



# Halton Residential & Nursing Care Home Commissioning Strategy

February 2009



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## **Introduction and Executive Summary**

The preparation of the Halton Residential and Nursing Care Home strategy has involved a substantial and robust examination of research, of national data and of data and information generously provided by comparator local authorities. Consultation with providers and other stakeholders has taken place and informed the development of the strategy. The resultant commissioning strategy remains a draft and is a basis for further consultations. It is consistent with national policy and guidance as well as being rooted in evidence based best practice.

This executive summary outlines the findings and key commissioning intentions. A more detailed analysis and exploration of the intentions are found in the main body of the report.

### **Relations with care providers**

Best practice dictates that a set of values is adopted to frame the commissioning relationship. These values are integral to both the immediate need to commission, procure and contract for high quality residential care provision on behalf of the citizens of Halton, but also to the longer term intentions to ensure personalised care choices.

### **Future forecasting of demand**

The strategy includes an analysis of future demand to 2015. It is anticipated that the level of demand for residential and nursing home care will reduce slightly over the next two to three years, but then a small increase is anticipated as a result of additional numbers of older people. Population figures show a small, but significant, potential increase in service users. Other factors apart from demographics significantly impact on future predictions of numbers of people requiring residential care. Halton currently purchases well below the regional average of residential care. The consequences of this are that those people who are living in residential care now, particularly those placed in the last three to four years, have high levels of dependency and those people entering residential care in the next five years will continue to have high levels of dependency. In effect residential care is “end of life” care for most people and this will continue over the next five years.

### **Future demand for residential and nursing home care**

The factors that impact on future demand for residential and nursing care includes:

- Long term funding for social care
- The Personalisation Agenda
- The Government’s dementia care strategy
- Change of government
- Economic downturn, for example on recruitment problems in the sector, or the impact of rising unemployment on the communities and individuals ability to cope
- Assistive technology in the community and within care homes

- Breakthroughs in medical treatment of dementia
- The extent of funding and development of extra care housing
- Primary care commissioning and PCT funding of continuing care
- Demography

For example POPPI data for Halton shows that the total population aged 65 and over predicted to have dementia will rise from 1,123 in 2008 to 1,262 in 2010 and to 1,291 in 2015; an increase over the 7 year period of 168 or 15%. The population aged 65 and over with a limiting long-term illness in Halton is predicted to rise from 9,301 in 2008 to 9,636 in 2010 and 11,195 in 2015; an increase over the period of 1894 or 20%.

### **Dependency levels**

The strategy is shaped so that people assessed as having high levels of physical and or mental dependency will receive a increased payment in accordance with the dependency model used. The tool used to assess and evaluate dependency will be developed over the next 12 months and be introduced in Year 2 of the new contracts.

Greater dependency levels require improved staffing levels and better-trained staff. The strategy concludes that it will be more effective to improve quality by recognising the dependency levels with resources to enable good quality care. When they are in place then the quality can be effectively managed via quality control systems. Therefore an extended dependency premium is introduced for people who need higher levels of care – whether this is because of dementia or physical care. A model to assess the dependency needs of residents by looking at their care plans will be developed as part of extending and enhancing premium payments.

The advantage of using a dependency model for paying enhancements is that it recognises the care input that is needed. One of the problems with rewarding for star ratings is that it is easier for homes to achieve a higher star rating if they have less dependent residents. It is also not known what impact using a star system has on prospective consumers of residential care. Halton wants to aspire to all residential care being excellent. When the modeling work is completed, along with the analysis of current dependency levels of residents of residential and nursing homes, the views of providers will be further sought. Initial consultation with providers demonstrates that in principle they are supportive of the direction of travel manifest in the strategy.

### **Contracting system**

Halton Council, in recognition of the rights of people to choose their care, and will continue with a contracting system of spot purchase for individual service users.

### **Commissioning intentions**

The strategy lays out a direction for commissioning residential and nursing care homes places for Halton citizens that is:

- Based on local, regional and national research
- Informed by consultations with key stakeholders
- Founded on values and effective working relationships with providers
- Designed to meet known forecast future demands
- Assessed related to service users presenting needs and their levels of dependency
- Flexible and outcome focused in it approach to procurement and contracting
- Joint with the PCT
- Offers a fair price to service providers within the resources available to the council

## **Relevant national drivers and strategies**

The overarching national driver for social care and integral to this commissioning strategy is ***Transforming Social Care*** as set out in LAC (DH)(2008) 1 by the Department of Health. This Local Authority Circular sets out information to support the transformation of social care as signaled in the Department of Health's social care Green Paper, '**Independence, well-being and choice**' (2005) and reinforced in the White Paper, '**Our health, our care, our say: a new direction for community services**' in 2006. It describes the vision for development of a personalised approach to the delivery of adult social care and context in which this policy is grounded. It also includes a copy of the Social Care Reform Grant Determination and the details of the new ring-fenced grant to help councils to redesign and reshape their systems over the next 3 years.

The key elements can be summarised as:

- The personalisation agenda and person centred or outcome based care including the introduction of individualised budgets
- Social care services need to include a whole range of partners, including health, housing, leisure and transport and cannot be addressed by adult social care alone
- People who use services need to be involved in all aspects of, not only the delivery of care, but the planning and development of care
- Dignity should be at the heart of all care
- National minimum standards for residential and nursing care, especially registration and inspection and the extension of General Social Care Council registration to include residential care workers

## **Strategic commissioning plans.**

The context for developing procuring and contracting for residential and nursing home care are the strategic commissioning plans for various citizen groups within Halton. These operate on a 3 to 10 year time frame and are multi-agency.

Strategic commissioning aims to:

- Establish local outcomes and key priorities co-produced with citizens and local communities
- Set up processes so that local citizens can shape, purchase and direct their own services if they wish to, regardless of sources of funding
- Commission to achieve outcomes
- Ensure that the workforce is sufficient and competent to meet the demands
- Commission in a way that is sufficiently flexible and adaptable to ensure that people can control their own support services

- Ensure that strategic arrangements are in place to implement the strategy
- Commission in partnership with other agencies – with people’s residential and nursing care these partners will be principally health, housing and leisure.

In an ideal world the practical commissioning, procurement and contracting work for residential care would flow on from the strategic commissioning plans (Joint Strategic Needs Assessments or JSNA) for the whole borough and its groups of citizens. The reality of the situation is that work needs to take place in the short term to address the contracting and procurement issues that are current or anticipated over the next three years in Halton; however cognisance of work being undertaken on the JSNA has informed this residential and nursing care home commissioning strategy, including proposals that allow for flexibility and adaptability. The more immediate contracting and procurement implications regarding residential and nursing care for Halton citizens is the subject of this commissioning strategy.

### **Managing gaps in supply**

Commissioning in Halton is nearly all through spot purchase. Therefore although Halton Council has a major role in influencing the market, it does not at present commission with particular organisations for a fixed number of beds, or a fixed service.

For older people there appears to be over supply of residential care beds and an under supply of residential and nursing care beds for people with dementia, and some problems in the supply of nursing home beds. For people with mental health problems there is too much residential provision – this is being addressed in part in the short term by a review of cases, and longer term by the development of a commissioning strategy for mental health.

As Halton does not block contract, but rather uses the market to manage supply via the use of spot purchases, it could be argued that de-commissioning does not need to occur. However, solely relying on the market to adapt to changing purchasing decisions can be risky. The scenario of various homes becoming unviable could put sudden strains on the system. Private sector investment decisions and the time taken to translate investment into the available service can take over five years. The strategy seeks to engage providers in a dialogue regarding how they can develop services to meet changing patterns of service demands. Changes to the contract to acknowledge the higher demands of providing appropriate services for people who are more dependent will play their part in shaping future provision. On a general level it is clear that more specialist dementia care provision needs to be developed in a systematic way. Dialogue with providers will be undertaken to plan for this.

Halton purchases well below the regional average of residential care, this evidence, combined with the views of the procurement teams and providers lead to the conclusion that those people who are living in residential care, particularly those placed in the last three to four years, will

have high levels of dependency. Halton is a low fee payer for residential and nursing home care. The combination of high dependency levels and low levels of residential care are having a significant impact on the market in Halton. The last time that Halton commissioned for care homes there were a greater number of people entering residential care and these people in total had lower levels of dependency. Providers are keen to re-configure services to meet the priorities of dementia care and people with high level physical dependency needs, or both. Providers all agree that they want to provide the highest quality of care that they can, but decisions on levels of investment will depend to a significant extent on fee rates. For example providers say that at the moment they cannot afford to invest in substantial building or refurbishment.

It is recognised that the market cannot change over night. The strategy will be shaped to time frames that are agreed with providers and the expectations of Halton to have high quality services. An example of this could include investment plans to improve the built environment and to create purpose built units, for example for people with dementia. Further consultation will continue to address price, dependency payments and provider views on standards. The price to be paid for care will be geared towards attaining high quality care and encouraging providers to undertake changes that are required.

It is difficult to predict what the future demand for residential care will be. An informed estimate regarding older people would be that there might be a continued small reduction in demand over the next three years, but a slow increase in the more medium term, with this increase being in the higher dependency categories. For mental health services there clearly needs to be a reduction in residential care. The situation in PSD and LD is more complex, particularly the issues surrounding the possible re-classification of supported living services to residential care.

The impact of the significant increase in PCT funding of residential and nursing home places is clearly having an impact on the residential care budgets. This creates a real opportunity, with partners in the NHS and providers, to increase investment in the sector to improve quality.

The strategy is predicated on a system of paying a fair price for care for those people with higher dependency needs. It considers options but rejects quality premiums as inherently inaccurate and distorting of the market. Further work will take place accordingly regarding specifications of care. This will include a dialogue with providers regarding staffing levels, training of staff and the built environment.

