FULL REPORT ON THE FUTURE OF RESIDENTIAL CARE FOR OLDER PEOPLE IN SCOTLAND

TASK FORCE FOR THE FUTURE OF RESIDENTIAL CARE IN SCOTLAND

FEBRUARY 2014

COSLA

The Scottish Government
Riaghaltas na h-Alba

Full report on The Future of Residential Care for Older People in Scotland

Task Force for the Future of Residential Care in Scotland

February 2014

"To support older people in Scotland, now and in the future, to live in homes where they feel safe and respected as members of their communities."

Residential Care Task Force Vision; July 2013

The Scottish Government, Edinburgh 2014

First published by the Scottish Government, February 2014
ISBN: 978-1-78412-277-5

eBook first published by the Scottish Government, February 2014
ISBN: 978-1-78412-278-2 (ePub)

Kindle eBook first published by the Scottish Government, February 2014
ISBN: 978-1-78412-279-9 (Mobi)

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Produced for the Scottish Government by APS Group Scotland
DPPAS23595 (02/14)

Published by the Scottish Government, February 2014

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Foreword

We are delighted to present the report of the Ministerial and COSLA Task Force on Residential Care for Older People, because we believe that older people within Scotland deserve the best that we, as leaders and providers of services, can deliver. The mark of a caring and mature country is how it treats the most vulnerable citizens within its society, particularly its older people.

Recent high profile media coverage of cases where the delivery of care has been well below standard has prompted much thought and discussion about the kind of care we would like to receive in our later years, and where we would like to receive it. The common standpoint we all share is that we would each like our care and the environment we live in to be personal to us and appropriate to our needs and wants, rather than a standard 'one size fits all' approach. Doing so will help older people and their families and carers feel care services are being provided for them and with them, rather than 'done' to them.

Standing still on the issue of the future of residential care simply is not an option. Twenty years from now, we will be in the fortuitous position of more older people living for longer, however, it is also anticipated that a smaller working-age population will be available to supply the care sector workforce that will be needed to look after them. All this in the face of anticipated tighter finances. Our expectations are changing too. As taxpayers, we expect high standards from our public services, and for those people who self-fund their care, they are entitled to expect high value for their money when it comes to the quality of care they receive and the standards of the environment in which they receive it.

The Task Force provides a once in a generation opportunity to reshape the provision of older people's residential care and to provide a blueprint for the future. Seldom are we afforded such an opportunity and it is one which all members of the Task Force and its sub groups embraced with a common purpose of making life better for older people through the provision of sustainable, high quality desirable care, fit for the next twenty to thirty years and beyond.

In creating our Task Force, we approached the organisations that we felt would be able to provide people with the required knowledge and expertise to contribute to a full and frank discussion about the issues existing in the sector today, the barriers to addressing them and the recommendations for doing so. Whilst it would have been understandable for individuals to come to the group ready to fight their corner, we are immensely proud of the manner in which the Task Force worked and arrived at the recommendations you will find in this report.

The Task Force's recommendations are based on older people's needs and wants being at the centre of high quality, safe residential care services, through the development of a skilled high quality workforce, in a flexible environment more fitting people's needs, via sustainable resourcing and commissioning.

Delivering on the Task Force's recommendations, through the development of a strategy for implementation will require national and local politicians and leaders to make strong, and sometimes unpopular, decisions to realign priorities and ensure that the commonality of purpose is maintained through a strength of commitment to the recommendations and, in particular, through joint working across the sector. The recommendations also place a responsibility on the wider community to embrace the

care and support we offer older people by making links with the places where our older people live.

We would like to thank all members and contributors for their collective input and support, against an incredibly short timeframe. We hope we have reflected all of the hard work and outputs from all involved to arrive at the set of recommendations in the report.

In publishing these recommendations, we recognise that the work has only just begun. With agreement on the way forward, the crucial work will be the implementation of our recommendations, which, we believe, can only take place with a full public consultation.

By maintaining focus on our long-term vision we believe that Scotland will provide residential care for its older people which will set Scotland at the forefront of countries which are striving to provide the best for their older people.

Douglas Hutchens, Independent Chair

Peter Johnson, COSLA, Health and Wellbeing Spokesperson

Context

Why people move into care homes

The decision to move into a care home or supported living arrangement is by no means an easy one, either for the person making (or accepting) the decision, or for the family member(s) or advocate making that decision for them. It can be an emotional and stressful time for all involved, not least because it is often taking place in response to a considerable increase in frailty and accompanying loss in ability and independence.

There are various triggers that can see someone move into a care home, some relating to the person's condition (e.g. requirement for more intensive levels of support), and other 'external' factors such as family members no longer being able to provide care. Generally, the majority of care home residents enter the home not through choice but necessity, and are there for the final months of their lives.

Residential Care in Scotland – The Journey So Far

In the late 19th century, for those who could afford to pay, the nursing reform movement led to the development of institutions which cared for people who were unable to continue to live within their own homes. These arrangements developed without significant regulatory oversight until the Nursing Homes Registration Act 1927; but real reform only came with the creation of the NHS and 1948 National Assistance Act, which placed a duty on local authorities to provide residential care for people who were unable to care for themselves for reasons of 'age or infirmity'. While this duty was generally enacted through the provision of council-operated services during the 1950s through to the 1970s, the 1980s brought a new era of private provision and outsourcing, the greatest shift being from NHS continuing care provision to independent nursing homes and the development of the current care home market.

This historical context speaks to a shift over time from state-run services to a market based model. However, unlike other areas of social care, a commissioning relationship did not develop between the local authority and the external provider. Rather, local authorities have largely limited their role to the facilitation of placements, contract management and to a lesser extent, care management and review. In reality, then, the local authority tends not commission residential care – it merely buys and consumes.

Within this context, a mixed economy of care has emerged – but with private sector predominance. While some councils have retained greater levels of in-house provision, and while the voluntary sector continues to play a small but important role in most local authority areas, almost all councils in Scotland are now highly dependent on care homes that are provided by private sector organisations.

Since the development of the National Care Home Contract in 2006, we have witnessed standardised contracts and more transparent and consistent approaches to funding care. This has largely overcome the variation and complexity in the contractual relationship between the individual, the provider and the council, which the Office of Fair Trading[1] was particularly critical of prior to the establishment of the

[1] http://www.oft.gov.uk/shared_oft/reports/unfair_contract_terms/oft635.pdf

National Care Home Contract. We have therefore made considerable progress on the procurement of care in care homes over the last decade. The current mix of provision demonstrates general value for money, especially when private and voluntary sector providers are compared with the cost of in-house provision.

We can also be generally satisfied that work undertaken since 2006 has improved outcomes for individual services users. The introduction of national care standards http://www.nationalcarestandards.org/ and a strong and effective regulatory regime, along with a payment for quality agenda that has been devised to reward the best performing care homes, has delivered a general improvement in the overall quality of care provided. However, the current mix of services within the care home market is not producing optimum outcomes, when viewed from a whole systems perspective. That is to say, there has been limited innovation in the Care Home market in terms of new models of care – for example, in the use of care homes as a means of providing intermediate care (to avoid hospital admission or facilitate discharge). Generic care provision has been variable, with growing numbers of providers operating at higher levels of quality but with a significant minority continuing to provide care at undesirable quality levels.

Equally, it has not been possible for commissioners at a local level to fully shape market behaviour, with the speculative development of residential facilities in some areas unbalancing supply and demand relationships; and, by contrast, supply issues in rural areas or where local property markets have inhibited investment in care facilities. Providers, for their part, argue that in the absence of clear commissioning strategies at local and national levels, they have had to speculate about future need and commissioning requirements.

Furthermore, isolated instances of instability and poor performance have contributed to calls for increased levels of scrutiny within the sector. Most notably, the demise of Southern Cross has raised questions about the financing and financial sustainability of the sector, its regulation and its capacity to deliver against the expectations of service users and commissioners.

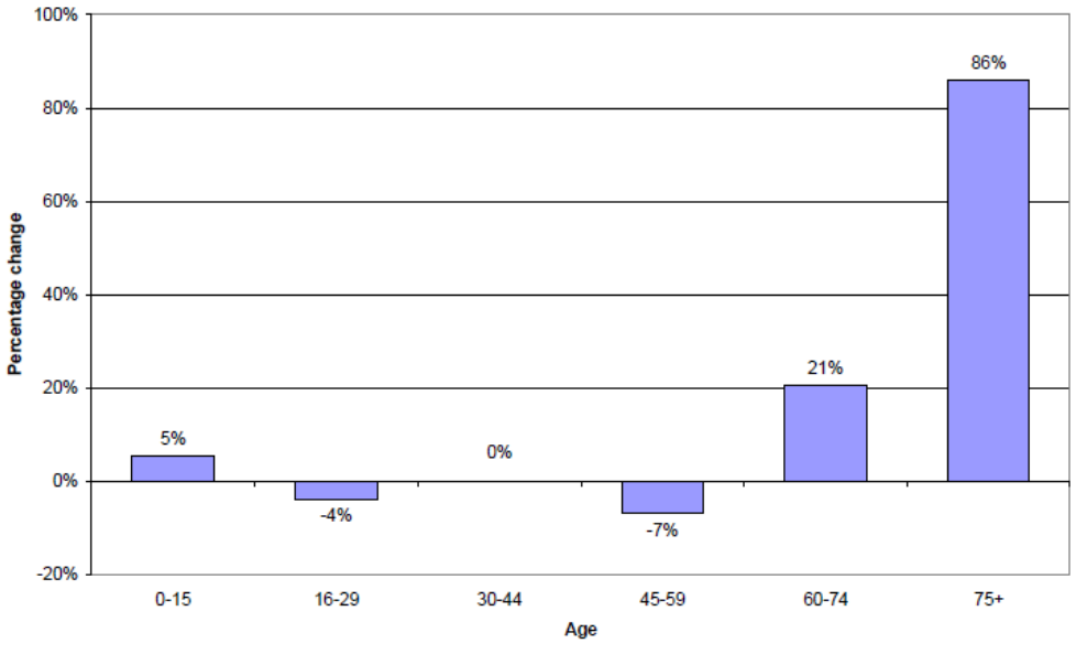
Current Landscape

Demographic projections of recent years have presented a picture of a growing older population and a shrinking working age population to support it.

