condition which Members of Planning and Licensing Committee requested be brought back to committee for determination	m. Applications for variations (Section 73 applications) to planning permissions which involve the variation or removal of a condition which Members of Planning and Licensing Committee requested be	No change

	brought back to committee for determination	
Applications which are recommended for refusal unless the refusal is on the grounds of insufficient information	n. Irrespective of whether any of the above criteria apply, any application which is recommended for refusal, unless the refusal is on the grounds of insufficient information.	Clarity provided so that even if the proposals meet other criteria, if there is insufficient information provided (despite repeated requests) they can be refused on those grounds alone. All other recommended refusals will be reported to Committee for a decision. Members' endorsement of the decision to refuse an application is considered to be beneficial if the decision is subsequently subject to an appeal.

Nottinghamshire County Council

Report to Policy Committee

17 July 2019

Agenda Item: 9

REPORT OF THE CHAIRMAN OF IMPROVEMENT AND CHANGE SUB-COMMITTEE

WORK OF THE IMPROVEMENT & CHANGE SUB-COMMITTEE

Purpose of the Report

1. To report on the work of the Improvement and Change Sub-Committee in monitoring performance and driving the Council's Improvement and Change Programme.

Information and Advice

2. The Improvement and Change Sub-Committee has responsibility for:

- Monitoring the Council Plan;
- Monitoring and driving the Council's Improvement and Change Programme;
- Considering performance reports in relation to the Council's ICT strategy.

3. The sub-committee is also leading on the cross-council programme of work, "Enhancing Customer Experience through Digital Development" as technology is a key enabler in the Council's ongoing change and transformation. The sub-committee chair is the lead member for this programme of work.

4. As part of the cycle of performance management the Chairman of the Improvement and Change Sub-Committee provides a regular report to Policy Committee. This report covers the period from July 2018 (the date of the previous report to Policy Committee) through to April 2019. It identifies key issues within its responsibility which the Sub-Committee has considered, as detailed below.

Monitoring the Council Plan

5. The Improvement and Change Sub-Committee reviewed the arrangements for the reporting of progress on the Council Plan and Departmental Strategies on 12 March 2018. It agreed a format of reporting to implement the Planning and Performance Management Framework, to enable effective monitoring of progress against the Council's commitments.

6. Through those arrangements the Sub-Committee has considered an overview of the activity undertaken to support delivery of the Council Plan; this has been done through 6-monthly

updates to the Sub-Committee. The progress reports present a dashboard setting out the Council Plan Core Dataset, giving a visual overview of progress against the Council Plan.

7. Delivery of the Council Plan is through the Council's four Departmental Strategies. Progress against each individual Departmental Strategy is considered by the relevant service committees every six months, covering all of the key activities and measures during the period. As part of the monitoring of the Council Plan the Improvement and Change Sub-Committee receives a summary of the performance highlights and challenges considered by these Committees across the key activities and measures of each Departmental Strategy. This ensures that departmental activity remains aligned with corporate objectives, identifies interdependencies and potential synergies which can be developed working across the council as a whole.

Monitoring and Driving the Council's Improvement and Change Programme

8. Delivery of the Council's Improvement and Change Portfolios and savings have been considered by the Sub-Committee on a quarterly basis, including progress on some key initiatives and achievement of savings overall.

9. Consideration was given in March 2019 to an update on departmental Improvement and Change Portfolios. This informed the Sub-Committee of the progress towards delivery of the Council's current savings targets and strategically significant programmes and projects. A further update was undertaken in June 2019.

10. Approval was given in January 2019 for amendments to the savings profiles:

- improved savings for transforming reablement, the 'preparing for adulthood' service and housing with care units
- amended savings for targeted reviews relating to commissioned packages of support
- reduced scope of the Children's and Families' contracts review with the exclusion of care type contracts
- decision not to proceed with the savings targets for the statutory school transport service.

Approaches to Transformation and Change

11. A key area of focus for the Sub-Committee is to encourage and drive through a whole Council approach to transformation and change. Informal feedback as part of the Peer Review was that this is essential if the Counci's ongoing approachto savings and organisational change is to deliver maximum benefits which are sustainable in the medium to longer term.

12. A report was presented in April 2019 proposing a new approach to developing an operating model and organisational structure for transformation and change. This followed from the creation of the Chief Executive's Department and the subsequent restructure at Group Manager level within the Finance, Infrastructure and Improvement Division. The

Transformation and Change team was established, bringing together the corporate Programmes and Projects team and the Build, Change and Engagement team from ICT services under a single Group Manager.

13. The opportunity was taken to review the approach to transformation and change within the organisation which has evolved over a number of years. A set of principles for transformation and change has been agreed and a new structure implemented. This work has laid the groundwork to enable this whole Council approach to transformation and change to be driven forward through the Sub-Committee in the coming year. Alongside this, the Sub-Committee has been active in considering progress with a number of specific areas of transformation activity, as identified below.