### **Key commissioning intentions in the strategy**

- (i) Core values and outcomes of residential and nursing care are developed with providers and service users

- (ii) A dignity charter is adopted, along the lines of the one found in Appendix 1
- (iii) A social partnership model of dialogue and consultation is established with providers that can mutually address matters of strategic intent, fees, workforce planning (including NMDS-SC) and training, quality and outcomes, and service user engagement.
- (iv) That the commissioning intentions of the PCT regarding the support that they can provide to people in residential care and their future intentions regarding continuing care funding are established in a partnership forum that is based on a statement of joint commissioning intent.
- (v) The strategy establishes a fair price for care in Halton with realistic arrangements for dependency premiums. A simple quality assurance system within the future service specification will place the onus on the care provider to provide evidence of quality outcomes for residents.
- (vi) The implications of CQC re-categorising support at home for people with various disabilities as registered residential care remains to be established. Advice will be sought from authorities where this has already occurred
- (vii) A re-profiling of the residential purchasing for people with learning difficulty will be undertaken as the research for the strategy shows this to be inequitable, dependency creating and unsustainable in the longer term. The work will be included under the ALD Housing and Support Strategy where it states under residential care: “For people who have lived in services for some time, providers will be encouraged to ensure they are given the same opportunities as everyone else to consider where and how their needs can be met in the future”.<sup>1</sup>
- (viii) The accommodation needs of people with dementia receive particular attention in the strategy and more is required. There will be further dialogue with providers to consider:
  - The accommodation options
  - Specialist (including health care) needs
  - Funding options and models
  - Particular needs of younger people with dementia
  - Workforce and training implications
  - Measuring quality and outcomes

### **The current market for residential and nursing care in Halton**

Currently the market is driven by spot purchase arrangements within a contractual framework agreement. Apart from an assessment and rehabilitation unit for older people all residential care is located within the independent sector. Consultation with providers demonstrated that they understand and accept the nature of the current contract; however they would welcome more and continuing dialogue regarding the development of the residential care market in Halton.

### **Market characteristics**

The current market is characterised by the following:

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<sup>1</sup> The people within the ALD residential/nursing homes are primarily from long stay hospitals and have lived there for many years.

The vast majority of residential and nursing care is for older people. There is however a small number of specialist homes for younger people and some use of external provision for particular specialist needs. There are also a number of homes that predominantly cater for the needs of older residents that also have CQC accreditation for providing PSD<sup>2</sup>, MH and LD beds.

Operationally, residential care budgets are managed separately along the lines of divisional structures (PSD, LD, MH and OP). This poses issues in terms of equity, but also problems when the needs of the service user over-ride the categorisation of service responsibility – e.g. young people with dementia, or older people with functional mental health problems. PSD and LD services pay significantly more for care home provision than OP services. For LD higher payments continue after the person reaches 65. However for MH and PSD services the responsibility for the budget transfers to OP services. This raises issues of equity and affordability.

The strategic intention is to effect improvements in the service and in equity by ensuring that assessment and procurement takes place from the part of the service that relates to the users primary presenting need. For example the older people's teams should assess someone with early onset dementia and conversely someone over 65 with a functional mental health problem would be best assessed by the mental health services.

The re-categorisation of need for some people to "Continuing Care" is having a significant impact on systems and budgets. Between the last quarter of 2007/8 and the end of quarter two 2008/9 the number of people who receive Continuing Care funding has doubled per 50,000 population.<sup>3</sup> The financial analysis up to period 10 this year indicates that this growth has continued. The PCT are contracting at a higher price than the local authority and this is leading to a shortage of beds for people within nursing homes. It would also appear that a considerable number of people who would previously have been funded by Halton Council are now being funded by the PCT. This is having a positive impact on the local authority budget and provides an opportunity to invest in residential social care.

The expansion of the number of people classified as Continuing Care is an opportunity to commission for residential and nursing care at the improved the fee levels intended.

There is a current premium payment for dementia care, which was introduced in response to the need for more dementia care beds. In period 5 of 2008-9 there were 93 dementia care payments out of 455 cases.

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<sup>2</sup> The terms PSD, LD, OP and MH are used for brevity in this report. The abbreviations are not intended to convey any disrespect. PSD is short for Services for people with a Physical and or Sensory Disability, LD is short for services for people with a Learning Disability, OP is short for services for Older People and MH is short for services for people with a Mental Health Problem.

<sup>3</sup> Numbers Receiving NHS CHC per 50,000 populations for Quarters 3 & 4 2007/8 and Quarters 1 & 2 2008/9. Source: Hansard.

There are substantial quality assurance processes in place, but there are no financial incentives to raise quality by paying a financial premium.

The residential and nursing contracting and procurement plans will in the long term be affected by the Accommodation Strategy – specifically any increase in supported housing<sup>4</sup>, supportive technology and the ability of the domiciliary care market to expand – both for private and contracted services. However it is not anticipated that over the short to medium term (1 to 3 year) that the Accommodation Strategy will have a major impact on the demand for residential care, especially for older people.

Commissioning and procurement plans will be affected by the acceptance and implementation of the 5 Boroughs Mental Health Partnership Strategy for Older People with Mental Health Problems. When implemented it is anticipated that more people will be supported in the community, or within residential care (as opposed to nursing home care).

The strategies of health partners involved in supporting residents with health needs has a significant impact on residential care – for example the degree and type of support care homes receive from district nurses, geriatricians, GP's, physiotherapists, dieticians and palliative care. Research indicates that these community services have an impact both on reducing residential care admissions, and also in sustaining people within residential and nursing homes and improving the quality of care. (Rowntree 2007).

Hospital discharge arrangements impact on the success of residential and nursing home placements.<sup>5</sup> These issues are being examined in the older person's commissioning strategy; however indication is that the arrangements in place in Halton are robust and effective.

In Halton people entering residential and nursing home care have a high degree of dependency and the local factors will have little impact in terms of number of admissions but the payment mechanisms will change.

There is little residential provision for PSD or LD within the borough, as the majority of support is within supported living or carers support at home.

### **Discussion – fee rates**

Consultation with providers and key staff within Halton Council acknowledge that the current rates are a significant impediment to achieving high quality care. At face value currently Halton pays £14.82 less per week than the comparator authorities for residential care, however when

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<sup>4</sup> The commissioning strategy for extra care housing compares Halton with four other local authorities and finds that Halton has significantly less extra care housing. The strategy estimates that 25% of older people currently in residential care could be accommodated in extra care housing. (This is based on a statistical analysis, not a case audit).

<sup>5</sup> Examples of this include community nursing "in reach" work, falls work, dieticians.

the “average” actually paid by the other local authorities is considered Halton pays £29.67 per week less than the comparator authorities. (This takes into account premium payments in other local authorities.) Halton currently pays £394.20 for residential care for people with dementia, this compares with the average of £402.43 for comparator authorities and £411.32 for comparator authorities when average premium figures are taken into account. In other words Halton currently pays £17.12 per week less per week than comparator authorities for dementia care. The table below illustrates this:

Premium rates apply	Local Authority	Column 1 Residential rate without premiums	Column 2 Residential with premiums	Column 3 Residential Dementia rate	Column 4 Dementia rate with premium
	Liverpool	322.00	322.00	394.20	394.20
Standard	Warrington	333.00	347.00	376.00	395.00
2*	Wirral	360.64	388.36	389.69	417.41
	Cheshire	367.64	367.64	446.39	446.39
	St Helens	350.00	350.00	409.00	409.00
2*	Manchester	373.54	382.88	388.54	403.54
Average	Lancs	362.00	387.00		
2*	Sefton	324.40	370.00	413.17	413.70
	<b>Average</b>	<b>349.15</b>	<b>364.00</b>	<b>402.43</b>	<b>411.32</b>
	<b>Halton</b>	334.33	334.33	394.20	394.20

**Table 1 Fee rates for some comparator authorities 2008-9**

There are four columns:

1. Standard residential rate older people, without any premiums
2. Standard residential rate for older people, that includes “reasonable” premiums where they apply. For example the Wirral pay a premium for achieving 2\* CQC. As 2\* is the most common CQC score then the assumption has been made that on average Wirral pay the 2\* premium rate.
3. Residential Rate + dementia rate (without premiums). This is column 1 + the dementia premium rate where it applies.
4. Residential rate + dementia premiums. This is column 2 + the dementia rate.

Laing and Buisson provide the only accepted costing calculator for older people’s residential care. Their figures for an area such as Halton are that the minimum cost of residential care is £463 per week (where the physical environment reaches minimum standards) and £491 for a higher physical standard. For people with dementia the costings are calculated as £491 for minimum physical standards and £566 for enhanced physical standards. (Laing and Buisson 2008).

Comparisons are difficult because Halton admits approximately 50% less per 100,000 people age over 65 into residential care than many neighbouring local authorities, and approximately 25% less than the North West average.

Nationally Halton is 10% below the national average. This leads to the conclusion that people admitted to residential care in Halton are more dependent, which has significant cost implications for providers and in terms of residential care is a cost saver for Halton. Admission rates for the under 65 age group are even lower per 100,000 population than those for the over 65's.

<b>Local authority</b>	<b>Number of people aged 65+ admitted to residential care per 100,000 population</b>
<b>Halton</b>	<b>661</b>
Warrington	1172
<b>North West Met District average</b>	<b>915</b>
<b>North West Regional average</b>	<b>818</b>
<b>England average</b>	<b>707</b>
Bolton	500
Bury	608
Knowsley	1092
Liverpool	1157
Manchester	981
Oldham	768
Rochdale	559
Salford	788
Sefton	996
St Helens	1362
Stockport	512
Tameside	986
Trafford	934
Wigan	739
Wirral	1412

**Table 2: Number of people aged 65+ admitted to residential care per 100,000 of the population  
March 2008 figures**

Halton currently limits annual uplifts to the annual increase that local authorities receive from government. Some authorities have worked with providers on cost models, both for basic price, and for enhancements, including a formula for annual uplift. <sup>6</sup>

### **Out of area placements**

These are currently the responsibility of care management. Halton Council support the policy of giving individuals choice of where they live, which includes living in a home located in another

<sup>6</sup> It needs to be noted that the sector has limited scope for efficiency savings because of the high degree of regulation, for example staffing levels, CRB checks, GSCC registration, nutrition standards, physical accommodation standards and qualification levels of staff.

authority. Most residents of Halton choose to live in Halton, and indeed there is a considerable preference expressed as to which side of the river. (In 2007-8 there are a total of 78 people supported to live outside the area out of a total of 420. There are some people for whom specialist services are required, e.g. younger people with brain injury who require rehabilitation.<sup>7</sup> It is unlikely that there would be sufficient demand within Halton to provide this sort of specialist provision. This particular need represents a growing budget pressure as head injuries are increasing.

### **Residential care for people with a learning disability**

There are very few external placements made for people with a learning disability.<sup>8</sup> The total number of people with a learning disability as of March 2008 in residential or nursing care supported by Halton is 40 people under the age of 65 and 4 people aged over 65. In Halton, 4 residential homes offer a total of 23 beds and 2 nursing homes offer 12 beds solely for adults with learning disabilities. The homes tend to be small, the largest has 8 beds; many of these residents use day care facilities in addition. The issues of whether the higher fee levels paid are justified for people who are able to use day care will be the subject of further exploration as the strategy develops. One large residential home retains 1 bed and a large nursing home retains a further two beds for adults with learning disabilities.