According to the latest figures from the National Records of Scotland, Scotland's population is projected to increase by 9 per cent between 2012 and 2037, however this increase is not spread evenly across all age groups of the population. As Figure 1 below shows, the population aged under 60 is projected to remain fairly constant with a small decrease in the 45-59 age group and a small increase in the number of the 0-15 age group whilst the number of older people is projected to increase significantly especially the 75+ age group. The number of people aged 75 and over is projected to increase from 0.42 million in 2012 to 0.53 million in 2022. It is then projected to continue rising, reaching 0.78 million in 2037 – an increase of 86 per cent over the 25 year period. Meanwhile, the number of people of working age is projected to increase from 3.35 million in 2012 to 3.48 million by 2037 (an overall increase of 4 per cent from the 2012 estimate).[2]

Under current law, changes to the State Pension qualifying age will increase to 67 between 2034 and 2036, and 68 between 2044 and 2046.[3] This will in the long term mean that staff in the workforce are likely to be working in the sector for longer, which itself will bring opportunities and challenges.

Figure 1 The projected percentage change in Scotland's population by age group, 2012-2037



Source : General Register Office for Scotland; Projected Population of Scotland (2012 based)

[2] http://www.gro-scotland.gov.uk/files2/stats/population-projections/2012-based/2012-pop-proj-publication.pdf
[3] https://www.gov.uk/changes-state-pension

Analysis and debate is on-going as to what exactly this means for health and social care, but the over-arching message is clear: our residential care sector as it exists at present is unsustainable and in certain cases, un-desirable. Just as the sector has evolved in response to developments in technologies and services over the last few decades, so too it must align itself to meet the needs and desires of our older population in the next twenty years.

The most recently available Scottish Care Home census, which provides information as at the census date of the 31st of March 2012 tells us that at that time there were 916 care homes for older people in Scotland providing 38,465 places to 33,636 residents.[4] Of those residents, at the time of the census, 32,555 (97%) were long stay residents – i.e. had the care home as their permanent residence. Short term and respite residents made up 1,081(3%) of residents.4

The fact that we are living longer can be put down to a range of factors, from perhaps healthier lifestyle choices, advances in medicine and technologies, and a preventative approach to health and social care that has been implemented at national and local levels.

By way of illustration, the gap between Life Expectancy and Healthy Life Expectancy (i.e. the years expected to be spent in a 'not healthy' state during the average lifetime) has been fairly constant for females between 1980 and 2008, but has tended to increase for males. The most recent annual estimates for Scotland are for boys born in 2010 to live 76.3 years on average, 59.5 of these in a 'healthy' state. Girls born in 2010 would be expected to live 80.7 years on average, 61.9 of these years being 'healthy'.[5]

Generally, both Life Expectancy and Healthy Life Expectancy are increasing for males and females across Scotland, allowing people to live independently for longer today compared to the 1980s for example. There has therefore been a marked shift in the demographics of care home residents, and we know that the average age of a resident in a care home is increasing due to the fact that people are moving into care homes at a later stage in life than previously.

Given the age, frailty and multiple morbidities of care home residents they can be defined as one of the most complex and vulnerable group of people in our communities, which has significant implications for the workforce providing their care and support. Added to this we know that 21% of the population over 65 have a care home as place of death so increasingly palliative and end of life needs also require to be met in a residential care setting.

Residents in care homes have increasingly complex and high levels of care and support needs. According to the 2012 census, 1 in 2 long stay residents (i.e. 16,277 people)[4] had a formal diagnosis of dementia. The true level of dementia is likely to be higher than this given that some of those residents will not have had a formal diagnosis but will have been identified as having a dementia.

[4] https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2012-10-30/2012-10-30-CHCensus-Summary.pdf?73347109557
[5] http://www.scotphn.net/pdf/PDF_171212_LH_MASTER_-_ScotPHN_OPHSCNA_epid_report3.pdf

In recent years, a preference towards caring for older people in their own homes or within the community rather than in a care home has been driven by policy intent in this area. The Scottish Government's vision for older people is that:

"Older people are an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting."

This vision appears to be taking hold. The number of older people receiving personal care services in their own homes has increased from 33,000 people in 2003-04 to nearly 47,000 people in 2010-11 and 2011-12.[6] This large increase in people receiving services in their own homes reflects an increasing older population and a move away from long-term care in hospital and care homes toward providing care in a person's own home for as long as possible. People receiving personal care services at home received on average nearly 7 hours of care each week in 2003-04. This has risen steadily to over 8 hours of care each week in 2011-12, showing that people receiving care at home have increasing levels of need.

Supporting our older population and their spectrum of needs, whether in a care home or at home, requires a considerable workforce with the right skills.

According to the Scottish Social Services Council's Workforce Report (2012), there are 115,410 people employed as carers delivering care in care homes (54,060), and care at home and housing support services (61,350).[7] To put this into context, 28% of the Scottish Social Services sector is employed in care homes, and 32% in care at home/housing support services.

Social care as a vocation has generally always been viewed as demanding and poorly paid. This has made it difficult to attract the right kind of people with the outlook and behaviours to boost its image, and indeed that image has suffered further recently. Despite the vast majority of the workforce working hard to deliver the best level of care possible, the few instances where the level of care and behaviour of staff has been sub-standard has tarnished the image of social care. Inevitably, this will take time to repair, yet the fact that such instances are coming to light both reassures us that regulation is working, and also underlines the areas we really have to get right within this piece of work.

The integration of Health and Social Care is set to change the landscape in which these services are delivered. Essentially, the Public Bodies Bill will create the framework for strategic planning to take place within partnerships to ensure that energies and resources are focussed on getting the services and placements that meet people's needs.

The manner in which care services are funded is also proving an issue. The main parties in the National Care Home Contract have found it increasingly difficult in recent years to reach consensus on the rates that providers should receive for publicly funded places; debate continues over the contribution of the individual vs. the state; and the difficult economic climate sees the gap between those who have

[6] http://www.scotland.gov.uk/Resource/0042/00429435.pdf
[7] Scottish Social Services Council, Scottish Social Services Sector – Report on 2012 Workforce data

means and those who have little means, continue to grow. Alongside this is the promotion of control and choice for service users via Self Directed Support. This is a hugely positive step towards the personalisation of care in Scotland, and is yet another factor that those responsible for designing, commissioning, purchasing and delivering care need to take into account.

All of this points to the need to consider the future role and function of the care homes market in Scotland.

Opportunity

Origins of the Task Force

Whilst agreement between the two parties involved in the National Care Home Contract does not fall within the explicit remit of the Task Force, the forming of the group does present the opportunity to ask if the product being commissioned now is the product we want to commission in the years to come. Indeed, going a step further, we can ask questions about the very manner in which we commission services.

There was broad consensus across representatives from the public and independent sector that a Task Force to look at the future of residential care was a step in the right direction. In approaching potential members of the group, an effort was made to ensure those people had the skills, knowledge and experience of the sector, but also the authority and autonomy to represent their organisations and to agree to pieces of work and final recommendations that might impact on those organisations. We were particularly pleased to have strong representation from colleagues in the Housing sector, as any discussion regarding the future of residential care needs to acknowledge housing's role as part of the continuum of care, rather than a stand-alone entity.

A list of the Task Force and Sub Group members is attached in Annex A of this report.

Remit

The Task Force's primary objective is to examine at a strategic level the key purpose and desired structure of residential care services fit for the aspirations and needs of future generations.

The remit of the Task Force was to:

- Outline strategic outcomes and priorities for adult residential care for the next 20 years;

- Scope out capacity planning processes and the interface with other services within the context of integration, joint commissioning strategies and diversification of the sector;

- Review the fee structure of care home placements, and provide options for a new fee structure and alternative methods for procurement;

- Audit the commissioning levers available to local Health and Social Care Partnerships and make recommendations about how these can be strengthened to ensure that the sector responds to the needs of the local population;

- Agree a compulsory risk register, to provide an early warning system for care providers experiencing challenges to the continuity of care – and an associated ladder of intervention for public authorities to co-produce solutions for exit or redesign of struggling services;

- Review of the basic structure of residency, exploring parallels with the housing sector and the introduction of a rights-based frameworks for residents, and whether it is desirable to separate-out daily living costs such as rent, food and utilities from the cost of care, allowing a move to tenancy arrangements; and

- Assess whether the various operational models of care home businesses bring different levels of risk (particularly around the split between property owner and care provider), and if appropriate make recommendations about how these might be overcome.

Intended Outcomes

The intended outcomes, and indeed the success of the group's work can be seen as its response to the points highlighted in the above remit. We have however, agreed an overarching 'Vision' which captures the kind of care services we would like to see created as a result of our work and which provided a focus for the work of the Task Force.

Vision

To support older people in Scotland, now and in the future, to live in homes where they feel safe and respected as members of their communities. We will do this by:

- **Adapting person-centred and personalised care and support solutions to people's changing needs;**
- **Developing accommodation and care options that are flexible, built around people's needs and also part of a wider community;**
- **Ensuring that rights to privacy and dignity are respected at all times;**
- **Nurturing a caring workforce which is passionate about delivering high quality person-centred services, and developing caring as a career of choice;**
- **Planning services responsibly to develop sustainable communities;**
- **Making funding and charges simple and transparent; and**
- **Assuring quality and safety.**

Structure of the group

At the first Task Force meeting in July 2013, the group agreed the work should be split across six core work-streams, each led by a member of the Task Force, and reporting in the first instance to the Task Force Steering Committee. The work-streams identified were:

Personalisation	**Commissioning**
Workforce	**Place making**
Funding	**Regulation**

Sub–group leads were asked to identify (from within and out-with the Task Force) the people they thought would be best placed to contribute to their respective discussions and have valuable input in drawing up a set of recommendations. They were tasked with providing a summary paper with those recommendations for the wider Task Force to review ahead of the writing of the final report in December 2013.

The Task Force Steering Committee (led by the co-chairs), was responsible for monitoring the progress of the sub-groups, establishing meeting agendas, and drafting the final paper. This structure also allowed for issues to be identified and addressed in between Task Force meetings, making the work of the group generally more efficient.

Membership of the Task Force and the Sub-groups is detailed within Annex A.

Part 1: People and Places

Starting off the recommendations for the future of residential care with a focus on people is no coincidence. Formulating policies, planning care services and designing new care settings should all start with the service user's perspective in mind.

Discussions about placing the needs and wants of the individual at the centre of what we do will invariably hear the phrases 'Personalisation' and 'Person-centred care' being used, dependent on whether the speaker is from a health background or a social care background. For the purposes of this paper, we are using the term 'Personalisation' to indicate that it is the full package of accommodation, hotel, and leisure and recreation that needs to be shaped round the individual, as opposed to the actual direct care activities.

A personalised approach needs to be embedded in how we deliver care for Scotland's older population if we want to truly talk about caring for people, as opposed to delivering care to them. We should also include the increasing number of unpaid carers who make considerable sacrifices to care for a family member or close friend. Seeing them as equal partners in care will help extend the reach of the personalisation agenda.

Of course, finances will determine the extent to which we can deliver a truly personalised care service, yet there are principles that can be embedded and policies that can be implemented either without additional cost or at relatively low cost with far-reaching impact.