14. Members approved a report in relation to digital development within the Council and provided input to a cross-council programme to improve the customer experience through digital development. This includes the roll-out of a 'MyNotts App' making it easier for residents to access Council services and effectively resolve issues and queries at their first point of contact with the Council.

15. The Improvement and Change Sub-Committee considered the progress of the Shared Lives Scheme, a highly successful way of helping vulnerable people to live with families, and live ordinary lives in the community. The Sub-Committee focussed particularly on the performance of the scheme between 2016 and 2018 and the factors that have had an effect on this.

16. The Sub-Committee received details of performance and progress against the Place Improvement and Change Portfolio, as contained in the Place Department Plan. This includes the journey of improvement, investment and commercial returns and doing things differently with less.

17. The Sub-Committee has also reviewed progress of the Smarter Working Programme in 2018 and the approach to the closure of this programme. As the Smarter Working Programme comes to a close the next phase of this work will now be taken forward under the Investing in Nottinghamshire programme as covered by a report to Policy Committee in March 2019. In 2018 the Smarter Working Programme delivered on a number of fronts:

- An upgrade in the scheduling software was rolled out across all Social Work and Occupational Therapy teams in Adult Social Care & Health (ASC&H) that provided improved functionality for staff

- The deployment of new ICT equipment and a reconfiguration of the office space in County Hall resulting in an additional 356 staff working out of the building – taking the headcount up to 1,144

- New ICT equipment deployed to 256 staff based at Trent Bridge House

- The Social Work team based at City Hospital moved from Valebrooke House to a site within the main hospital. As part of this move they received new equipment, access to Lync telephony and Wi-Fi coverage had been reviewed

- New ICT equipment deployed to over 100 staff based at Prospect House in Beeston.

Progress in Delivery of the Council's ICT Strategy

18. The Council's ICT Strategy 2017-2020, was agreed by Policy Committee in July 2017. It identifies ICT strategic themes supporting business transformation across the Council – workforce mobilisation; customer channel shift; business performance reporting; partnership working and reliability; and compliance and these shape much of the activity and priorities within ICT Services.

19. The Improvement and Change Sub-Committee has monitored ICT Services performance and developments including:

- Quarterly reports providing an update on key projects and performance measures for ICT Services and outlining the major planned activities over the next 6 month period.

- A progress report in April 2019 on the Council's Cloud Services Programme to deliver the transition of ICT services away from the County Hall data centre to cloud based solutions by the end of 2019. To support the future development of this programme Improvement and Change Sub-Committee supported a new governance model with a cross departmental cloud programme board being established and reporting to the Sub-Committee.

- An overview of the Prince 2 project management methodology used in ICT services. The Sub-Committee considered the fit of the Prince 2 approach with the authority's processes of identifying options for change to deliver savings and efficiencies, and focuses on cost, timescale, quality, scope, risks and benefits.

- A report and presentation describing how investment in new technology has enabled transformation of service delivery across a number of service areas, specifically:
  - Automatic Scheduling;
  - Interoperability and Integration;
  - Portals;
  - Future technology

The Way Forward

20. In the previous report to Policy Committee on 18 July 2018, Improvement and Change Sub-Committee set out a number of programmes that would be reviewed. The Committee has already reviewed a number of these programmes as follows:

- The Journey to the Cloud
- The Smarter Working Programme
- The operating model for managing support to transformation and change
- Digitalisation
- ICT programmes & performance

- Cross-Council transformation programmes
- Exploring Member led transformation reviews – not yet reviewed.

21. As part of the future work programme the Improvement and Change Sub-Committee is due to consider Departmental updates on Improvement and Change from each of the Council's four Departments and six-monthly progress reports on delivery of the Council Plan, along with additional areas of work for the next year.

22. The Sub-Committee continues to inform improvements to performance reporting to Members, including the Council's evolving use of data and inteligence. Following further discussion at Improvement and Change Sub-Committee in June, work will be undertaken to review how high level performance data is presented to Members. This will ensure Members retain a strategic overview of the whole Council picture and are also able to drill down to performance data of specific areas where potential issues have been identified.

Other Options Considered

23. The Improvement and Change Sub-Committee reviewed this report on24 June 2019 before recommending it to Policy Committee. The matters set out in the report are intended to provide effective and proportionate performance management reporting to Policy Committee in accordance with the responsibilities set out in the Constitution.

Reason/s for Recommendation/s

24. To provide members with an overview of the Sub-Committee's progress in monitoring performance of activity within its remit and to note actions to identify key future work areas.

Statutory and Policy Implications

25. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

26. There are no financial implications arising directly from this report.

RECOMMENDATION

1) It is recommended that Committee review the work of the Sub-Committee and consider whether there are any actions or requirements for further information arising from the report.

Councillor Reg Adair
Deputy Leader of the Council and
Chairman of the Improvement and Change Sub-Committee

For any enquiries about this report please contact:
Nigel Stevenson
Service Director for Finance, Infrastructure & Improvement

Constitutional Comments (SLB – 7/9/19)

Policy Committee is the appropriate body to consider the content of this report. If Committee resolves that any actions are required it must be satisfied that such actions are within the Committee's terms of reference.