### **The market for residential care for people with a physical disability**

Numbers in Halton in permanent residential care are well below the regional average and below average by national standards.<sup>9</sup> Halton Council and the PCT have been jointly reviewing people in residential and nursing care and are aware of 1 person who might be able to be discharged into the community.

Respite care can be an issue as the number of places are limited, however it is considered not worth having any block booking. Most people with a physical or sensory impairment prefer to arrange their own respite with external providers. This preference is likely to increase with individual budgets and direct payments.

### **The market for residential care for older people**

Older people's residential and nursing placements account for approximately 90% of admissions and of total numbers. Halton is placing about 50%, in comparison to some neighbouring authorities, of its total number of older people per 100,000 people in residential

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<sup>7</sup> There were 6 temporary admissions in 07-08. The admissions tend to be acquired brain injury people requiring specialist support. This would tend to be external placement for period of rehabilitation and then discharged into residential and nursing or community living in Halton

<sup>8</sup> CSSR returns show 12 people supported externally in 2008, 11 in 2007, 10 in 2006. Only 2 of these were permanent. Only 2 permanent admissions in 2008 into residential / nursing home care (external or internal) No "in house" placements .

<sup>9</sup> DH returns show a total of 5 people supported in residential and nursing care in 06 and 07, and 8 in 07-8. Five of the 8 people supported are placed externally. There were 2 admissions to permanent residential care in 07-8. There were 6 temporary admissions in 07-08 (Finance department state 16 in 07-08 These figures need reconciling)

care.<sup>10</sup> The implications for admissions to care in Halton compared with neighbouring authorities are:

- People entering care in Halton are more dependent.
- Halton are admitting people to residential care who need two people to affect a physical transfer, whereas in St Helens for example all people requiring two persons moving and handling assistance go into nursing care. (Similarly with support in the community)
- People entering care in Halton will be likely to live for a shorter period.

Given that Halton residents are more likely to have higher dependency levels, the implications of costs incurred by providers is recognised in the strategy. Intermediate care to assess people is being used effectively in Halton. For example in Warrington and St Helens people are not being assessed for intermediate care if they are deemed likely to need residential care on discharge from hospital. The sector has significant vacancies for standard residential care, (although this is not true for all homes), which is likely to continue and probably increase, particularly as the previously less dependent residents placed a few years ago die or move to nursing home care. The demand for residential care in the future will be for those people who are most dependent, particularly with dementia care needs, or dementia care with physical needs as well.

Currently Halton have a mix of large (part of a regional or national chain) and small providers, (Locally based owner managed homes, with a maximum of two other homes). CQC scores are reasonable for most homes and are somewhat above national averages. There are 7 \*\*\* star homes, 15 \*\* star homes, 3 \* star homes and 1 not yet rated. Broadly the star ratings accord with people's experiences and generally the homes with high scores have fewer vacancies than those with low scores.

There is a shortage of registered dementia care or nursing home places. (In part this is a function of the impact of PCT purchasing of Continuing Care beds). There are no block contracts for respite care, which means that people, at times, have difficulty in finding respite care.

The Alzheimer's Society (2007) estimate that two thirds of people in residential care homes have dementia, but only 60% of this figure is in registered dementia beds. Darton (2006) states that 45% of care home residents have moderately severe to very severe cognitive impairment. The situation in Halton is likely to reflect these national figures. Dementia is the strongest determinant of entry into residential and nursing care for the over 65s. This figure is likely to increase as people with lower level needs are continued to be supported to live at home.

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<sup>10</sup> 2007 returns, a further significant reduction is predicted in 2008-9.

A primary strategic intention is to gear contractors up to providing good dementia care.

### **The market for residential care for people with mental health problems**

A whole systems review of mental health care is taking place, which will include a review of residential and nursing care. Information obtained to date indicates:

- There are a number of people currently placed in specialist accommodation out of area. For some, this is the most appropriate accommodation but for a small number of individuals, it is due to a lack of intensive supported accommodation within Halton.
- There are a number of people in residential care in Halton who are being assessed as suitable for supported accommodation in the community. The consequence will be independent sector over-provision.
- Younger people with dementia are posing issues for mental health services and in terms of assessment and service planning are best supported by older people's services.

### **Outcomes for service users**

In terms of outcomes for citizens Halton wants to offer both choice and services that place people's individual needs at the centre of provision.

Halton wants to commission services that:

- Are high quality
- Offer value for money
- Have sufficiency of supply
- Are as local as possible to the individual's preferred geographical location
- Serve both individuals purchasing their own care and people accessing care via care management
- Enable the market to respond effectively to the changing needs and desires of people who use services
- Best meet people's needs for specialist support
- Are evidence based in terms of best practice.

There is a specific dialogue with the PCT around their strategic intentions regarding continuing health care in care homes and how a joint approach to commissioning and funding may benefit everyone in the longer term. Consultations with the PCT include the arrangements for the provision of continuing health care support in care homes and as a part of support to people at home

## Outcomes for service users

There is considerable guidance on best practice in the commissioning of services. However, there is little good quality research about which commissioning strategies are the most effective. The IDeA and CSIP guidance stress a comprehensive approach and this strategy follows that approach. Current government policy documents such as **Putting People First** (2007), and **Transforming Social Care** (2008) are the foundation. These provide the implementation strategy for the Green Paper, *Independence, Well-being and Choice* (2005) and the White Paper, *Our health, our care, our say: a new direction for community services* (2006). The changes that will result by 2010/2011 will have major implications for many aspects of commissioning. The plans resultant from this strategy is compatible with the whole system changes that must also be planned in the relatively short term. For example individual budgets will have an impact in re-configuring services over the next five years. Initially, the main impact in Halton will be on services in the community followed by residential and nursing home care – particularly for older people.

There are high-level outcomes for all those using health and care services defined within the white paper *Our Health Our Care Our Say*. Therefore the determination of local outcomes needs to be undertaken with the intent of contributing towards the overall achievement of these outcomes, which are:

- Exercising Choice and Control.
- Improved Health and Emotional Wellbeing.
- Personal Dignity and Respect.
- Quality of Life.
- Freedom from Discrimination and harassment.
- Making a Positive Contribution.
- Economic Wellbeing.
- Leadership and Management.

Determining and agreeing local outcomes in Halton will be undertaken at two levels:

- General outcomes that are in line with locally agreed priorities and are of broad benefit
- Individual outcomes agreed with service users.

Individual outcomes will be determined through the assessment and care planning process and will be clearly identified and measurable, so that effective monitoring can be undertaken. The results that individuals want to achieve from using services will vary according to personal circumstances, but may include:

- Greater access to community based services
- Feeling safe
- Being more independent

- Meeting more people.

The capacity to measure progress and achievement of individual outcomes is essential to outcome based commissioning. Halton Council use care plans to identify outcomes with individuals and all the residential homes use the care plans and develop them further. Providers recognise the importance of care plans that define individual outcomes. The use of care plans will be stressed in the service specification as central to quality and work undertaken to ensure that care plans are used as an active tool to meet the needs and aspirations of all individuals. The providers are very positive about the relationship with social workers.

The achievement of outcomes in care plans to determine fee rates have been considered in developing the strategy. There are examples of some learning disability services where fee levels have been determined by care assessment but not to link fee levels to the achievement of agreed outcomes. This approach has not been pursued, as there is a danger that the process could become too bureaucratic and relationships with and between providers could be damaged by disagreements over measuring achievements. Many of the residents in residential or nursing services in Halton will by definition of their medical conditions deteriorate physically and mentally. The effort of commissioning and contracting staff in the borough will focus on making sure everyone works together in ensuring person centred care.

## **Partnership Working**

Partners include

- People who use, or may use services in the future and their relatives and friends<sup>11</sup>
- Health – both the PCT and the provider Health Trusts
- Housing
- Leisure – activities for people in care homes are vital for quality of life
- Employment where this is relevant
- Current and future providers.

The IDEA model of commissioning states: “A cornerstone of implementing good purchasing has to be the quality of relationships between commissioners and providers. These will have been reinforced by providers’ involvement in drawing up and commenting on elements of the

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<sup>11</sup> Providing information about services and access to them.

- Involving users and carers needs to take place at several levels:
- Involving users in decisions about their own individual care
- Involving users in the development of quality standards and monitoring how services are delivered.
- Involving users and carers in future service development and commissioning.
- Use of the Complaints and Compliments Process.

commissioning strategy”.<sup>12</sup> The development of the strategy has included some dialogue with providers and this draft strategy is a platform for further consultations.

## **Contracting plan**

A set of core values, couched in outcome terms, for individual service users is the foundation of the strategy and the service specification. At the heart of these outcomes is dignity for those who use services. It is recommended that a set of core values and outcomes for residential and nursing care are adopted. The core values are found in Appendix 1.

The following sections of the strategy are derived from research, consultation with providers and other stakeholders, data analysis and dialogue with key Halton Council staff. They highlight in broad terms how the commissioning intentions and the outcomes for services users will be delivered through a contracting and procurement plan for residential and nursing care in Halton over the next few years.

## **Managing the market**

To effectively manage change within the procurement and contracting process there need to be a range of approaches

- A view of residential care that is holistic – including leisure, environment, mental and physical well being.
- A systematic strategy to engage partners with the aim to improve quality (DH 2001). The strategy needs to include the providers contribution to design, delivery and continuous improvement
- A strategy that supports innovation and risk taking, whilst ensuring that people are safeguarded.

## **Developing specifications**

Examples of contracts and specifications from a number of local authorities have been evaluated. They all have strengths and weaknesses. Specifying services in Halton will be a collaborative process and include both service users, at a general and an individual level, as well as providers. The inclusion of providers is an important part of building relationships and developing the market and can be achieved.

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<sup>12</sup> CSIP recommend that the following factors are agreed between commissioners and providers:

- an understanding of costs
- understanding of capital investment costs and risks
- performance monitoring
- process for deciding upon future expenditure and investment
- approach for considering the costs of the providers risk and hence reward
- a local workforce plan based on the NMDS-SC that ensures sufficiency of both supply and quality.

CSIP<sup>13</sup> recommend simplicity, fairness, equality, efficiency, sustainability, proportionality and suitability in contracts and specifications. Halton is following these principles and is producing a simpler specification as an alternative to that in current usage.

The proposed specification makes clear the required CQC ratings to be maintained by any service provider, so that a 'good' rating is the required minimum, with an 'adequate' or "poor" rating triggering a contract review and improvement plan. If there is a failure to improve then penalties will be applied - ultimately a revocation of the contract.