In planning for the future of residential care, the personalisation agenda cannot be separated from any discussions about the physical environments we would like to deliver care within. There is inevitably a close connection between the environment a care service is delivered in, and the people who deliver the service – the workforce. For the purposes of this report however, we have set out Personalisation at the front and by itself to emphasise the fact that this needs to be at the forefront of our thinking.

Personalisation

Policy and Legislative context

There has been much progress in bringing a more person-centred approach to health and social care services in recent years. Within an NHS context, new standards in patient safety and patients' rights have been introduced, alongside on-going person-centred work associated with the NHS Quality Strategy.[8]

Local government and social care providers in the third and independent sectors have likewise been on a similar journey for some time. Personalisation is about empowerment, it is about rebalancing power relationships, and it is about co-producing solutions that allow individuals to improve their lives. And importantly, it has to be available to all.

This work has recently developed a focus around Self-Directed Support (SDS), with the 2013 Act enshrining the right of the individual with eligible support needs to exercise control over their support. Self-directed Support (SDS) is an approach designed to bring about independence and choice for people with care or support needs. It involves identifying a budget for an individual's support and puts them in control of how that budget is invested to meet agreed outcomes. This can be provided via a 'real budget' (a direct payment to the individual in place of services) or a 'notional budget' where an individual fund where the person takes on-going control over their support.

The Social Care (Self Directed Support) (Scotland) Act[9] was passed by the Scottish Parliament in November 2012 and is expected to come in to force on 1st April 2014. Following the bill's passage, the Scottish Government published draft regulations and guidance for consultation in spring of 2013.

The Act sets out four general options for individuals to exercise control over their support:

- *Option 1* - Direct Payment
- *Option 2* - The supported person selects the support which is required, which is then arranged by the local authority
- *Option 3* - Support is selected and arranged by the local authority
- *Option 4* - A combination of the above

The general provisions of the SDS Act will apply to care homes, as they will for other areas of social care. The Scottish Government has consulted on whether people living in residential care should be entitled to Direct Payments and in its response to the consultation, Ministers confirmed that they are going to pursue some test site activity on Direct Payments for residential care.[10]

Irrespective of how that work develops, we already know of imaginative arrangements that have been piloted around the use of Direct Payments to build a

[8] http://www.scotland.gov.uk/Resource/0039/00398674.pdf
[9] http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Self-Directed-Support/Bill
[10] http://www.scotland.gov.uk/Publications/2013/12/4240/1

package of support at home, rather than enter into a care home. The Alzheimer Scotland work in North Ayrshire is instructive here.

Work Underway

The practical implementation of SDS will require a shift towards outcomes based assessment and review. Recent developments within this field include the creation and gradual roll-out of 'Talking Points', which is an outcomes-focused assessment process designed to put the individual in control of their support arrangements. Work undertaken by Scottish Borders Council, the Joint Improvement Team (JIT) and a number of independent sector providers demonstrated that this approach is just as applicable to residential settings as to care at home.[11] However, its success will require strong leadership, a commitment to cultural change and the tenacious pursuit of personalised care.

In a similar vein, 'My Home Life'[12] is a collaborative movement focused on personalising practice within care homes for older people. It is underpinned by an evidence base developed by more than 60 academic researchers from universities across the UK. It identifies best practice in care homes for older people in the 21st century and has a particular focus on personalisation:

- Giving older people the opportunity to integrate their past and present life experience along with their priorities for the future;
- linking with communities;
- thinking creatively about meeting communication needs;
- being open to meeting particular spiritual, cultural, social and sexual needs sensitively;
- understanding and respecting the significance of relationships within the home;
- recognising roles, rights and responsibilities; and
- creating opportunities for giving and receiving, and for meaningful activity.

While these are two good examples of personalisation initiatives in care homes, the consensus among key parties such as the Mental Welfare Commission and the Scottish Human Rights Commission is that there is much work to be done before personalisation becomes an embedded principle in the sector.[13,14] Guardianship and the embedding of the Mental Health Act are seen as high priorities to further the Personalisation agenda.

Models of Personalised Care within Grouped Settings

There is general agreement that the future of residential care needs to be different if personalised outcomes are to be optimised. Over the last two decades, while there

[11] http://content.iriss.org.uk/careandsupport/assets/docs/1_JIT_TP_Care_Home_Framework.pdf
[12] http://myhomelife.org.uk/
[13] http://www.mwcscot.org.uk/media/53179/CC__MWC_joint_report%20Remember%20Still%20Me.pdf
[14] http://www.scottishhumanrights.com/careaboutrights

have been improvements in the delivery of care within residential settings, there has been a more limited development of personalised arrangements.

Some of the less desirable features of group living – such as shared bedrooms and bathrooms – have gradually been phased out; but in general terms care packages continue to be designed for the convenience of the commissioner and provider rather than the service user.

That is not to say that high quality care and support is not being delivered – very often it is; but the design of that experience tends to be based on the group environment rather than tailored to individual preference. Moving away from this circumstance will require significant culture change, and potentially greater levels of private and state investment.

So what is to be done? The optimisation of personalised service arrangements will require reform in a number of areas:

Finance and Funding

- Greater transparency in the fee rate attached to care within a grouped living arrangement, separating out the cost of care, rent, board and recreation;
- Consideration of the conditions of residence, ranging from tenancy or owner occupier models through to residency agreements; and
- Greater control over personal budgets and income sources such as pension arrangements.

Care and Support

- Enhanced individual leverage to control the care package, based on individually identified outcomes and goals;
- Normalisation of healthcare arrangements – accessible GP, nursing and other specialist input as required;
- Greater control over the 'who-what-where-how-when' of care delivery; and
- Greater opportunity to involve unpaid carers in support arrangements.

Daily Living

- The normalisation of daily living arrangements, including expanded opportunities to live with a spouse, partner or friend;
- Greater opportunities for life outside of the home; and
- Greater control and choice over recreation and physical activities.

In our view, the features of a more personalised care arrangement will be differentially expressed depending on the structure of the residential or grouped living model. In general, three types of accommodation will be at the heart of the development of the residential sector over the next period: an evolution and expansion of the extra-care housing sector; a residential sector focused on rehabilitation and prevention (step-down / step-up care); and a smaller, more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs.

Model	Care Function	Characteristics
Extra-care Housing	Independent Living	- Flexible delivery arrangement (opportunities to increase or decrease care input) - Different physical configurations but typically multi-unit single campus at core (with opportunities for hub and spoke) - Care adapted but otherwise fully functioning private residences - High personalisation potential - Tenancy / ownership models
Short-term Residential Intermediate Care	Transition Care	- Flexible delivery arrangement (opportunities to increase or decrease care input) - Different physical configurations - Physical environment structured towards rehabilitation (e.g. self-service kitchen) - Moderate personalisation potential - Residency model
Specialist Residential	Long-term Care	- More structured delivery arrangement (with higher levels of care input) - Single site residential but with opportunities for hub and spoke - 24-hour care input, often palliative or end-of-life care, with specialist clinical input - Moderate personalisation potential - Residency model with some potential to introduce tenancy / ownership arrangements

These categories are, of course, not definitive, mutually exclusive or exhaustive – but they broadly capture the future care functions of the residential / grouped care sector.

While personalised care should be supported across the broad areas outlined above, it was suggested that housing-based models offer the greatest possibility of personalised service. That is because this model potentially maximises control over funding, environment, care and recreation. However work will need to be undertaken across all care environments to ensure that personalisation is a central driver of service design.

The delivery of the reforms set out above could, in principle, transform the delivery of care and support in the residential sector. We know that some of this is being done already: for example, a person living with their spouse in a self-contained unit, underpinned by a tenancy type arrangement, who has care delivered by a combination of family members, externally purchased provision and some on-site support. We also know of people with high levels of dependency being supported in specialist accommodation but with support tailored to their own ends: support from the family GP and geriatricians; care input from family members; mealtimes and recreation designed around personal preferences. Or again, someone who has been discharged from hospital and who has yet to regain their independence can access short-term residential care with a rehabilitation package built around personal

capabilities and goals. So it's not that this cannot be achieved – it's just that these examples are not happening at scale.

Case Study One: Croftspar

Croftspar is a group of eight individual homes in Springboig, Glasgow, which has built-in assistive technology and access to 24-hour care. It was developed by Alzheimer Scotland, Glasgow City Council and Cube Housing Association. It supports people with dementia to live independently, to hold their own tenancy and to maximise their natural support mechanisms.

The full cost of the development in 2004 was £773,444, with the initial cost being borne by Glasgow City Council. The tenants pay rent and service charges to the housing provider and will typically receive housing benefit.

Glasgow City Council funds Alzheimer Scotland to provide the care and support. There is a means-tested contribution from tenants towards the cost of their care.

The facility is part of a wider community, it provides a dementia-friendly environment and it offers therapeutic support. The indications are that this has helped to address cognitive impairments, functional limitations and behavioural issues. The arrangement has helped to delay deterioration and it has enhanced coping capacities.

From the perspective of engendering a personalised approach, it could be argued that this approach has many virtues: it would allow an individual to build a matrix of support with the relevant input from family and internal and external providers and the right balance between residential and home life. It would mean enhanced flexibility to access care at the right times and in the right way.

At the same time, the separation of 'hotel costs' (accommodation and living costs) and care costs presents some challenges for providers; for example, in relation to workforce and more general financial planning, as the type and level of provision required in the medium to long-term is driven by individual's choices and therefore harder to predict and plan for. Furthermore, the question of responsibility for the health and safety of external staff coming into the residence also arises, along with

issues as varied as adult protection, regulation and insurance. For example, it is likely to mean that the registration requirements of the Care Inspectorate need to be reformed.

Case Study Two: CARRICKSTONE INTERMEDIATE CARE SERVICE

The main aim of Carrickstone Intermediate Care Service is to support the individual to return home. Staff members are focussed on the rehabilitation goals of each resident, encouraging the individual to undertake personal care tasks for themselves. The staff group works very much as a single team, combining professional roles, adopting a holistic approach to delivery.

Carrickstone House is located in Cumbernauld and owned by Four Seasons Health Care. The unit provides 20 intermediate beds via a contract agreement with NHS Lanarkshire. The beds are managed by consultant geriatricians from Monklands District General Hospital supported by GP input. The Allied Healthcare Professional (AHP) input to the beds is provided by NHS Lanarkshire utilising in reach staff from the Community Assessment and Rehabilitation team. Nursing care and Hotel services are provided by Four Seasons. The weekly contract cost per bed is £780.

Admission to the unit for the majority of patients occurs after an inpatient admission to Monklands Hospital. The Care of the Elderly team in Monklands identify patients from the Cumbernauld area who require ongoing rehabilitation or a period of "interim" care before a decision is taken regarding community care assessment.