Financial Comments (SES 9/7/19)

There are no specific financial implications arising directly from this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Division(s) and Member(s) Affected

- All

Nottinghamshire County Council

Report to Policy Committee

17 July 2019

Agenda Item: 10

REPORT OF THE SERVICE DIRECTOR, CUSTOMERS, GOVERNANCE AND EMPLOYEES

WORK PROGRAMME

Purpose of the Report

1. To review the Committee's work programme for 2019-20.

Information

2. The County Council requires each committee to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the committee's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and committee meeting. Any member of the committee is able to suggest items for possible inclusion.

3. The attached work programme includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

4. The Policy Committee will be asked to determine policies, strategies and statutory plans developed or reviewed by other Committees of the Council. Committee Chairmen are invited to advise the Policy Committee of any additional policy reviews that are being considered.

5. The following changes have been made since the work programme was published in the agenda for the last meeting:-

   a. The following items were added to the agenda for July 2019:
      - Feasibility Costs for the Carlton-le-Willows Academy (Greater Nottinghamshire Education Trust) Basic Need Expansion
      - Increasing Residential Capacity for Looked After Children.

   b. The following item was deferred from July 2019 to October 2019:
      - Disposal of Abbey School site, Mansfield.

   c. The following item was added to the work programme:
      - Provision of Primary Schools at East Leake and Bingham – add to September 2019

   d. The following items were removed from the work programme:
      - Safer Nottinghamshire Board update – removed from July 2019 (this item is scheduled for September 2019 instead)

- Nottinghamshire Best Start Strategy 2020-2025 (this item will be submitted to Policy Committee at the point that the Strategy has been developed and requires approval)

- Acquisition of land to the rear of 48 High Street, Hucknall (this issue will be addressed as part of a wider report covering the Hucknall Town Centre Improvement Scheme).

Other Options Considered

6. None.

Reason for Recommendation

7. To assist the Committee in preparing and managing its work programme.

Statutory and Policy Implications

8. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION

That the Committee considers whether any amendments are required to the Work Programme.

Marjorie Toward
Service Director, Customers, Governance and Employees

For any enquiries about this report please contact: Keith Ford, Team Manager, Democratic Services, Tel: 0115 9772590

Constitutional Comments (SLB)

9. The Committee has authority to consider the matters set out in this report by virtue of its terms of reference

Financial Comments (NS)

10. There are no financial implications arising directly from this report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

None

Electoral Division(s) and Member(s) Affected

All

POLICY COMMITTEE - WORK PROGRAMME (AS AT 9 JULY 2019)

Report Title	Brief summary of agenda item	Lead Officer	Report Author
18 September 2019			
Provision of Primary Schools at East Leake and Bingham		David Hughes	Steve Pointer
Information Governance Policies review	To review the policies previously agreed by Policy Committee	Marjorie Toward	Caroline Agnew
Accessibility Strategy	To seek approval for the Accessibility Strategy which assists pupils with Special Educational Needs and Disabilities to access the National Curriculum.	Colin Pettigrew	Chris Jones
Safer Nottinghamshire Board Update	To provide an update on the work of the Board.	Anthony May	Vicky Cropley
Update on Futures, Advice, Skills and Employment, including Enterprise Adviser Network		Adrian Smith	David Hughes/Marion Clay
16 October 2019			
Outside Bodies Update Report	To notify Committee of any changes to the Council's Outside Bodies Register and to seek approvals where appropriate (in line with new processes agreed by Policy Committee on 22 May 2019).	Marjorie Toward	Keith Ford
Disposal of Abbey School site, Mansfield	To approve the disposal of this site.	David Hughes	Steve Keating
13 November 2019			
Use of Urgency Procedures	Six Monthly Update report on the use of the Council's procedures for taking urgent decisions.	Marjorie Toward	Keith Ford
11 December 2019			
15 January 2020			
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12 February 2020			
Nottinghamshire Knife Crime Strategy Update	Update on the activity of the newly established posts and the outcomes for Nottinghamshire's young people (as agreed by Policy Committee on 22 May 2019)	Colin Pettigrew	Rachel Miller
18 March 2020			
22 April 2020			
Outside Bodies Update Report	To notify Committee of any changes to the Council's Outside Bodies Register and to seek approvals where appropriate (in line with new processes agreed by Policy Committee on 22 May 2019).	Marjorie Toward	Keith Ford
13 May 2020			
Use of Urgency Procedures	Six Monthly Update report on the use of the Council's procedures for taking urgent decisions.	Marjorie Toward	Keith Ford
County Council Civic Service	To seek approval for the funding for the 2020 annual Civic Service	Marjorie Toward	Keith Ford
17 June 2020			
County Councils Network Conference 2020	To seek approval for attendance at this annual conference.	Marjorie Toward	Keith Ford
15 July 2020			