## **Monitoring**

The monitoring of contracts and specifications is more difficult when using an outcome-based approach. It is easier to measure outputs than to measure outcomes, but it is possible to develop systems and processes that can measure progress towards achieving the stated outcomes. The individual review process is the key to effective monitoring of individual outcomes; however the process is only effective if reinforced by commissioning, procurement and quality assurance mechanisms. The monitoring process will also take into account the QA processes of CQC and reflect the quality ratings awarded by the inspectors. There is a national recommendation that local authorities do not increase their contract monitoring to take account of a reduced inspection level for high rated providers. The overall effect of a substantive increase in monitoring for good providers would negate the reduction in bureaucracy intended by the ratings system. However, it will still be essential to have a contract monitoring system robust enough to ensure that:

- The amount of service being paid for is the amount that is being delivered
- The service users for whom Halton is paying, either directly or via a direct payment or individual budget, are satisfied with the quality of the service that they are receiving
- Individual service users' outcomes as set out in their care plans are being met
- Services do not simply stand still, but demonstrate development and improvement.

The view from the provider consultation was that the contract monitoring is excessively bureaucratic, time consuming and repeats quite a lot of the CQC inspection. . The providers all spoke highly of the care review process and they felt that this should be integral to quality assurance. The quality assurance and contract compliance role has been developed along these lines and improved monitoring of services is to be implemented that will involve greater observation of services and interaction with service users.

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<sup>13</sup> CSIP Fairer Service Specifications June 2007 states contracts and specifications should be based on the following fundamental principles:

- Simplicity: plain English wherever possible, with clear explanations of jargon.
- Fairness: reflecting a fair and proper balance between commissioner and provider, with risk properly allocated.
- Equality: contracts should be the same for every sector.
- Efficiency: enabling commissioners to achieve quality services at value for money costs.
- Sustainability: embodying a general approach to a proper working relationship which fosters sustainable, long-term provision (where appropriate) in the interests of service users.
- Proportionality: achieving what is necessary or highly desirable in the simplest possible way. Document length should be reduced as much as possible and the "kitchen sink" approach abandoned.
- Suitability: reflecting the service that is required and the actual agreement between parties.

The role of the local authority in supporting providers to improve was raised in the consultations. It is a role that reduced with the externalisation of inspection. Some authorities have filled that vacuum by creating posts that concentrate on supporting providers; others have supported the setting up of a residential association, or workforce support group. Providers in Halton have been reluctant to go down these routes. Further work will be undertaken with providers to establish the reasons for the reluctance to engage, as the benefits can be significant.

At the heart of monitoring is the definition of good quality care. There is a body of research that states that the key issues that drive quality are: good management and leadership, effective management policies for communicating with staff, central to which are effective supervision and appraisal, effective team work, staff feeling valued and a philosophy of care that places the needs and wishes of the resident at the centre. Additional key elements are effective care plans that are used all the time and are understood by all staff in the homes as well as involvement of outside professionals and residents and families. Effective care plans enable choice and independence to be enhanced.

Currently there is over supply of standard residential care in Halton, although this does not apply to all homes. There is a shortage of nursing and dementia care, with some placements having to take place out of borough. The PCT funding of continuing care is increasing the pressure on beds for people with dementia care but overall has a positive impact on the pool of money available across the borough.

The level of private purchase of residential care is not known precisely, however information from the providers indicates that as a proportion of overall beds the number of privately funded individuals is not great. Some providers state that private purchasers are subsidising Halton BC service users. A number of providers also charge a “top up” fee for Halton BC service users. Similarly the level of service provided to private purchasers is not known; in part this may depend on the level of fees charged.

Work has been undertaken to compare Halton’s current provision related to some comparator authorities and against national averages. In summary Halton is regionally a low provider of residential care per 100,000 of the population

Other factors that will impact on the future demand for residential and nursing home care will be the development of alternatives to residential care. For many people there will be no realistic alternative to entering residential care, however for some people admission to residential care may be delayed or prevented. (Halton is a low provider of residential care, but there are authorities with even lower levels of residential and nursing home care). Some of the possible alternatives to residential care are detailed in Appendix 4.

In summary it is anticipated that there will be a continued reduction in demand for residential care that is financed by Halton Council over the next three to four years,. It is anticipated that number of people requiring residential and nursing home care with high level dependency needs as a proportion of the overall figure will increase. Several providers are working with Halton to make changes in the registration in anticipation of future demand

### **Commissioning for quality and price**

Achieving quality can be progressed in a number of ways. The likelihood is that a holistic approach to achieving quality is needed. There has been little objective research on the impacts of various approaches to improving quality. This is in part because there has not been consensus on defining good quality care, measuring quality, or looking at the impact of other factors. Wanless (2006) states that councils will need to engage in long-term relationships with a wide variety of providers. It is Halton's intention to do this.

### **Improving residential and nursing care**

Home from Home (2007) indicates that there is a lot of variation in the quality of care a person might receive in residential and nursing homes. "Some homes are clearly doing a fantastic job, but why is this not the case for all?" The experiences of carers reported tell that it is the people delivering that care that matters the most. Home from Home states that, "Many homes are still not providing the level of person centred care people, particularly with dementia deserve". Key problems include:

- Poor provision of activities and occupation
- Not treating residents with dementia with dignity and respect
- Relationship between care home and relatives or friends
- The support from external specialist services, e.g. OPMH teams, is unacceptably variable.<sup>14</sup>

One quarter of care home managers said that accessing advice from external services is one of the top three challenges in providing good care. My Home Life looks at things within care homes that can be done to improve quality of life. The report states that there are five essential processes for creating good quality care:

1. Understanding that communities are created through relationships between residents, family, friends, staff and the wider community
2. Recognising roles, rights and responsibilities and the need to balance risks
3. Creating opportunities for giving and receiving
4. Creating opportunities for older people to realise their potential
5. Establishing a community atmosphere.

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<sup>14</sup> One third of care home managers reported no support or very limited support from the local older people's mental health service Home from Home (2007).

The above points were reported within the context of adequate resources to provide that care. CQC and others have made progress towards defining quality of care in terms of outcomes or person centred care for the service user. However one of the key challenges is the methodology for measuring success in an outcome performance system. For example many people living in care homes are often not able to express opinions about the quality of their care because of their dementia and/or because critical appraisal of an organisation that one is dependent on is not easy. CQC have developed a tool called SOFI with the aim to try and capture, in a systematic way, the experience of care for people who use services who would otherwise be unable to communicate this to an inspector. The SOFI system relies heavily on observation of interactions and behaviours. SOFI clearly is an effective tool, however using such an approach is time consuming and expensive.

Quality in residential and nursing care cannot be completely defined in terms of outcomes because there are statutory (national minimum) standards that must be adhered to. These standards include physical minimum standards and minimum standards in terms of management and organisational processes. There is good evidence that good physical standards and good management and organisational processes do have an impact on the quality of care. For example there is strong evidence that good leadership and human resource management practices influence outcomes. There is also evidence that at their core services are as good as the people who are delivering them. Therefore a well-motivated and trained workforce, including managers, is essential. Commissioning needs to maximise the opportunities for staff to be trained and motivated. Adequate staffing numbers, with few temporary or agency staff is an important determinant of good quality (Skills for Care 2008).

Another factor that appears to influence outcomes in terms of quality for users is the pay of staff. Within the sector most care workers are paid at, or slightly above minimum wage. There is evidence that where staff are paid higher, after adjustment for regional variations in pay rates, then quality as defined by CQC scores is higher (Skills for Care 2008).

### **Specialist dementia care**

Currently there is a lot of interest in dementia care and correspondingly in how dementia care is best provided in a care home. One of the options is specialist units, or specialist homes, as opposed to homes that support people with dementia as part of the overall service. There are pros and cons to both views and the research evidence is somewhat limited. There are also cost implications for providers in operating specialist units. Overall there appear to be benefits in having specially designed units for people with dementia. However there does need to be a degree of caution. Not all units are good, there are implications for residents and staff in the non-specialist parts of homes and the development of units can be expensive. In Halton some

of the homes would not be suitable to adapt. Creating specialist units is a complex process as there is considerable evidence that certain factors in the physical environment assist people with dementia. There are also significant staffing issues – considerable investment in training is needed and there may be recruitment issues linked to the low level of wages currently paid.

For dementia care, better performing homes tend to be smaller in size, but not exclusively. Homes that specialise in the care of people with dementia, or have a dedicated unit do appear to improve outcomes for people with dementia; however such specialism does not guarantee improved outcomes (CSCI 2008).

Research indicates that many persons with dementia can be served equally well in either setting. However, those with major medical care needs benefit from nursing home residence. The implications of this are that it does not make sense to have a different price level for dementia care in nursing homes or residential homes.

### **Quality premiums**

An increasing number of local authorities use a premium payment system to reward good quality care.<sup>15</sup> The problem lies in defining “good”. Authorities have approached this in a number of ways. The most common is to use CQC scores to trigger premiums. Others use another external measure such as ISO, IIP, number of staff qualified, or a combination of these factors. Another system that is popular in some local authorities is the use of the RDA performance system.

A caveat to the above position on rewards for performance is that there does need to be recognition that the CQC model to assess quality is methodologically sound and that there does need to be recognition of the importance of the CQC star rating system. CQC scores, as reported in the LAMA and CRILL also impact on the overall performance scores of local authorities. In Halton the CRILL and LAMA is reasonable to good. There are specific areas of improvement to be noted including staff training, qualifications, activities and quality assurance systems.

The contract will state that all providers need to achieve “good” or “excellent” ratings. This objective will be realised within the first 12 months of the issuing of new contracts. Halton Council will work with providers to help them improve their CQC rating. If however residential homes fail to achieve a “good” or “excellent” CQC rating, following a period of support then the Council reserve the right to reduce the fee rates until higher scores is achieved. If a home is

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<sup>15</sup> UK councils are increasingly using quality criteria to determine fees for care home providers, but there are concerns the practice is being used to cut costs, market analysts Laing & Buisson. A survey of 151 councils by its monthly publication, [Community Care Market News](#), found that a quarter had linked fees for older people’s care homes to quality criteria in 2008-9. But it suggested as many as three-quarters could be doing so by the start of 2009-10.

assessed as “poor” the Council will work with the provider and CQC to improve the performance. The Council however reserves the right not to place people within the home until there is an improvement.

Transparency is needed for people entering residential care. The Office of Fair Trading (2004) criticised local authorities and Government for failing to provide sufficient transparency regarding charges, both for those people who are self-funders and those who are eligible for financial support from the local authority. The contract with providers will ensure that providers are transparent regarding charges, particularly “top ups” and charges for additional services.