Individuals can also be "stepped-up" from the community to Carrickstone via the responsible consultant geriatrician and can arrange transfer direct from the individual's home to the unit, thereby negating the need to go to an acute site.

Weekly multi-disciplinary meetings take place in the unit each week. These are attended by AHP's, Social Work, Medical and Nursing staff. Each patient has rehabilitation goals against which progress is reviewed daily.

Over half of intermediate care service users return home, where a transition team will continue to offer support at home. A number of the patients do not reach their rehabilitation goals in which case alternative support options are explored.

The development of protocols between care homes and care at home providers could mitigate some of these risks and there are lessons that can be learnt from other sectors in terms of financial modelling which takes account of the impact of individual choice. Moreover, it would be difficult to argue that these challenges on their own constitute sufficient reason not to explore options, or worse, to effectively restrict choice and control by failing to do so.

There is also a need to get into the detail of what sort of variation and choice can be provided in respect of the non-care services that a residential facility could provide: for example, can we facilitate greater choice over meals - what, when and where? Can we give more power to individuals to personalise their surroundings – to choose fixtures and fittings, and the layout of non-communal physical space?

Good Practice example: Specialist Long-term Care

Increasingly, specialist long-term care will involve more complex care packages, often requiring physician support. In addition to the traditional nursing care arrangement, each resident will be registered with a GP of their choice and can access GP support as required. There will also be NHS liaison and specialist nursing to help support nursing practice within the care home, access to Pharmacy support and (importantly) access to a range of specialist medical input, including, where appropriate, consultant geriatricians.

Nursing staff will be expected to have the training and skills to support complex nursing needs including: Tracheostomy Care; Percutaneous Endoscopic Gastrostomy (PEG) feeding; Delivery of IV fluids and/or IV antibiotics and Delivery of oxygen. The needs of residents will often be complex and unstable.

If we were to stratify the funding, it would allow for a clearer sense of what non-care service options cost and would allow for a range of packages to be developed – but a downside might be that we see quite dramatic variation in the quality of hotel services available. Just as in life, some people would be able to afford a high quality experience and others would not – the same would be true of the residential sector – but perhaps more pronounced. The solution here would be to ensure that certain minimum standards are obtained, underpinned by regulation and contractual obligations.

Recommendations

There is consensus that there is untapped potential for the residential sector to become more personalised; but it is not certain that we will realise that potential without an effective strategy to oversee its development.

To that end, the Task Force asks that in the production of a Scottish Government/COSLA strategy on reshaping residential care, the following recommendations are taken forward:

- **The Scottish Government, COSLA and ADSW should make sure that arrangements are in place to support well-informed decision-making for people considering residential care**. This will require effective information and advice being given to older people around the options that are available to them under the SDS legislation – drawing on the best practice profiled by Alzheimer Scotland and others. Advocacy groups for older people would promote the importance of transparency and help provide older people with full understanding of service provision and cost before they enter into a care home, as well as to provide them with a voice once they become residents.

- A formal engagement (board type) structure should be created for all care homes, based on the school parent council model to facilitate and strengthen ties with the community and to provide a layer of reporting and accountability.

- **The Joint Improvement Team, Scottish Care, the Coalition of Care and Support Providers in Scotland (CCPS) and ADSW should support the roll-out of outcomes based assessment and review** within residential settings, learning from the initial 'Talking Points' pilot work undertaken in Scottish Borders. This will require strong leadership, a commitment to cultural change and the tenacious pursuit of personalised care at local levels by commissioners and providers.

- **People living in grouped care arrangements should be able to exercise choice and control over their care, support and daily living arrangements**:
  a) It is recommended that work is taken forward by COSLA, Scottish Care, CCPS, ADSW and a small number of providers on the personalisation of services within residential care as a proof of concept. In particular, the disaggregated delivery of hotel and care arrangements should be trialled to establish whether it is practicable and economically viable.

  b) At a policy level, the Scottish Government and COSLA – with the relevant partners - should systematically review and remove any structural barriers to reform. For example, this is likely to require a change to Care Inspectorate registration requirements.

- **The Scottish Government, COSLA and Scottish Care should undertake work to ensure that charging arrangements are transparent and stratified**. If a fee is not broken down into its constituent elements, it does not allow the consumer to decide if value for money is being offered, or indeed

whether an element of that package would be better procured from elsewhere. See Annex B for work by Laing and Buisson which has done this in for fees in England.

- **The Scottish Government, COSLA, Scottish Care and CCPS should ensure that people are able to access the right type of tenure**. For some, particularly within extra-care housing arrangements, this will mean an opportunity to enter into a tenancy or ownership arrangement; for others, it may mean a more flexible residency agreement.

Conclusion

There is no disagreement with a future vision of residential care which is more heavily personalised, with greater opportunities for customers to express choice and control over the services they use. The practical application of that aspiration is more difficult to express and it is evident that a number of obstacles will need to be overcome before we can expect a shift in that direction. However, it is our view that if the recommendations above are pursued, we will begin to see a shift towards more personalised arrangements for older people.

Part 2: Home and Environment

A personalised approach to care needs to be delivered in a setting and surroundings that themselves support this agenda. Furthermore, the people delivering the care need to be committed to the principles of personalised, quality care. Two of our sub-groups, 'Place Making' and 'Workforce' have given consideration to these elements and developed recommendations for creating the right environments for care to be delivered in, and a valued and professionally skilled workforce to deliver high quality care.

While Place Making does offer the potential for an element of blue-sky thinking to take place in terms of the design of care settings we would like to see in the future, it is important to remember that we aren't necessarily starting with a blank sheet of paper. There is a vast estate of care homes and housing with care sites across Scotland, some which may no longer be fit for purpose, but the majority of which are providing a safe and secure environment for people whose needs would not be as well served in their own home on the one hand, or a hospital ward on the other.

The social care sector is a growing employer in Scotland, yet struggles to attract the right people in sufficient numbers to give us confidence in the sustainability of the workforce. A major challenge exists in building a valued workforce, something that requires a refresh of the image of the workforce as a whole. This can be done by taking steps to attract the right people into care as a vocation, but also by investing the time and money required to improve the culture within the workforce, and in turn, attitudes towards it.

Place Making

Overarching Principles

1. The Scottish Government and COSLA's vision for older people is to support them to remain in their own homes or other homely settings. We need to take steps now to develop a range of 'other homely settings' that will meet the needs and aspirations of a larger population of older people for the next 20 years. At the same time, there is a need to promote supported shared-living as a positive choice and not simply a second best necessity.

2. Future care provision should be planned, located and designed to maximise community and family/carer involvement, and service integration. This may include the potential for co-production and co-location. Just as with schools, care settings should be an active part of communities, and be seen as community assets, rather than as ghettos for the elderly.

3. Care Homes and Housing with Care should be seen as part of a continuum of provision for older people and be subject to the same planning processes. To make this a reality, we need to create a more integrated planning framework that encompasses the range of care and accommodation and applies a consistent set of principles to new development.

4. Scotland's older population is as diverse as its younger population, and so the planning of care provision has to reflect cultural, racial, and lifestyle diversity. Older people are not a homogeneous group. Individuals and groups may therefore want different things and have different priorities. Place Making has

to be part of our wider commitment to personalisation and the move away from a one-size-fits-all approach.

Fitness for Purpose

If in talking about creating new care environments that look different from the care homes and housing with care that we use today, then forward planning is essential. There is a lengthy lead in time for designing and delivering new builds, not least due to the investment required in those new buildings and adaptations required to existing sites. We also have to then live with the buildings we commission for a realistic period of time, meaning it is important to get it right in the first place. In order to assess current capacity and plan future provision we need to be clear about what we want accommodation-based options to deliver, and the range of needs they have to meet. This is in addition to meeting basic quality and registration requirements. In order to future-proof buildings, we need to anticipate now the likely future demands on provision. For example, all care facilities ought to be dementia-friendly, and there is good evidence of what this needs to look like. The Dementia Studies Development Centre at Stirling University has a toolkit for building and service design and also provides a consultancy service.[15] In addition, the Dementia Design Working Group has been established to facilitate new thinking and practice in the provision of residential dementia care. Their 'Design for the Mind: Discussion Document' has been developed to assist wider stakeholder engagement

Similarly, if we want future provision to put more emphasis on personal space, then we need to look now at how that can be achieved, and what the impact is likely to be on capacity and cost.

This also needs to be reflected in the regulatory framework(s). The registration requirements for new or adapted provision need to reflect strategic direction. If we look to create more of a continuum of provision encompassing both Housing with Care and Care Homes then there will be a need to have a corresponding integration of the regulatory frameworks of the Housing Regulator and the Care Inspectorate.

It also requires us to adopt a fresh approach to commissioning: commissioning fit for purpose places, not placements. Providers can only invest in the development of new styles of Place Making if the commissioning process offers sufficient guarantee of a return on investment. Our current approach to commissioning placements is focussed primarily on numbers and tends to produce more of the same standard product. The financial institutions are perhaps understandably more risk-averse than in previous years and will only lend for new development if there is security of demand. This has had a knock-on effect of new developments being taken forward either by public bodies, or aimed at the self-funder market which gives developers a greater guarantee of a return. The purchased care sector is being seen as more unpredictable at the present point in time, although still an area for potential investment if the commissioning is managed in such a way to instil confidence that the demand for this part of the market exists. There is general consensus that the standard procurement model used by councils (rather than a Place Making commissioning approach) is by no means perfect. A solution could be identified with the integration of health and social care, which requires joint commissioning strategies to be created within partnerships. This is a new framework which offers

[15] http://dementia.stir.ac.uk/

the ideal opportunity for a new focus on Place Making within the commissioning approach.

National and local auditing of the care estate

An obvious starting point on the path to creating desirable care settings for the future is to understand what we are currently working with. There is a need to determine to what extent the current range of provision meets the capacity and fitness for purpose requirements, and the extent to which the existing place-making footprint is adaptable to meet future need. Of the 910 Care Homes for older people, and the housing with care provision, we should ask some key challenging questions:

- How much of it is what is wanted or needed going forward?
- How much accommodation will need replacing in the foreseeable future?
- What is the gap between what we have at present and our place making vision for the future?
- What do we need to do to bridge that gap, through adapting what we have or through new development?
- How much commissioning and investment will it take?

To answer these key questions there needs to be an accommodation audit of existing provision. In keeping with Strategic Joint Commissioning it is argued that this could be the responsibility of Local Partnerships to carry out, in order to reflect local needs and priorities. However, given the scale of the challenge in relation to care for older people, there also needs to be a degree of national support. There may need to be links between the maintenance and development of the care estate and future funding, access to capital etc. Doing so will give us confidence that we have the means and support at our disposal to help us achieve our vision for the future of care in Scotland.