### **Partnership work and quality of care**

A partnership approach with health to support residents has a positive impact on quality. It makes sense for residential and nursing home care to be jointly commissioned by the PCT and Halton Council, with a joint budget. The broader commissioning strategy for older people will consider that option.

The future demand for care and types of care will be discussed in detail with providers as well as price and quality issues. In Halton there has been a limited relationship with providers at the commissioning level. Work with providers, and indeed neighbouring councils, will be instigated to develop a strong workforce development partnership, along the lines of the Black Country Partnership for Care<sup>16</sup> Providers acknowledge the considerable improvements in training that have taken place as a result of the work of the training and development section of Halton Council. They consider however that there is considerable scope to develop this work.

### **Summary and next steps**

Ideally the commissioning strategy for the purchase of residential care should flow from the wider community strategies. However practicalities dictate that procurement plans need to be laid down ahead of work on Joint Strategic Needs Assessment and user led outcomes based commissioning strategies geared to a personalised model of support and funding. This strategy documents the immediate approach to procurement of residential care and how this must remain cognisant of changes consequent of personalisation and individual budgets.

1. The initial financial modeling has been completed and the resultant, indicative fee rate including dependency premium, has now received formal approvals
2. The strategy is to be used as the basis for a further consultation process with stakeholders.
3. Assessment tools to ascertain the levels of mental and physical health needs of all service users who are being assessed for residential care will be used to contribute to the identification of individual outcomes. Initial feedback from providers to this aspect of the

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<sup>16</sup> Black Country Partnership for Care <http://www.skillsforcare.org.uk/view.asp?id=973>

strategy is positive and more details of the proposals will be shared in the second consultation phase.

4. Work has begun on considerations for the contract and specification for residential and nursing home care based on the strategy.

## **List of Appendices**

1. Proposed Dignity in Care Charter including dignity monitoring and CQC standards
2. Demographic Data - Population information for Halton – from POPPI
3. Admissions to residential and nursing homes – comparative data
4. Monitoring and managing the market
5. Five Boroughs Mental Health Partnership – plans for older people with mental health needs.
6. Dementia care - do specialist units enhance the quality of life?
7. Financial Summary
8. References and bibliography

## Appendix: 1

### Proposed charter: Dignity in Care.

This Charter should be seen as complementary to National Minimum Standards for Older People and CQC inspection methodology.

Outcome	Process	Measures	CQC outcomes	Target	Who responsible
<p><b>Dignity</b></p> <p>Each resident is treated with respect and as a unique individual and each individual feels that they matter.</p>	<p>Care plans are used as a working tool.</p> <p>All staff receive training and support to achieve these aims</p>	<ul style="list-style-type: none"> <li>○ To be seen at reviews</li> <li>○ CQC reports and AQAA</li> <li>○ Provider quality assurance</li> <li>○ sample of care plans</li> </ul>	Standard 7, 8, 10	Care plans demonstrate that they are used as a working tool CQC 2 * <sup>17</sup> or above	Care Managers (CM) Contracts Unit (CU) Providers
	<p>Providers ensure that all staff know the individual history of each resident that they work with and their likes and dislikes.</p>	<ul style="list-style-type: none"> <li>○ To be observed at reviews (CM)</li> <li>○ CQC reports / AQAA</li> <li>○ Contract compliance unit to see a sample of care plans</li> </ul>	Standard 7,8,10, 14	All staff have knowledge of the residents they are working with CQC 2 * plus All care plans demonstrate that staff have knowledge of individual	CM CU Providers

<sup>17</sup> CSCI becomes Care Quality Commission in April 2009. Reference to CSCI would change to reference to CQC

				histories	
	Providers support residents and their relatives to give their views on whether residents are treated with dignity and to identify areas for improvement	<ul style="list-style-type: none"> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> <li>○ AQAA</li> <li>○ Contract compliance CU to interview sample of residents / relatives / advocates<sup>18</sup> and to make observations</li> </ul>	Standard16	CQC 2 * plus	CU If residents group CU to garner views Providers
Each resident feels safe from any form of abuse	All care staff, residents, families, advocates and other professionals have an understanding of abuse and to know what action to take if they witness abuse. (Where an individual has no next of kin, or contact with a next of kin, or “significant other” consideration must be given to independent advocacy. The issue of advocacy must be recorded in the care plan).	<ul style="list-style-type: none"> <li>○ Staff training records</li> <li>○ Information given to all relatives and others (To be confirmed in sample surveys)</li> <li>○ AQAA</li> <li>○ policies and procedures are in place in the home regarding abuse</li> <li>○ Selected interviews with staff (CC)</li> <li>○ Selected interviews with relatives etc (CC)</li> <li>○ Selected interviews with residents (CC)</li> <li>○ Care plan to contain evidence of action regarding advocacy if</li> </ul>	Standard 18	No substantiated complaints CQC 2 * plus	Complaints Unit CU Providers

<sup>18</sup> Reference to residents, relatives, significant others, advocates applies to all the references to contact compliance

		<ul style="list-style-type: none"> <li>o required (CM)</li> <li>o Contract monitoring regarding policies and procedures</li> <li>o CQC and AQAA</li> </ul>			
<p><b>Respect</b></p> <p>Each resident feels that they are treated with respect. Residents are treated with the same respect people want for themselves or members of their family</p>	Staffs ensure that residents are listened to and are treated with courtesy and not patronised.	<ul style="list-style-type: none"> <li>o Views of residents and relatives recorded at reviews and actions incorporated into care plans (CM)</li> <li>o CQC reviews</li> <li>o Provider quality assurance</li> <li>o Interviews with residents and relatives</li> </ul>	Standard 8,9,10	No substantiated complaints All views are positive, or if not plans in place to improve CQC 2* plus	CU CM Providers
Residents have and feel that they have the right to have relationships	Staff are encourage residents to have relationships with other residents and people outside the home	<ul style="list-style-type: none"> <li>o Care plans</li> <li>o Reviews</li> <li>o Selected interviews with residents and relatives</li> <li>o Provider quality assurance</li> </ul>	Standards 12,13,14	CQC 2 * plus No substantiated complaints	Providers ,CU, CM
Residents feel that they are treated as an individual with their own needs, wants desires and expectations	Each person is supported by staff to express their individual preferences and their preferences are acted upon	<ul style="list-style-type: none"> <li>o Care plan (CM)</li> <li>o Reviews (CM)</li> <li>o Provider quality assurance</li> <li>o Selected interviews with residents and relatives</li> <li>o Selected interviews with staff</li> </ul>	Standard 14	CQC 2 * plus No substantiated complaints	CM CU Providers
<b>Privacy</b>	Staff encourage residents to demonstrates	<ul style="list-style-type: none"> <li>o Care plans</li> </ul>	Standard	CQC 2 * plus	CM

Residents feel that they can have privacy and autonomy	their wishes regarding privacy and autonomy	<ul style="list-style-type: none"> <li>○ Reviews</li> <li>○ Provider quality assurance</li> </ul> Selected interviews with residents / relatives	8,9,10		Providers, CM
Residents feel that they are maintaining their independence, choice and control whilst managing any risks	Staff to encourage residents to do things for themselves, and exercise choice, even if this takes longer than doing things for people. The degree that people will want to do things for themselves and exercise choice will vary. A process for managing risk is used	<ul style="list-style-type: none"> <li>○ Care plans, which include risk assessments (CM)</li> <li>○ Reviews</li> <li>○ Selected interviews with residents and relatives</li> <li>○ Selected interviews with staff</li> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> </ul>	Standard 3,12	CQC 2* plus	CM CU Providers
Residents feel that their likes and dislikes are met	Staff ascertain each residents likes and dislikes to ensure that care is personalised.	<ul style="list-style-type: none"> <li>○ Care plans,</li> <li>○ Reviews</li> <li>○ Selected interviews with residents and relatives</li> <li>○ Selected interviews with staff</li> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> </ul>	Outcome 12,14, 15	CQC 2 *	CM CU Providers
People do not feel lonely and isolated.	Residents are encouraged and supported to have meaningful relationships with others.	<ul style="list-style-type: none"> <li>○ Care plans,</li> <li>○ Reviews</li> <li>○ Selected interviews with residents and relatives</li> <li>○ Selected interviews with staff</li> <li>○ CQC reports</li> </ul> Provider quality assurance	Outcome 12,13,14	CQC 2 * plus	CM CU Providers

Residents feel that they are given meaningful choice	Staff give a personalised service and treat each person as an individual Staff listen and support people to express their needs and wants Staff engage with family members, carers and care partners where this is appropriate	<ul style="list-style-type: none"> <li>○ Care plans,</li> <li>○ Reviews</li> <li>○ Selected interviews with residents and relatives</li> <li>○ Selected interviews with staff</li> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> </ul>	Standard 8	CQC 2 * plus	CU CM Providers
Residents feel that they are citizens and have the rights and responsibilities of citizens, including the right to complain without fear of repercussion	Residents are supported and encouraged to maintain entitlements associated with citizenship. Residents and their families know how to complain without fear of repercussions	<ul style="list-style-type: none"> <li>○ Selected interviews with residents and relatives</li> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> </ul>	Standard 16	CQC 2 * plus No substantiated complaints	CU CM Providers
Residents feel as fulfilled in their life as they can be	Staff assist residents to maintain confidence and a positive self esteem Staff support residents to achieve personal aspirations	<ul style="list-style-type: none"> <li>○ Selected interviews with residents and relatives</li> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> </ul> <p>Care plans and reviews</p>	Standard 12	CQC 2 *	CM CU, Providers
Residents feel they have choice in what they eat and when they eat it Residents enjoy the food	Residents are supported to make choices about their food The importance of good food in residents lives is recognised by all staff Staff understand the importance of good nutrition	<ul style="list-style-type: none"> <li>○ Selected interviews with residents and relatives</li> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> <li>○ Contract compliance</li> </ul>	Outcome 15	CQC 2 *plus	CM Providers CU

Residents feel well supported by all staff	All staff are recruited and trained to meet the needs of all residents as individuals <sup>19</sup>	<ul style="list-style-type: none"> <li>○ CQC reports</li> <li>○ Provider quality assurance</li> <li>○ Contract compliance</li> <li>○ Selected interviews with residents and families</li> <li>○ Care plans and reviews</li> </ul>	Outcome 27,28, 29	CQC 2* plus	CM CU Providers
Policies and procedures will be in place to support Dignity In Care, to challenge discrimination and inequality, and to respect individual needs, covering <ul style="list-style-type: none"> <li>• Whistle blowing</li> <li>• Equal opportunity</li> <li>• Complaints and compliments</li> </ul> Safeguarding adults.		All CQC standards met	Standard 18	CQC 2* +	Providers, CU, CM
<b>Commissioning</b>					
Involve all stakeholders and partners, including users, carers and providers, to commission high quality personalised care	Consultation in commissioning process, On going work through the life of the contract	Feedback from providers		CQC 2* +	CU, Providers, users and carers CM

<sup>19</sup> Those who commission services and those who provide them have a responsibility to ensure services are properly staffed and funded and are properly trained, vetted, supervised and supported

**The above will be supported by an approach to commissioning that is based on the following principles**

### **Principles of Commissioning**

- **Service user focus.**

Services exist only to meet the service users / residents needs.