There are parallels in the work undertaken by NHS National Services Scotland on the Health Estate. As the 2013 Report states:

'This is the third year that the State of NHS Scotland Assets and Facilities Report has been published. The report is now widely recognised as a key reference document which is used to inform decisions on the continuing investment in assets and facilities services to deliver the Scottish Government's "2020 Vision" for sustainable high quality in health. Getting the right assets and facilities services in place will be central to achieving the "2020 Vision" and will require major change to the type and distribution of assets and facilities services and the way in which we prioritise investment in the future.' This is primarily for public estate facilities.

While there are obvious difficulties in replicating such an exercise across the care home estate (not least the fact that all independent providers would have to 'sign up' to taking part for the long-term) there may be some benefit for Local Partnerships in looking at how the NHS exercise was conducted and how it has helped shape priorities and decision making.

Similarly the Care Inspectorate is able to identify the extent to which care home accommodation meets current standards through analysis of inspection findings in relation to overall quality of environment. As of 31st October 2013, 5.9% homes for older people were at grade 2 (weak) for environment, and only 0.7% were at grade 1 (unsatisfactory). 93.6% of homes were therefore deemed to be adequate (3) or

above in terms of quality of environment. Moreover, although only 2.6% achieved grade 6 (excellent), 29.6% were graded 5 (very good). In other words, the vast majority of the sector as a whole appears to be meeting the basic quality standards. However, this does not in itself address issues of the suitability of accommodation or flexibility in relation to future place making.

Accommodation and Care

Further work is required on determining the desired mix of accommodation across the housing with care and care home continuum. This needs to look at ranges of need and cost comparisons.

At present, Housing with Care and Care Home provision are often discussed as if being at opposite ends of the spectrum of care and accommodation, with nothing much in the middle. There can be an oversimplified view that Housing with Care is seen as being part of community, and Care Homes as being more institutional. In fact both are equally valuable in meeting different ranges of need and circumstance.

Housing with Care is ideal for people with lower levels of dependency, who retain the ability to manage their own affairs, who continue to be engaged with social networks, and who require something less than a fulltime package of care and support. Housing with Care offers tenancy rights, and in relation to accommodation places greater emphasis on personal space than on group living. In cost terms, Housing with Care will tend to cost more to the public purse in overall terms, but as a proportion of this will be through Housing Benefit and Pension, the net cost to Council social work budgets may be less.

Care Homes are correctly suited to people with higher levels of dependency who require a complete package of 24 hour care. Given their complexity of need, a residency agreement rather than tenancy is deemed more appropriate. The emphasis of the accommodation is on group living, shared space and care delivery rather than personal space and independence, although homes will strive to provide the best of both worlds. In cost terms, the overall cost to the public purse is lower, but other than the DWP element, the cost is largely borne by social work for publicly-funded residents.

Nor should these be seen as the only options. Care Villages such as Auchlochan and Inchmarlo, have sought to provide a range of retirement, supported living and care options within a campus environment, in a way that blurs the distinction between ‘own home’ and ‘care home’. There has also been the development of Intermediate Care provision with an explicit focus on short-term care, re-ablement and rehabilitation.

Place Making within local partnerships should facilitate the availability and accessibility of all the accommodation and care options, to maximise choice and the tailoring of care packages to an individual’s needs and circumstances. This can best be done through an integrated approach to care planning that sees all accommodation and care as part of a single system.

Location and Distribution

Care and Accommodation provision is not evenly distributed across Scotland at present. There are areas of under provision as well as areas with excess capacity,

and although this is something that can perhaps be more clearly seen in an urban vs. rural context, it is also true even within the one local authority area.

If we take Glasgow as an example, much of the development of care home provision has been in the east of the city where land and build costs have been lower, and there are parts of the south and west of the city that are under-resourced. In a similar way with Housing with Care, there are parts of the country with no provision of this sort at all.

The balance of provision may also look different in rural areas, where the delivery of home care support has to take on board the challenge of distance. This has tended to create a corresponding reliance on residential, but often non-nursing, care. Achieving the optimum balance and location of provision requires a joined up approach to planning and commissioning to ensure targeted development in line with strategic needs. Such targeted development may also require a differential model of procurement that recognises the cost and volume issues in certain areas.

Where services, such as step-up and step-down provision, are designed to support health care delivery, future co-location may worth exploring. For example, the possibility of such provision being part of hospital development to support admission and discharge strategies. Delayed discharge occurs in the health system when a patient is well enough to leave hospital, yet due to the lack of availability of suitable support, they are unable to return home, or to a residential setting. 126,000 bed days were occupied by delayed discharge patients in NHS Scotland during the quarter July to September 2013. The most recent figures published by ISD showed that over 50% of patients subject to a delayed discharge from hospital found themselves in that position as they had to await a place in a care home.[16] The cost to the NHS is considerable, and clearly there is work to be done between hospitals, care homes and social work departments to address the issue. In tackling delayed discharge, it would be an advantage to site an intermediate care facility in the grounds of a hospital than 'boarding beds' in the hospital itself.

Equally, there may be opportunities for community co-production and shared ownership of care provision. The idea of small groups of service users "going it alone" by pooling their SDS Direct Payments to set up their own care and accommodation service is perhaps a little unrealistic given that many people in this group are either incapacitated or not able to fully comprehend the complexities within commissioning processes and contracts. However, the idea of care homes being seen as community assets and managed by community groups in the same way as sports and leisure facilities is not beyond the bounds of possibility. Similarly, as with the care village model, there may be ways of enhancing the opportunity for residents to have a stake in the ownership and management of the place they live in.

Generic v Specialist Provision

Much existing provision has been developed on the basis of a one-size fits all approach. The design of future premises may need to reflect more clearly the range of needs and care pathways, and in so doing will have to be an integral part of the personalisation agenda. Smaller units within core and cluster arrangements may

[16] http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2013-11-26/2013-11-26-DelayedDischarges-Summary.pdf?82784670592

provide a way of balancing the provision of targeted accommodation with shared services and some economy of scale.

This is a complex issue. Correctly there are concerns about the compatibility of different types of care within the one setting:

- how to balance the needs of people requiring respite or rehabilitation, with those requiring longer-term or end of life care;
- how to provide a dedicated environment for people with advanced levels of dementia, without creating a sense of segregation or stigma;
- how to develop the idea of a 'care hub', combining residential care, day care, and other community based outreach services, without losing the integrity of the care being provided.

There may also be parts of the country where smaller numbers require care homes or other care facilities to multi-task, because it would not be viable to have separate free-standing provision. From a service user perspective, the goal is also for care settings to offer a 'home for life' and to avoid or minimise the need for a move as needs change. There is a desire to see services developing specialist knowledge, skills and provision, without this becoming unduly limiting in terms of flexibility.

We have examples of the good use of separate units within larger care complexes, BUPA at Rodgerpark, for instance, with the development of Palliative and End of Life Care, or HC1 at Highfield for Intermediate Care. There are also care homes that offer a range of day care, respite, and home support. The key to this being done well is allowing facilities to diversify in response to local need, providing each service component is properly planned and resourced. The Care Inspectorate are in agreement that this may need to be matched by a flexible approach to Registration which allows services to innovate and develop new models of care within the framework of their existing registration. It also needs to be supported by good assessment and care planning, so that the focus is on individual needs and outcomes, rather than categories of care.

Personalising Accommodation and Care

As discussed above, Housing with Care has tended to place greater emphasis on personal rather than shared space, individual rights, control and ownership of the accommodation base, and the promotion of independence. There is no reason why these aspects should not apply to all accommodation-based care, even where 24 hour nursing care is required. It is primarily a matter of culture and cost. The care sector has been on a journey from institutionalisation to personalisation and the vast majority of services have made huge strides in terms of culture and care planning. Place Making also needs to reflect this journey in terms of enhancing identity and ownership. The My Home Life initiative[17] which we are rolling out across Scotland under the auspices of the Change Fund, is a very good vehicle for promoting this shift.

In order to improve public image and confidence in care accommodation, there also needs to be a clear commitment establishing care settings which are imaginative, high-quality, aesthetically pleasing and integrated into the heart of communities. If the goal is to encourage the involvement of families, friends and the wider

[17] http://www.myhomelife.co.uk/

community in the care experience, the location and style of accommodation is going to make this easier or harder.

Moreover, whilst accepting that in everyday life, the level of accommodation people can access is according to means, there might perhaps be some concern about the development of a 2-tier care sector, where developers target self-funders and provide a higher standard of care environment than is available for publicly-funded care.

Investment and Disinvestment

Investment is going to be required to maintain and improve existing care accommodation, and to develop future capacity. The more significant the shift that is wanted in the style of care provision, away from the existing service footprint, the greater the required level of investment and timescale for development is going to be. Similarly, there will be a need for planned and supported dis-investment where there is excess capacity or provision which is no longer fit for purpose and not adaptable to meet future patterns of need. This needs to be done through a coordinated planning and commissioning process and not be left to market forces. Providers will need to be helped, if need be, to exit the market in a positive way, without the risk of service disruption. Sudden action to decommission sites would likely create instability rather than a strategic shaping of the market. Certain high level decisions may also need to be made about the future ownership of care premises, and there may be desirability in exploring models of public/private partnership in the development of new provision.

This may simultaneously benefit Local Authorities (as commissioners and providers) and the independent sector. Councils seeking to develop new capacity to replace existing in-house provision may find that doing so in partnership with an independent sector (and voluntary sector) provider is a more cost effective option whilst retaining a degree of control, than either keeping the development entirely in-house or completely outsourcing. Similarly, independent sector providers may in some areas find it more viable to pursue development in partnership with the local council, through the leasing of premises or the making available of sites. We have already seen examples of the latter in Edinburgh, where land and building costs would make it impossible for the independent sector to develop new provision aimed primarily at publicly purchased care. A partnership approach to development can produce benefits to all parties in such conditions.

As discussed above, an audit of the care estate, once we have determined the blueprint for future provision, may also highlight the need for Government to be involved in making the required level of investment possible.

Vision

Place Making is about creating a range of high quality aesthetically pleasing shared-living care and accommodation options for older people that offer the maximum opportunity for the retention of both personal identity and community involvement.

Recommendations

We recommend that in relation to Place Making:

- Each Local Partnership publishes its forward looking Place Making agenda, together with a 5 year plan of its commissioning and purchasing intentions in relation to accommodation and care provision for older people, and that this should form the basis of engagement with providers as to what it would take to deliver.

  An audit of the care estate be carried out, primarily locally, but in a way that allows for a national overview, to determine the quality, capacity and fitness for purpose of care home and housing with care provision, and that this be used to inform planning, commissioning and investment decisions. Care Home and Housing with Care provision is dealt with as part of a single system of care planning and funding, so that individuals have choice and access to the option best suited to their needs and circumstances.