- **Realism about cost and price.**

The aim of procurement is to obtain the best service at the best price for the local authority and the people for whom it acts as agent. Such prices and market structures must give providers financial viability, including an acceptable profit, return on investment or full cost recovery.

- **A long-term view.**

Services cannot develop if providers are uncertain whether they will remain in business in two or three year's time. Strategies and contracts must cover sufficiently long time periods to enable meaningful medium to long-term plans to be thought out, agreed, implemented and reviewed.

- **Firm but fair.**

The local authority, as purchaser, has duties of care about both the needs of vulnerable people and finances. It must monitor service quality and evaluate service effectiveness using evidence-based, benchmarked criteria. Performance against such criteria can then be used to either commend excellent providers, and to improve, or ultimately terminate, poor providers.

- **True partnership.**

The local authority must be prepared to give up power, trust the providers' professionalism and competence and work in a way that acknowledges, reinforces and rewards the mutual dependence that exists between purchaser and providers.

- **Mutual awareness and respect.**

The local authority must understand and respond to the commercial realities that providers work within. Equally, providers must understand the mechanisms, vagaries and pressures on local authority funding and budgets.

## CQC standards

### 1. Improved health and emotional well being - Choice of Home (Standards 1–6)

#### Standard 1

Prospective service users have the information they need to make an informed choice about where to live.

#### Standard 2

Each service user has a written contract/statement of terms and conditions with the home

#### Standard 3

No service user moves into the home without having had his/her needs assessed and been assured that these will be met

#### Standard 4

Meeting Needs

#### Standard 5

Trial Visits

#### Standard 6

Service users assessed and referred solely for intermediate care are helped to maximize their independence and return home.

### 2. Health and Personal Care (Standards 7–11)

#### Standard 7

The service user's health, personal and social care needs are set out in an

#### Standard 8

Service users make decisions about their lives with assistance as needed individual plan of care

#### Standard 8

Service users make decisions about their lives with assistance as needed

#### Standard 10

Service users feel they are treated with respect and their right to privacy is upheld

#### Standard 11

Dying and Death

### 3. Daily Life and Social Activities (Standards 12–15) - Social Contact and Activities

#### Standard 12

Service users find the lifestyle experienced in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.

#### Standard 13

Service users maintain contact with family/friends /representatives and the local community as they wish.

#### Standard 14

Service users are helped to exercise choice and control over their lives.

#### Standard 15

Service users receive a wholesome appealing balanced diet in pleasing surroundings at times convenient to them.

#### **4. Complaints and Protection (Standards 16–18)**

**Standard 16.**

The registered person ensures there is a simple, clear and accessible complaints procedure

**Standard 17**

Resident's rights are protected

**Standard 18**

Protection Service users are protected from abuse.

#### **5. Environment (Standards 19–26) - Premises**

**Standard 19**

Service users live in a safe, well-maintained environment.

**Standard 20**

Service users have access to safe and comfortable indoor and outdoor communal facilities.

**Standard 21**

Service users have sufficient and suitable lavatories and washing facilities

**Standard 22**

Service users have the specialist equipment they require to maximise their Independence

**Standard 23**

Individual Accommodation: Furniture and Fittings

**Standard 24**

Services: Heating and Lighting

**Standard 25**

Services: Hygiene and Control of Infection

**Standard 26**

The home is clean, pleasant and hygienic

#### **6. Staffing (Standards 27–30)**

**Standard 27** Staff Complement

Outcome Service users are in safe hands at all times

**Standard 28** Qualifications

Service user's needs are met by the numbers and skill mix of staff

**Standard 29** Recruitment

Service users are supported and protected by the home's recruitment policy and practices.

**Standard 30** Staff Training

Staff are trained and competent to do their jobs

#### **7. Management and Administration (Standards 31–38)**

**Standard 31** Day to Day Operations.

Service users live in a home which is run and managed by a person who is fit to be in charge, of good character and able to discharge his or her responsibilities fully

**Standard 32. Ethos.**

Service users benefit from the ethos, leadership and management approach of the home

**Standard 33 Quality Assurance.**

The home is run in the best interests of service users, effective quality monitoring systems are in place

**Standard 34 Service Users Money**

Service users are safeguarded by the accounting and financial procedures of the home

**Standard 35 Service Users Money.**

Service users' financial interests are safeguarded.

**Standard 36**

Staff are appropriately supervised

**Standard 37. Record Keeping.**

Service users' rights and best interests are safeguarded by the home's record keeping policies and procedure

**Standard 38.**

The registered manager should ensure so far as is reasonably practicable the health, safety and welfare of service users and staff

## Appendix 2: Demographic Data

The population aged 65 + is set to increase over the same period by 3500 from 16,800 to 20,300 or 21%. However the rate of increase of dementia and limiting long-term illness do not exceed the background level of growth in the numbers of over 65s and hence there does not seem to be a need to add any loading for these factors to the previous analysis. (Note: the lower rate of increase for dementia for this period may be attributable to the very high level of increase in the 65-74 age groups of 26%. The greater increase in the 'younger' age band will lower the overall rate of increase of dementia relative to the increase for all people over 65. This then works through, into an increase in the over 80s between 2015 and 2025 of 30% accompanied by an increase of the number of older people with dementia of 32 %.

The much forecasted 'bulge' in the proportion of over 80s within the population of over 65s appears likely to appear somewhat later in Halton than our analysis period up to 2015. The period to 2015 will in fact see particular growth in the 'younger' age-bands of older people. However there will be a need at a later date to take account of the likely increase in levels of ill-health and disability, and in particular dementia, that is likely to accompany this 'bulge'. Other factors apart from population projections will have a significant impact in Halton. These include the continued trend for service users to choose community care and the reduction of numbers of people currently in residential care as people who were assessed several years ago die.

### Population information for Halton – from POPPI

	2008	2010	2015	2020	2025
People aged 65-69	5,200	5,400	7,200	6,900	7,000
People aged 70-74	4,300	4,400	4,800	6,500	6,200
People aged 75-79	3,400	3,400	3,700	4,100	5,500
People aged 80-84	2,200	2,400	2,500	2,800	3,100
People aged 85 and over	1,700	1,800	2,100	2,400	2,900
<b>Total population 65 and over</b>	<b>16,800</b>	<b>17,400</b>	<b>20,300</b>	<b>22,700</b>	<b>24,700</b>

### Ethnicity

--

**White** (this includes British, Irish and Other White)

**Mixed Ethnicity** (this includes White and Black Caribbean; White and Black African; White and Asian; and Other Mixed)

**Asian or Asian British** (this includes Indian; Pakistani; Bangladeshi; and Other Asian or Asian British)

**Black or Black British** (this includes Black Caribbean; Black African; and Other Black or Black British)

**Chinese or Other Ethnic Group**

### Long term illness

	2008	2010	2015	2020
People aged 65-69 with a limiting long-term illness, living alone	644	669	892	855
People aged 70-74 with a limiting long-term illness, living alone	746	763	832	1,127
People aged 75-79 with a limiting long-term illness, living alone	866	866	943	1,045
People aged 80-84 with a limiting long-term illness, living alone	753	822	856	958
People aged 85 and over with a limiting long-term illness, living alone	653	691	806	921
<b>Total population aged 65 to 74 with a limiting long term illness, living alone</b>	<b>1,390</b>	<b>1,432</b>	<b>1,724</b>	<b>1,982</b>
<b>Total population aged 75 and over with a limiting long term illness, living alone</b>	<b>2,272</b>	<b>2,379</b>	<b>2,605</b>	<b>2,924</b>

**People aged 55 and over by age (55-64, 65-74, 75-84, 85 and over), with a limiting long-term illness and by tenure, year 2001**

	People aged 55-64	People aged 65-74	People aged 75-84	People aged 85 and over
Owned, with a limiting long-term illness	3,436	3,058	1,809	462
Owned, without a limiting long-term illness	5,611	3,358	1,238	159
Rented from council, with a limiting long-term illness	738	827	674	171
Rented from council, without a limiting long-term illness	459	455	300	58
Other social rented, with a limiting long-term illness	750	612	497	143
Other social rented, without a limiting long-term illness	426	339	202	30
Private rented or living rent free, with a limiting long-term illness	223	217	276	111
Private rented or living rent free, without a limiting long-term illness	177	123	113	42
<b>All people</b>	<b>11,820</b>	<b>8,989</b>	<b>5,109</b>	<b>1,176</b>

**General health\unpaid care**

**People aged 65 and over by age (65-74, 75-84, 85 and over), by general health and provision of unpaid care, projected to 2025**

	2008	2010	2015	2020	2025
People aged 65-74 with poor health who provide unpaid care to a partner, family member or other person	362	373	457	510	503
People aged 75-84 with good or fairly good health who do not	3,222	3,337	3,567	3,970	4,948

provide care to another person					
People aged 75-84 with good or fairly good health who provide unpaid care to a partner, family member or other person	369	382	408	454	566
People aged 75-84 with poor health who do not provide care to another person	1,544	1,599	1,710	1,903	2,371
People aged 75-84 with poor health who provide unpaid care to a partner, family member or other person	156	162	173	193	240
People aged 85 and over with good or fairly good health who do not provide care to another person	778	824	961	1,098	1,327
People aged 85 and over with good or fairly good health who provide unpaid care to a partner, family member or other person	60	63	74	84	102
People aged 85 and over with poor health who do not provide care to another person	467	494	577	659	796
People aged 85 and over with poor health who provide unpaid care to a partner, family member or other person	37	39	46		

### Supported residents in care homes

**Older people aged 65 and over in local authority residential care, independent sector residential care, and nursing care during the year, purchased or provided by the CSSR (Council with Social Services Responsibilities), projected to 2025.**

	2008	2010	2015	2020	2025
Total number of older people in residential and nursing care during the year, purchased or provided by the CSSR	560	580	677	757	823

### Admissions to supported permanent residential and nursing care

**Older people aged 65 or over admitted to permanent residential and nursing care during the year, and financially supported by the council, projected to 2025**

	2008	2010	2015	2020	2025
Number of older people admitted to supported permanent residential and nursing care	134	139	162	182	198

### Helped to live at home

**Older people aged 65 and over helped to live at home, projected to 2025**

	2008	2010	2015	2020	2025
Number of older people helped to live at home	2,100	2,175	2,538	2,838	3,088

### Appendix 3: Admissions to residential and nursing homes

Figures from DH re residential and nursing (including 2007-8 figures where available)

#### Supported by Halton –

- Supported by Halton - all ages 2006-7 = 490 people
- Supported by Halton - all ages 2007-8 = 420 people

#### Residential and nursing homes supported per 100,000 pop for age 18 – 65 (2006-7)

<b>Halton = 43</b>	Blackpool = 36
Blackburn = 29	Warrington = 35

#### Over 65 residential placements per 100,000 pop 2006-7

England = 766	Sefton = 1108
North West = 917	Stockport = 607
<b>Halton = 716</b>	Knowsley = 1,123
Blackburn = 496	Liverpool = 1,209
Blackpool = 544	Rochdale = 613
Warrington = 1,458	Barnsley = 554
Southend = 231	Poole = 374
Thurrock = 323	Leicester = 374
Hartlepool = 438	Bournemouth = 480
St Helen's = 1,383	Wirral = 1614

#### Number of permanent admissions to residential and nursing care 2006 - 2007 (S7.1)

Halton age under 65 = 5 (rate of 8 per 100,000), England average = 17 per 100,000  
 Halton age 65 + = 130 (rate of 802 per 100,000 England average = 739 per 100,000)  
 Not much variation across the country

For people with a learning disability CSSR returns show 12 people supported in 2008, 11 in 2007, 10 in 2006. Only 2 of these were permanent. Only 2 permanent admissions in 2008 into residential / nursing home care (external or internal) No "in house" placements – although some short stay admissions to Oak Meadow.

CIC - 2 residential homes and 2 nursing homes and the second provider has 2 residential homes– Wide Cove and Smithy Forge.

Residential statistics – Table S10 (sheet 13)

Table S10	Residents supported outside the CSSR area in registered accommodation at 31 March 2007 for all ages								
by client group and type of care									
All ages					People aged 65 and over				
	Total	% of all supported residents	Residential care	Nursing care	People with physical disabilities	People with mental health problems	People with learning disabilities	Others	All client types
England	47,675	19	33,365	14,315	4,080	3,535	11,360	989	27,710
Halton	85	18	45	45	5	10	10	1	63
2007/08	78		40	38	5	10	11	2	50

Comment - on par with national average

Total Council supported residents at 31 March 2007 and 31st March 2008 by type of registered accommodation Table S5 (Sheet 8)						
	Total of all supported residents*	Local Authority Staffed	Independent Residential	Independent Nursing		
Halton 06/7	490	20	315	150		
2007/08	420	26	254	139		

People aged 65-74

Age 75- 84

Age 85 and over

Residential

Nursing

Residential

Nursing

Residential

Nursing

2006-7	30	20	80	50	125	50
2007-8	30	23	62	38	97	36

Comment - shows downward trend

**Council supported residents  
in TEMPORARY registered residential and nursing care by age group and type of care**

All ages

2007/08 55  
42

**Council supported admissions to permanent residential and nursing care**

by client group and type of care

(Some figs missing)

	People aged 18 - 64				People aged 65 and over			
	Total all age groups	People with mental health problems	People with learning disabilities	Other people	All client groups 18 - 65			
	Number	Number	Number	Number	Total	Rates per 100,000 pop 18-64	Total	Rates per 100,000 pop
England	69,000	1,535	1,995	200	5,470	17	64,425	799
<b>Halton</b>	135	0	0	0	5	8	130	802
2007/08	109	7	2					

**Comment** - rate per 100,000 for under 65 low, for 65 + on par with national average 2006-7 figs (07-8 figs missing)

**Council supported admissions to registered residential and nursing care by type of stay, type of care and age. Includes rates per 100,000 of pop. Year to 31st March 2007**

	Residential Care				Permanent Admissions			
				Rate	Nursing Care			Rate 100,000
	Under 65	Rate <sup>2</sup>	65 or over	100,000	Under 65	Rate	65 or over	
<b>ENGLAND</b>	<b>4,115</b>	<b>13</b>	<b>41,500</b>	<b>515</b>	<b>1,360</b>	<b>4</b>	<b>22,920</b>	<b>284</b>
Halton 06/7	-	-	75	471	-	-	55	331
2007/08			68		5		34	

**Comment** – residential care rate per 100,000 below England average

For nursing slightly above England average (06-7 figs only available) (Maybe affected by relatively low no. continuing care beds paid by health in 06-7)

**Table S10** Residents supported **outside** the CSSR area in registered accommodation at 31 March 2007 for all ages by client group and type of care

England, 31 March 2007

	All ages								Numbers and rates
	Total	% of all supported residents	Residential care	Nursing care	People with physical disabilities	People with mental health problems	People with learning disabilities	Others	People aged 65 and over
									All client types
England	47,675	19	33,365	14,315	4,080	3,535	11,360	989	27,710
Halton	85	18	45	45	5	10	10	1	63
2007/08	78		40	38	5	10	11	2	50

**Comment** - on par with national average

## **Appendix 4: Managing and monitoring the market**

Wanless states that the quality of social care services is influenced by a number of factors:

- Extent to which people who use services are listened to when describing their experiences
  - Quality of providers
  - Effectiveness of councils' commissioning strategies
  - Operation of the market
  - Effectiveness of regulation.
- (i) Wanless states that at present it seems that many local authorities determine their own priorities and hope or assume that the independent sector will supply appropriate services. He says that councils are not good at signaling their purchasing intentions in the short term, nor do they signal the need for new services. Councils are also reported as not signaling the services that might be needed in the long term, regardless of the numbers of people the local authority might support financially
- (ii) Wanless also stressed the issues of capacity in the workforce as an important factor and local authorities are urged to work with the sector to support recruitment, retention and training and development. (Wanless 2006).

The proposals in this strategy aim to address the issues raised by Wanless. A holistic approach to ensuring high quality care is being proposed, which includes changes to the current contracts and specifications, but also recognises the importance of other factors identified by Wanless, such as price and working together to improve services.

Private equity houses and banks invest substantially in social care organisations. These investments enable private and voluntary sector organisations, which provide by far the majority of social care, to develop, improve or expand what they can offer. Over recent years there have been a considerable number of mergers and acquisitions in the care home market, resulting in fewer homes being registered with the Commission but with slightly more places. Just four operators – compared with 10 in 2004 – own some 80,000 places, or nearly one-fifth of those for older people. Yet despite such recent consolidation, a considerable number of single homeowners remain in the market, with some 70% of providers owning fewer than three homes. Some analysts have said that the care home market is hollowing out, with larger and very small players predominating and fewer medium-sized operators. For many homeowners, including the larger corporate groups, councils are the key driver of what is purchased. Not only did investors focus on fairly short time horizons, councils too were seen as not being good at signaling their medium- (the next three to seven years) or long-term (10 to 20 years) intentions. Despite this, council contracts were seen in many areas as a key factor driving investment decisions in services. (CQC 2007)

### **Calculation of reasonable costs and fair fees**

There are four main components of care home costs:

- Staffing

- Repairs and maintenance
- Other non-staffing current costs and
- Capital costs.

### **Staffing costs (From Laing and Buisson)**

Many long term contracts for nursing and care only throughout the country now build in two or more inflation factors to reflect changes in broad groups of costs. Most frequently, a wage index is applied to the bulk (50 – 70%) of the baseline fee and RPI for the remainder. Though this does not capture all of the variation in rates of change in cost, it addresses the primary concern of care home operators - that use of RPI alone is bound to reduce their margins over a period of time, because labour is such a large component of cost and because labour efficiency savings are generally denied by regulatory controls on labour inputs. The particular wage index typically used in many such long term contracts is the Office for National Statistics (ONS) average earnings index for health and social work, on the grounds that this may be expected to reflect movements in public and private pay rates most closely aligned with care home staff costs. The Index is published as series S56 in *Labour Market Trends* by the Office for National Statistics.

It would not be appropriate for the Councils to pay sub-standard homes at the same rate as for good quality homes. If it were to do so, the Council would find itself paying fees to sub-standard care homes at a level that would generate super-profits for them. To deal with this issue we propose that the Councils should apply a 'non-compliance discount' formula for discounting the building and equipment allowance in fees payable to each individual home by an amount which reflects the degree to which the home falls short of standards to be agreed by each Residential care.

### **CSIP's Framework for Local Authority Commissioners**

(i) Identifies some higher commissioning objectives for local authorities:

- Empowering personal budget holders
- Ensuring that accessible information is readily available
- Safeguarding - ensuring mechanisms are in place to protect people from abuse and undue risk
- Developing the market for personalisation
- Supporting citizens to shape the market for themselves.

(ii) The key difference is in moving towards commissioning and contracting for results rather than activities. This process requires some adaptations to contracting and monitoring processes and involves working closely with service users on various levels. However, the move to focusing on the outcomes achieved from the purchase of services rather than the delivery of activities is intended to result in a more effective service that both meets and satisfies the needs of service users.

(iii) The clearer the outcomes, the easier it is to design a service specification and the easier it is to monitor delivery. Nationally there is already a large body of research relating to key service quality issues identified by service users from a range of studies, such as those by Help the

Aged<sup>20</sup>, Social Policy Research Unit<sup>21</sup>, Joseph Rowntree Foundation<sup>22</sup>. The Joint Strategic Needs Assessment required to be undertaken jointly with the PCT will be the basis for determining local high level outcomes, and it will be important to ensure effective collaboration with service users and providers in developing the priorities and outcomes for the population of Halton that commissioners wish to deliver, for example: more people helped to live at home. However it is not sufficient to determine outcomes. It is also necessary to consider how contracts can be more outcomes focussed. Basically, outcome based contracting is designed to:

*"...shift the focus from activities to results, from how a programme operates to the good it accomplishes."*<sup>23</sup>

(iv) The distinction between this and current practice is in defining the funding for a service not in terms of outputs achieved, such as: how many places have been supplied or how many weeks of stay have been provided, or not taking the position that: 'we will develop a specialist dementia care service', but instead on what outcomes have been, or need to be, delivered. For example:

- Identifying improvements in defined physical symptoms and behaviour
- Improvements in physical functioning and mobility
- Increased involvement in social or development activities amongst the population receiving services.