- Local partnerships be encouraged to explore options for the co-location and co-production of care and accommodation for older people

- Place Making and the development of Accommodation and Care, reflect a fundamental commitment to Personalisation.

- Local partnerships adopt a strategic approach to investment and dis-investment, in developing future accommodation and care provision, and that this is supported by Government where necessary and appropriate.

- An engagement structure should be created for all care homes, based on the school parent council model to facilitate and strengthen ties with the community and to provide a layer of reporting and accountability.

Conclusion

What we think of as a 'care home', and what such provision looks like, should correctly evolve and change over time. There needs to be more of a continuum of accommodation and care options. At the same time, the need for settings that provide integrated packages of accommodation and care, including nursing and 24/7 provision, either on a short or medium term basis for people with a range of particular care needs, seems likely to remain. Doing this on a group living basis can provide both a degree of efficiency and an in-built sense of community. Having the right range of accommodation options to meet current and future need in relation to the care of older people is therefore crucial. From a Place Making point of view, it is clear that the desired direction of travel is the creation of homely settings, which are fit for purpose, which protect the rights of service users and allow them to have a greater stake in their accommodation, and which promote an optimum level of independence and community connectedness.

Workforce

The anticipated changes in Scotland's demographics, and the attached increase in complex conditions will of course have implications for the care sector's workforce in terms of the skills, values and behaviours required to undertake the role and for employers and commissioning authorities in terms of funding. The ability of the sector to meet an increased and broad range of needs will only be as good as our ability to equip it with the necessary skills and attract the right people into care as a desirable vocation.

The following section seeks to develop discussion as part of a National debate on how we as a society in Scotland value the care of older people and prepare and reward a highly skilled and motivated workforce to deliver care that is person centred and of a high quality.

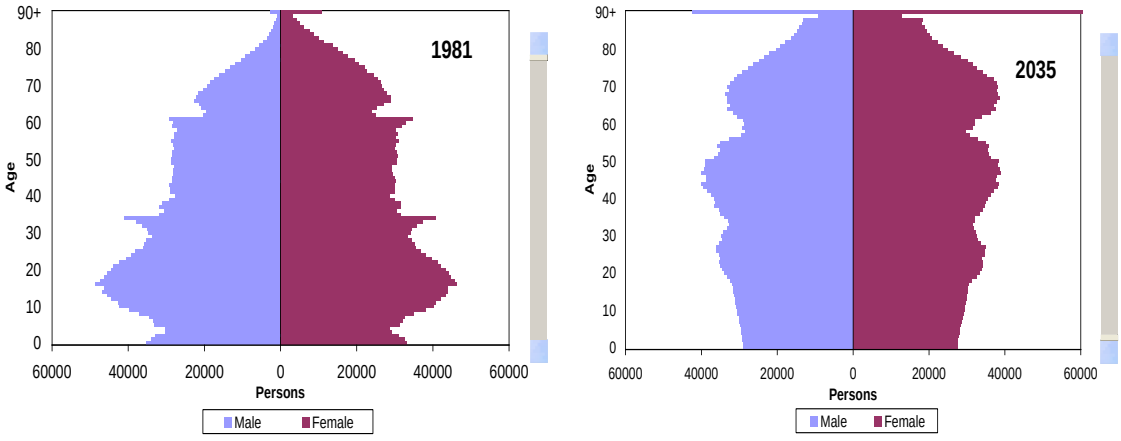
The Residential Care Workforce

Over the next twenty years, there will be a considerably greater increase in the over 60 population in comparison to the 16-59 age group (see Figure 1 under 'Current Landscape').

Clearly, this means there will be greater competition across all areas of the economy for labour resource. The care sector, which already struggles to recruit in areas of high employment, will face a tougher challenge in making itself an attractive option against other sectors that currently pay better and have a better image, all at a time when there will be more of a need for a strong workforce. It will potentially place a significant strain across the whole system and on the people who depend on care services for their own wellbeing, or that of a loved one.

As Figure 1 below demonstrates, it is also expected that the working age population will have more people in their late 40's – 60's than was the case in the early 1980s.

Figure 1 Population pyramids for 1981 and 2035.



Source : http://www.scotphn.net/pdf/PDF_171212_LH_MASTER_-_ScotPHN_OPHSCNA_epid_report3.pdf

This can be attributed to falling birth rates in recent years, but aside from the actual demographics, there is the added context of people having to wait until they are 67 and eventually 68 before qualifying for their state pension. The current care

workforce is ageing, with the average age in the sector currently being around 46 years – a key consideration when we consider the physical demands of caring as a career. In addition there is a significant gender imbalance, with 85% of the care home workforce being female. There needs to be consideration of how to support an ageing workforce to ensure we maximise their knowledge, experience and caring values while accommodating and adapting to a potential reduced physical capacity.

Table 1 below sets out the number of people working in the care sector in Scotland, by sector and by care type. 68% of the sector work in the independent and third sectors and just over 28% of those that work in care in Scotland are employed in a care home setting.

Table 1 – Scottish Social Services Workforce

Service Type	**Headcount**	**% of Scottish Social Services Sector**
Care Homes for adults	54,060	28.3%
Care at home/housing support	61,350	32.13%
Total	**115,410**	**60.4%**
54,360 (47.1%) of this workforce is employed in the independent sector		
Total Scottish social services workforce comprises: **41% independent sector 32% public sector 27% third sector**		

Source: *Scottish Social Services Council, Scottish Social Services Sector – Report on 2012 Workforce data*

Registration, Qualifications and learning of workforce

The Register for social service workers is function based, rather than qualification based, meaning that to register with the Scottish Social Services Council (SSSC) a worker must be performing a relevant role in a service registered by the Care Inspectorate rather than holding a specific qualification, before they become eligible to register.

Under the Statutory Regulations passed by the Scottish Government in 2009, service providers will be committing an offence if they employ or continue to employ, a worker in a service who is not registered with the Scottish Social Services Council (SSSC) or another relevant regulatory body e.g. the General Teaching Council, Nursing and Midwifery Council.

The qualifications for registration are based on the National Occupational Standards (NOS), which form the basis of the suite of qualifications, Scottish Vocational Qualifications (SVQs) in Health and Social Care (HSC). Nationally, the SVQs are linked to the Scottish Credit and Qualifications Framework (SCQF), which means that all awards in Scotland (secondary education, FE, HE, vocational) articulate with each other.

The SVQ qualifications are work based – they are assessed in the workplace and delivered flexibly, enabling candidates to work while learning and being assessed on their knowledge and competence in practice, measured against the NOS. This sometimes requires time away from the workplace which may have to be backfilled.

In addition to possessing the core qualifications to practice there are a wide range of training and development requirements needed in the setting. Depending on the role, this may include skills and knowledge related to administration of medications, falls prevention, nutrition, anticipatory care planning, first aid, tissue viability, rehabilitation, moving & handling, health & safety and so on. Increasingly in the future, skills will be required in relation to self-directed support, adult protection, providing more personalised services and skills with regard to inter-agency working.

Learning and development for staff, in the context of the changing and more complex needs of people who use services, will require a higher range of skills and greater accountabilities from the workforce. These activities usually need to be purchased and may also require time away from the workplace, both increasing costs in the sector.

Future Skills – Residential Care Workforce

It is clear that a skilled and trained workforce in the future will have to have the capability and training to enable the sector to address the significant challenges and changes in the population of older people who live in care homes and their changing patterns of need. These include:

- Increasing frailties and long term conditions;
- Dementia care (use of Promoting Excellence) and Elderly Mentally Infirm (EMI);
- Intermediate care models which demand new and developing skills and techniques;
- Maximising the use of technology to underpin care and support and ensuring technological links to other care sectors i.e. health services; The pace at which telehealth and telecare is developing and playing an increasing role in maximising independence makes the provision of robust training in this area essential;
- Reablement models and promoting self-management;
- Palliative and end of life care; and
- Skill mix & staffing numbers – developing workforce planning tools to support appropriate levels of skill to meet patterns of need – across the totality of the care home workforce.

It can be seen that increasingly there is a need to provide and secure highly specialist care and support for those with the most complex needs and behaviours.

It is important that good links are established across community care and all health services (primary, community and acute settings, including mental health) to maximise the available support and expertise to care home residents and to the people who care for them in the home. While we do not advocate older people's entire health and care needs being met within the care home setting or by care staff, we recommend that the Joint Strategic Plans that will be developed under Integrated working and the Public Bodies Bill are used as a vehicle for partnerships to specify how the full spectrum of primary, community, acute and social care provision will be

configured in order to support older people including those who are resident in care homes, to remain cared for in a homely setting for as long as possible.

In order to support the sustainability of appropriate skills in the care home sector it is important that a number of factors are addressed:

- It is critical that Nurses, GPs, Social Workers and Allied Health Professionals (AHPs) in training can experience high quality learning placements in the care home sector – both in order to promote some AHPs and others choosing to work in the sector in the future and to ensure those health professionals who go on to work in the NHS have an awareness and appreciation of the needs of colleagues working in the residential care sector. This would also ready the wider workforce for the potential use of care homes as step-up/step-down and rehabilitation facilities.

There are significant issues in terms of developing this workforce for both individual workers and employers. These include:

- Costs in the context of downward financial pressures;
- Staff recruitment and turnover;
- Staff motivation in the context of this predominately being a low-wage workforce and in the context of the levels of staff 'burn out' – a recognised syndrome which can occur in people working in stressful working environments with high job demands and low resources ;
- Pressure on training and development budgets;
- Availability of assessors and trainers; and
- Staff time, expenses and backfill to undertake learning and the impact training and development has on rotas and the cost to provider.
- As part of their training, GPs don't currently spend any time within care homes, meaning they are often entering these environments for the first time as a qualified GP 'blind' to the ways in which care homes operate and the level of dependency of the residents.
- There is a disparity between the public and independent sectors in relation to the level of centralisation and training available.

Wages, Terms and Conditions

There is no parity for the independent and third sectors in terms of pay or other terms and conditions with NHS or local authority equivalent jobs. Successive downward financial pressure on settlements and efficiency targets mean reduced budgets to the public sector and a consequent impact on the independent and third sectors. While the National Care Home Contract has seen the application of uplifts on the weekly rate for care home placements it continues to be the case that this remains a low wage industry and it is also recognised that uplifts are not necessarily passed across to workers as wage increases, given the other demands on the sector

including maintaining environmental standards, training requirements and meeting costs of recruitment.

Current financial challenges and savings targets in local authorities mean that even less resource is going to be available in future, and any recommendations in terms of the workforce need to be seen in the context of there being little new money to support its development.