## **Alternatives to care homes**

### **Intermediate care**

(i) One of the important factors in gauging future demand for care home places is the position regarding alternatives – both the quantity, but also an informed view about their effectiveness as alternatives. This section looks at the major alternatives and summarises some of the research findings about the effectiveness of alternatives to residential care.

(ii) The Age Concern/Mental Health Foundation review of intermediate care cites a UK study that compared nursing home 'intermediate care' (aimed at rehabilitation and discharge back home) with permanent 'home for life' nursing home care for people with dementia. The behaviour of participants in the intermediate care group deteriorated more than those in permanent settings, and those who moved back to their own home fared worst of all. So, high-quality care homes have an important role.

(iii) Experience in Halton with intermediate care, however, suggests that if used as part of assessment then people can be diverted to non residential provision.

### **Extra care housing**

Extra care housing, a form of home-based care, can offer an alternative to a care home for some people, including those with dementia. There is a reasonable consensus that if a person who is already living in extra-care housing develops dementia then it is usually possible for them

<sup>20</sup> Our Future Health, Older People's Priorities for Health and Social Care, Help the Aged 2000

<sup>21</sup> Patmore and McNulty, Making home care for older people more flexible and person centred, SPRU, University of York, 2005

<sup>22</sup> Raynes, Clark and Beecham, The report of the Older People's Enquiry into 'that bit of help', Joseph Rowntree Foundation 2006

<sup>23</sup> Margaret Plantz, Martha Greenway & Michael Hendricks (1999). *Outcome Measurement: Showing Results in the Non-profit Sector*. United Way of America Online Resource Library

to remain living in the accommodation. This is because they are already familiar with the surroundings and have built relationships with neighbours. It may be more challenging if someone moves into extra-care housing after the dementia has developed beyond the early stage. Separate from this there is still considerable debate whether 'dementia wings' should house dementia residents together within extra-care housing schemes, or whether they should be integrated among other elderly residents. The housing strategy needs to address the issues at a local level

### **Home care**

Clearly the extent and quality of home care will have a considerable impact on the demand for residential and nursing home services. Similarly the extent and quality of support at home provided via direct payments and individualised budgets.

As Halton is procuring and renewing contracts for domiciliary care at the same time as for residential and nursing home provision, shared modelling between the two strategies is taking place.

### **Dementia care in the community.**

Work conducted in Finland found that offering intensive community-based support from a dementia family care coordinator for two years significantly reduced admission into institutional care during the first months of the intervention, but by the end of the period the institutionalisation rates were the same. Institutionalisation was thus delayed but not avoided.

Halton, via the Domiciliary Care Strategy, the Accommodation Strategy and the Mental Health for Older People Strategy is exploring both alternatives to residential care, but also the support from the community and health to residents in residential care between a care home and community support approach to dementia care. It is timely to do this.

## **Appendix 5:**

### **Five Boroughs Mental Health Partnership – plans for older people with mental health needs.**

A holistic view of the mental health needs of older people in Halton is being addressed in the Five Borough Partnership Trust Strategy. Proposals include a Complex Care Unit (pan borough) and Continuing Care Units (probably borough specific). The Complex Care Unit would take in people that had challenging behaviour and through a detailed assessment and structured treatment plan aim to get people 'sorted' within 6 months or so and ready to move on or back to the community, res/nursing home or continuing health care facilities.

The Continuing Care facility would be for those assessed as needing continuing health care - they already provide this service to Warrington and would like to extend it to all areas.

Proposals also include the establishment of a comprehensive Assessment and Treatment Centre (ATC). This would provide a single point for initial referrals and offer a range of assessments (social work, nursing, OT, speech and language, physio, and clinician) and a range of inputs including carer support, counseling, also an Inreach/Outreach service into residential and nursing homes assisting the staff to manage complex care needs, skilling them up and enabling the facilities to avoid unnecessary hospital admissions.

## **Appendix 6: Dementia Care**

### **Do specialist units enhance the quality of life?**

Dementia care is being given an increased profile, specifically with the plan to produce a dementia care strategy in the autumn of 2008. The Department of Health launched its National Dementia Strategy consultation document on 19 June 2008. Called "*Transforming the quality of dementia care – consultation on a National Dementia Strategy*", it sets out the case for change, fifteen recommendations and a series of consultation questions aimed at improving the lives of people with dementia and their carers. The consultation period runs until 11<sup>th</sup> September. The consultation document addresses four key themes: -

- Raising awareness
- Early diagnosis and interventions
- Improving the quality of care
- Delivering the National Dementia Strategy

*The Dementia UK (Kings Fund 2006)* report estimates the cost of dementia for the UK as a whole to be about £17 billion per year, and projects that the number of people with dementia will double to 1.4 million in the next 30 years. The National Audit Office has identified problems in the current systems of health and social care for dementia. Its report *Improving services and support for people with dementia* estimates that approximately two-thirds of people with dementia don't receive a formal diagnosis – or have contact with specialist services – at any time in their illness. It is also of concern that such diagnosis and contact, when made, often only occurs late in the illness and when the person with dementia is in crisis – so the opportunities for harm prevention and maximising quality of life are limited.

The Personal Social Services Research Unit/London School of Economics (PSSRU/LSE) model (Comas-Herrera *et al* 2003) projects that between 1998 and 2031 the number of people with cognitive impairment in England will rise from 461,000 to 765,000, of whom approximately half will also have problems with daily living. The model's associated projections for the change in demand between 1998 and 2031 the numbers of people with cognitive impairment in institutions would need to rise by 63 per cent, from 224,000 in 1998 to 365,000 in 2031 (Kings Fund 2006).

There has been a lot of debate as to whether it is better to provide specialist care for people with dementia in specialist units. Heeg, S (2007). This study looked at impact of setting up special dementia care units and the impact on the quality of care.

The study looked at:

- Environment
- Adapting organisation and management
- Training staff in person centred care

Over a three year period 2000-3 special Alzheimer's units were set up in 6 units, which until then had no policy of separating people out with dementia, guided by experience in France,

Sweden and the Domus units in UK. Extensive literature search across Germany, US and Europe found there had been mistakes in the introduction of such units.

Conclusions:

- Some indication that the specialist units not the right environment for people with mild to moderate dementia.
- At the level of the individual there were marked overall improvements in the quality of life of some people.
- Difficult to draw general conclusions because the residents are all by definition deteriorating physically and mentally. If residents deteriorating massively at the physical level then very difficult to stabilise the mental well being.
- It seemed easier to focus staff development in the small units because of the small numbers of staff.
- However a tension created in the residential nursing home because of potential and actual clash of cultures between the staff on the specialist units and the rest of the home. You cannot institute such changes unless you institute changes in the whole home.
- Very demanding for staff – all the effort and can feel hopeless because people are declining. Staff need a good structure of support.
- In Germany the experience is that a relatively homogeneous group of people with dementia composed of people with similar needs and behaviours tends to produce less conflict than integrated units.

The units were for about 12 people and modelled on a household.

- The design of the areas does make a big difference
- Needs to be a minimum communal space of 5 square metres per person.
- The built environment also had an impact on staff. If well designed easier to relate to residents and use a person centred approach.
- The physical dimension is important, but is not the crucial factor for increasing the quality of life with people with dementia. The home can only provide quality of life to people with dementia through the appropriate interaction between the built environment and the organisation structure, within the conceptual framework of a dementia quality care approach.
- However there are clear indications that certain physical characteristics such as narrowness in shared spaces, restricted possibilities to move around, or acoustic stress are likely to be partly responsible for specific kinds of challenging behaviour.

Care homes often lack the type of design features that enhance the environment for those with dementia, such as high light levels, non-institutional dining areas, highly visible toilets and the use of colour and decor to ease corridor negotiation. This is despite the high proportion of

residents who have dementia symptoms, and the fact that many with advanced dementia have no alternative to residential care.

The top three challenges to providing good dementia care from a care home manager's point of view relate to developing a staff team with the right attributes and skills and keeping them motivated. The development of the National Dementia Strategy should provide an opportunity to produce workforce development plans. *We have seen that, with the right support, people can have independence and choice in care homes.*" (Denise Platt).

Key findings of a large scale literature review indicate that staff who know their residents and appropriate approaches to care can help minimize distress and behavioral symptoms. This requires trained staff who receive supervision designed to improve their interactions with residents. Also, pleasant environments, which provide opportunities for residents to improve their functioning, can lead to more independence in daily activities. Possible environmental interventions involve modifications to make the institution as homelike as possible with access to secure wandering places. *Alzheimer's Care Today*. 9(1):24-32, January/March 2008. *Tilly, Jane Dr PhD; Reed, Peter PhD*

## Appendix 7: Financial summary

### Assumptions:

1. There is an assumption of turnover of 33% per year within residential and nursing homes
2. That the basic residential care rate will increase by 4.95% in year 1. The proposed new rate has been derived by taking the average cost for the comparator local authorities of residential care (without any premium payments).
3. That out of area placements are not included
4. The figures are for older people's care only i.e. codes 6204 and 6205
5. Figures are gross and do not take into account income
6. The figures detail the situation as of the end of period 11 and extrapolate from that position

With the above assumptions the figures for Halton are as follows:

	2008/9	2009/10	Monetary increase	% Increase
<b>Residential basic sum</b>	334.33	350.88	16.55	4.95
<b>Dementia Residential</b>	394.20	413.71	19.51	4.95
<b>Basic Nursing</b>	357.25	374.93+FNC	17.68	4.95
<b>EMI Nursing</b>	378.23	431.18+FNC	52.95	14

## Appendix 8: References and Bibliography

Alzheimer's Care Today. 9(1):24-32, January/March 2008. *Tilly, Jane DrPH; Reed, Peter PhD*

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Outcomes for residents improve when there is a dedicated nursing and physiotherapy support.

For example an initiative in NE Somerset and Bath provided targeted input to residential homes, to meet the nursing needs of residents where they live and to train care home staff in basic nursing. The early detection of illness and resulting opportunity for early intervention was a major part of the team's work. Residents were likely to benefit from improved quality of life.

Overall, estimates of costs and savings ranged from a 'worst case' scenario of £2.70 extra to a more likely scenario of £36.90 saved per resident per week. Savings were mainly in reduced use of NHS services. The Primary Care Trust and Adult Social Services both funded the intervention, highlighting the need for partnership working to sustain funding.

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