Reports and submissions for this section suggest that providers are addressing financial challenges in a number of ways. Supervisory and managerial tiers within care homes in some areas have been stripped out to sustain services at the frontline and development and training budgets are reported as being under pressure. In turn these approaches potentially reduce opportunities for career progression in the sector, making entry into the workforce a potentially unattractive career prospect. This also impacts on staff support and morale as supervision of staff, if available, is often reported as being used as a management and performance tool rather than as personal and professional development tool. All of this compounds the challenges we face in securing a sustainable and skilled workforce in this sector in coming years. New means of rewarding provision and the workforce need to be explored to address this, notwithstanding the current financial pressures.

Living Wage Debate

Some of this is played out in the current debate on the Living Wage and the national Minimum Wage. Anti-poverty groups across the UK have campaigned for an end to 'in work' poverty through introduction of an agreed Living Wage. The agreed Living Wage in the UK is currently £7.65 and the National Minimum Wage is £6.31 for adults and £5.03 for those aged 18 to 21 years.

A number of employers have committed to paying a Living Wage, including in November 2012, the Scottish Government for those staff whose pay it is responsible for. A proposal for a private Member's Bill which would have created a requirement for private sector employees working on public sector contracts to be paid the Living Wage had been consulted on in 2012, but this was withdrawn at the consultation stage.

Most local authorities in Scotland have also either introduced the Living Wage for their staff or are committed to its introduction; including for care home and care at home staff where the authority employs them.

In comparison, current trends suggest that wages in the independent and third sectors are not keeping pace with the national Living Wage, with a high proportion of workers in the care sector being paid close to, or at, the National Minimum Wage. This creates a risk of the development of a two tier workforce in the care sector and also creates a challenge in terms of staff recruitment and turnover in areas where the independent, third sector and public sector staff are employed. In practice this means that workers may enter the sector through the lower paid independent and third sector route, receive induction, training and qualifications and then move into higher paid public body employment. This creates turnover and cost challenges for the independent and third sectors who find themselves in a perpetual cycle of recruitment and managing vacancies. It should be acknowledged that while

independent and third sector providers must, as a minimum, pay staff the National Minimum Wage, there are no mechanisms that can compel them to pay more than this.

There is a clear need, set against the challenging context we face, to ensure the social care sector is a career pathway of choice so that it can attract people with the skills, values and behaviours desired to look after and support some of our most vulnerable citizens. Current projections suggest a need to significantly increase and retain the number of people entering the sector to meet increasing and evolving need. At the same time, the demography of a decreasing working age population with greater competition for workers across the lower paid end of the employment market is recognised as a significant challenge in relation to the availability and sustainability of the workforce.

Re-shaping residential care for older people is not just about keeping down costs of providing care but has to be about fundamental improvements in the quality of care which is provided (against the context of increasing complexity and workforce challenges). One of the most effective means of delivering consistent standards of care is to ensure that staff are well trained, respected and rewarded and this must mean that remuneration reflects the value placed on these important roles. Care should be an aspirational role which attracts people wanting to deliver high quality support, with adequate and equitable levels of pay rewarding the role. In particular regard to training, workforce development plans should be developed not in silo, but across sectors and professions to ensure that opportunities for development are clear and the risks of duplication are minimised. This is also likely to help develop a level of 'cross fertilisation' of staff between sectors and organisations.

Levelling up the terms and conditions in the care sector toward the Living Wage (or beyond) would need to be seen in the context of a range of measures designed to increase the challenges in the workforce and consideration would need to be given as to how funding increases, if made available for this, would impact positively on workforce outcomes and outcomes for people that live in care homes. It would be expected that care home contractual processes would be the vehicle for setting out the consequential quality improvements from any funding increase.

However challenging it is in the context of public sector finance in Scotland, the issue of salaries, terms & conditions of employment and parity across the whole social services workforce, needs to be part of the much wider debate on how we care for and support older citizens.

Specialisation and Flexibility

Both independent and third sectors can demonstrate areas of specialisation in the workforce – particularly in relation to the third sector's focus on Learning Disability, Mental Health, Alcohol and Drugs, Physical Disability and Sensory Impairment. In workforce terms this can however mean that workers train in a single area of specialism and stay there for the rest of their career. However, the core competencies of their qualifications should be transferable throughout social services settings if they choose to move.

It is also increasingly the case that due to the complexity of need and frailty seen in older people in care home settings that we need to consider older people's care itself as a specialism with an appropriately trained and supported workforce to meet the multiple complexities of this population. If there is a difference in the level of training available to staff within the independent sector and those in the public sector, this will be a barrier to the long-term flexibility and resilience of the care sector as a whole.

We would strongly encourage more thinking on the transferability of the workforce across the public, third and independent sectors, to ensure maximum flexibility, skills sharing and person centred focus of care. This is particularly pertinent in giving wider consideration of seamless pathways of care and the 'whole system' approach necessary now and in the future to address the challenges of demographic change and financial pressure and we would encourage Joint Strategic Planning development work to consider workforce planning and shaping across the whole spectrum of staff working in care. In this way, we might envisage care staff operating across a care home for step-down care and then, to ensure continuity, supporting an older person's transition back to home. Similarly, at times of significant pressure, registered nurses might be deployed by NHS Boards into care homes to support more complex care or relieve significant system pressures. This will require innovative approaches to staffing services across the full pathway of care.

Palliative and end of life care

The provision of good palliative and end of life care is part of the core work of residential care. Many older people living in care homes, both nursing and residential homes, have a range of chronic and potentially life threatening health problems. These can include diseases such as cancer, heart disease and dementia. These conditions tend to worsen over time and can leave residents in a fragile state of health, facing painful and difficult symptoms in their final years. Furthermore, 21% of the population over the age of 65 die in care homes. Given this, care homes are an increasingly important setting for palliative and end of life care and support.

In order to be able to provide high quality palliative and end of life care, care homes need to develop good internal resources and have well trained and well supported staff. Residential homes which have no registered nursing staff on site also need good links and support to local healthcare systems including primary and community services, as well as to specialist care resources. Also, there is real potential here to utilise telehealthcare technology to develop such links.

Key challenges in improving palliative and end of life care in residential and care home settings mostly relate to workforce issues. These are:

- Developing and embedding a culture which supports staff to provide good palliative and end of life care;
- Sustained and consistent leadership and management with the necessary focus on quality care in this area;
- Retaining staff which will help to sustain and embed the appropriate culture;
- Obtaining and affording high quality courses – which in itself raises challenge of cost and cost of backfilling participating staff;

- Developing and sustaining good consistent links to local NHS and General Practice Services and creating clear community care hubs which support people living in care homes. The locality focus to be developed under Integration as set out in the Public Bodies Bill provides a clear opportunity to configure services around communities, which, of course, include care homes.

Behaviours, Values and Culture

It is very important that we don't focus on keeping costs down ignoring the significant need to promote, foster and develop the right behaviours, values and cultures in the residential care workforce, to enable it to provide the best, person-centred, safe and effective care. The NHS for instance, has training for staff on the Patient Safety Programme, yet there is no equivalent provision within the social care sector and it may be considered that the programme should be rolled out to all within this sector. In order to ensure the delivery of genuinely person centred care we also have to ensure that the staff working in these environments also feel, and are, valued. There is real potential in considering the role of care homes and the care home sector in the Person Centred Care Collaborative work and we would encourage local collaboratives to actively engage with the sector and develop with them the capability to become involved.

From submissions to the working group we heard that the essence of good care across the complex care and support provided in residential care ensures that there is not a focus only on 'task' but on 'being with' residents, focussing on personal outcomes, relationships and being person centred.

Kindness, compassion and whole person care were key themes emerging from contributions to this section.

Current pressures on finances and availability of workforce can mean it is challenging to positively recruit for these traits or to focus on them as part of the on-going training, development and quality improvement in residential homes. However, they will have an increasing focus as we move to personalise services and where people that use services have more choice and control in the use of their own budgets.

Care Homes as Community Resources and the role of Volunteers

While not strictly within the remit of this section we recognise that there is a significant amount of volunteering taking place already in the care home context. This includes volunteering for befriending, leisure and recreational activities and community focussed activities, in addition to assisting in the governance of facilities as outlined earlier.

We suggest that consideration is given, perhaps within the developing Joint Strategic Planning processes, to developing roles for volunteers in supporting people that live in care homes and that Third Sector Interfaces, working with the public and independent sectors are charged with developing this agenda.

Sustainability and availability of the Workforce

This is a key challenge both at the present time and projected into the future. Demographic change in Scotland suggests that, as well as there being an increasing proportion of people over 85 with complex care and support needs, this is compounded by there being a decreasing working age population available to fill care and support roles.

In some areas of Scotland, particularly areas of high employment such as in Aberdeen and in cities with a large choice of low paid jobs, these problems are even further amplified as competition with retail and seasonal hospitality industries is intense. Over and above this, recruitment problems in the workforce are also being felt in the public sector and this creates further challenge across the whole system, as all sectors are effectively recruiting from the same shrinking pool.

Challenges for Reshaping Residential Care

As indicated earlier, further challenges exist in the context of the changing policy context that the Reshaping Residential Care Task Force is working within - specifically with regard to Reshaping Care for Older People, Adult Health and Social Care Integration and Self Directed Support. All these policy areas demand service change and they drive organisational development across all sectors. This will require investment and a re-prioritising of resources in order to ensure real change. Without such investment we will not be able to see the necessary shift in the balance of care delivered or sustained and will not be able to realise the outcomes from integrated and seamless models of care and the efficiencies that can be derived in working in that way.

Recommendations

The Workforce sub group makes the following recommendations:

- That as a matter of some urgency, financial modelling of a national commitment to the Living Wage in the care sector is undertaken, to support a national debate on appropriate payment and reward in caring as a career; this should include modelling against other comparable health and local authority sector roles.

- That all Joint Strategic Commissioning Plans include, as part of their needs analysis, a scoping of the workforce issues in the care home sector in their partnership. This scoping should include an analysis of skills and training requirements and gaps, issues of recruitment challenge and gaps and opportunities for role and career development.

- That consideration and testing of a national workforce planning tool for the care home sector is undertaken.

- That training and development opportunities through the use of technology, innovation and new (and more cost-effective) ways of learning are scoped in order to support excellence in practice and employers in releasing staff time to

train. Training and development should be extended to include service improvement and safety programme tools and initiatives.

- That given the increasing levels of dementia seen in residential care home settings, we ensure that the good practice set out in Promoting Excellence is enshrined in a formal qualification and that work is undertaken with the sector to support the roll out of appropriate levels of training in palliative care needs in each facility.

- That research is undertaken on the level of burn-out experienced by staff in care home settings, and that models of supervision and support are developed to address this.

- That Third Sector Interfaces, as part of the Joint Strategic Planning process, create a vision for developed volunteering roles in support of people that live in care homes.

- That, as part of their training, GPs should undertake a placement within a care home in order gain an understanding of the ways in which care homes operate and the level of dependency of the residents.

Part 3: Supporting Sustainable, Quality Care Services

Regardless of the setting in which someone is receiving their care package, getting the Commissioning, Funding and Regulating mechanisms right is crucial to ensuring the experience is as smooth as possible and ultimately provides high quality care and value for money.

Unfortunately another element that has become increasingly important is the need for robust contingency planning, something which is essential to ensure the continuity of care for service users and residents. Ideally the swift and strong response by the Care Inspectorate and local authorities to recent cases where standards have fallen short will have sent out a strong message that sub-standard care is not acceptable, but also, the creation of joint-strategic commissioning strategies and the review of the care standards will mean that all parties are clearer on what is expected of them in the delivery of care.

But inspections and funding streams needn't be the only source of threat to the continuity of care, and we need to acknowledge that there are events (e.g. flood, fire etc.) that simply can't be predicted.

Commissioning

Background

Since the development of the National Care Home Contract in 2006, standardised contracts and more transparent and consistent approaches to funding care have been established. This has largely overcome the variation and complexity in the contractual relationship between the individual, the provider and the council - something the Office of Fair Trading was particularly critical of prior to the establishment of the National Care Home Contract. Considerable progress has therefore been made on the procurement of care in care homes over the last decade, resulting in a more stable and efficient purchaser-provider relationship through a national model contract and fee structure that all councils have used.

However, the current mix of services within the care home market is not producing optimum outcomes. There has been limited innovation in the sector. For example, the development of intermediate care facilities at scale has not happened (which would build up the confidence and abilities of older people who are ready to be discharged from hospital but not yet fit enough to live independently in their own home). In addition, generic long-term care provision has been variable, with a significant minority of operators continuing to provide care at undesirable quality levels.

Within this context, it has not been possible for local partners (NHS Boards, local authorities, third and independent sector) to fully shape market behaviour and as such there have been growing levels of interest in moving towards a commissioning model.

Why do we not commission care homes at the moment?

Historically, the focus in Scotland has been limited to a process of improving the purchaser-provider relationship that exists with the care home sector. While this has delivered the gains identified above, the development of a more managerial or commissioning based relationship has not been sought, which would move beyond the purchaser-provider paradigm. This was in part due to confidence among commissioners that the private sector (which is the predominant sector), based on an appropriate return on capital investment, would make sound business decisions in localities with serviceable demand. In turn, consumer choice was held to drive market behaviour (in the sense that any market functions by responding to customers' preferences). As such, there was deemed to be less need for the purchaser (the local authority) to define what services were required since the end-user would be in a position to identify service requirements by exercising choice within the market place. In other words, the accepted paradigm was that care home operators would do the 'commissioning thinking' based on consumer preference and local authorities would simply buy the product.

However, as the business models of providers became more elaborate, coupled with a downturn in the economy and a shift in policy direction, we have witnessed a gradual erosion of occupancy rates and a previously unknown financial fragility within the sector. What is more, consumer choice has not delivered the innovation and market responsiveness that we would have expected. In a rational world, service users would avoid poorer quality homes, which would then be forced to exit the market; but in practice, the variability of information, fluctuating standards, the wish of service users to be placed close to their family or community, and the financial power of large national providers who can protect poorly performing homes, all distort the operation of choice. And even in those circumstances where business failure does happen, there are significant political and professional reasons to disallow this form of market correction (there is significant evidence that sudden and unplanned closures impacts on the health and life expectancy of care home residents).

For all of these reasons, a commissioning model never developed. But precisely because of the deficits outlined above, now is the time to develop this thinking.

Why is commissioning important?

In taking forward the Reshaping Care for Older People Programme, partnerships are required to establish, through their strategic joint commissioning plans, how the balance of care will shift over time, as they seek to move away from reliance on institutional care facilities such as hospitals or care homes.

The commissioning process involves: assessing and forecasting population need; planning the range, type and quality of services and support mechanisms that need to be put in place to meet those population needs; putting in place arrangements to deliver or procure these services and support mechanisms; and reviewing the process by establishing whether objectives have been met. Health and Social Care Partnerships will develop a commissioning plan across the spectrum of early intervention and prevention, through diagnosis, treatment, rehabilitation and better management of long term conditions to long term care.

This commissioning agenda is fundamental to the future integration of health and social care services – and is now the accepted process for dealing with 'whole system' service redesign. For example, unless we invest in anticipatory care and appropriate care at home capacity, unscheduled care may become more challenging to manage.

Under the proposals for health and social care integration, the new Health and Social Care Partnerships will be responsible for developing commissioning plans, in partnership with the third and independent sectors. These plans may also provide for the tools of re-commissioning and decommissioning, described in more detail later in the discussion.

Commissioning for the Care Home Sector

As part of the strategic commissioning process, the Public Bodies (Joint Working) Bill will require integration authorities to:

- Embed patients/clients and their carers in the decision-making process;
- Treat the third and independent sectors as key partners; and
- Involve GPs, nurses, other clinicians and social care professionals in all stages of the planning work, from the initial stages to the final draft.

Good strategic plans should:

- Identify the total resources available across health and social care for each client group and relate this information to the needs of local populations;
- Agree desired outcomes and link investment to them;
- Assure sound clinical and care governance is embedded;
- Use a coherent approach to selecting and prioritising investment and disinvestment decisions; and
- Reflect closely the needs and plans articulated at locality level.

The group agreed that taking a commissioning approach should, over time, shape and manage the care home sector.

National perspective

It has been acknowledged that local partnerships need significant support to take this work forward. This was highlighted by Audit Scotland which was critical of commissioning skills in Scotland in its report Commissioning Social Care[18] (2012), and recommended that local authorities, along with Health Boards and other relevant

[18] http://www.audit-scotland.gov.uk/docs/health/2012/nr_120301_social_care.pdf

partners, should develop commissioning strategies, a recommendation that was accepted.

A national steering group has been established to take forward joint strategic commissioning, which in addition to producing a common definition of commissioning, has overseen the production, and ensuing launch, of a Learning Development Framework in order to assist those responsible for improving joint commissioning skills and capacity across local partnerships.

In particular it explores the skills needed to deliver effective joint strategic commissioning of older people's services. However, it is intended that the material is useful for other groups of patients and service users as well – the joint commissioning skills involved are relevant to all populations, service users and patients. It is of particular use to:

- Senior Partnership leaders, executives and commissioning managers;
- Officers with responsibility for training, organisation development and HR; and
- Individuals wanting to develop their own joint commissioning skills.

The Framework was developed, in consultation with a wide group of stakeholders, by the Institute of Public Care (IPC), part of Oxford Brookes University and published in November 2012. It helped shape partnerships' first iterations of their local JSC Plans, which were prepared for February 2013.

Following completion of the Learning Development Framework, the Joint Improvement Team (JIT) was tasked to lead on the development of a National Improvement Support Programme (NISP). This involved scoping the various initiatives that are planned and underway by national partners to support this agenda and details what support partnerships can expect to receive directly from the JIT. Over time the NISP will provide a medium for introducing greater coherence and co-ordination across the commissioning improvement landscape.

We will, in particular, work with partnerships to build up expertise analysis of joint data, including details on dependency levels within the current cohort of care home residents, reasons for admission, lengths of stay etc. This combined with analysis of future trends will be important in undertaking a Joint Strategic Needs Assessment.

Joint Strategic Needs Assessment

Joint Strategic Needs Assessments (JSNAs) analyse the needs of local populations to inform and guide the commissioning of health, wellbeing and social care services within each partnership area. The main goal of a JSNA is to accurately assess the care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities.

Market Facilitation

Market facilitation can be broadly defined as follows:

"Based on a good understanding of need and demand, market facilitation is the process by which strategic commissioners ensure there is sufficient appropriate

provision available at the right price to meet needs and deliver effective outcomes both now and in the future."

As we move to a position where more people are funding their own care it could be argued that there is less need for the state intervening in the relationship between the provider and the consumer. However, if we leave the care home sector to be entirely driven by market forces then we would have to acknowledge that some businesses will fail and that will mean vulnerable people being rendered homeless. Should this happen on a large scale then we would be faced with another Southern Cross crisis. Also, in a pure market the tendency is to gravitate towards larger suppliers who can offer greater economies of scale. Whilst in some aspects of public care this may be desirable there may also be a good case to protect small local organisations who supply a different kind of service. In addition, the majority of care purchases are still funded by the state. The duty of care and the duty to ensure best value remains with the local authority.

Some sort of market facilitation therefore will be vital but should move away from a paternalistic approach of 'the state always knows best' and into a world where strategic commissioning fully involves providers and service users to ensure the right levels and variety of supply of quality care are available.

Market Facilitation Statement

In order to help facilitate the market, partnerships should develop a Market Position Statement, a brief analytical document that presents a picture of demand and supply now and in the future. It should indicate the necessary changes, characteristics and innovation to service design and delivery identified as needed to meet the needs and preferences of the population using those services. It should be developed in terms of improving outcomes for service users and driving up quality.

A good Market Position Statement should include:

- The overall direction strategic commissioners wish the market to take;
- Predictions of future demand across the whole market, identifying key pressure points and the rationale behind assumptions made;
- A picture of the current state of supply covering strengths and weaknesses within the market;
- The areas where a partnership would wish to see services develop and those areas where it will discourage additional service provision;
- An integrated workforce development plan to ensure there is the skilled staff to deliver the services needed; and
- The support that can be offered towards innovation and development.

Commissioning for the care home sector should not be problematic where the provision level is adequate or where new provision is sought in areas of under capacity. Dealing with excess capacity or diversifying the current scope of provision will require partnerships to decommission or re-commission.

Decommissioning

Decommissioning can be a response to a planned change to meet changing needs and expectations of local populations, or to national and local policy drivers including shifting patterns of expenditure, or sometimes it is a response to an unforeseen event, such as the failure of a service in terms of its quality or viability. Clearly we would prefer this to be developed as a planned process rather than a reactive process. Whatever the trigger the characteristics of an effective decommissioning process are straightforward:

- Careful preparation;
- Clarity about what is to be achieved and why;
- Transparency and good communication; and
- Keeping the service user as the focus of the activity.

Decommissioning is the process of planning and managing changes in service, usually either a reduction or a termination, in line with commissioning objectives. It is not necessarily as clear cut as stopping an entire service completely. It may be that a new service will replace what has been taken away, or the existing service will be changed in some way.

Re-commissioning

Where we are looking to make changes to these services, we might refer to the process as re-commissioning. This would commonly be called reconfiguration or service redesign, and is a part of the commissioning process that might follow on from decommissioning and disinvestment decisions. Some new developments may arise through diversification by existing providers. For example a care home may diversify into offering a wider range of outreach services into the community, or may offer more specialist or short-term alternatives such as step-up or step-down care. We would seek to encourage moves to diversify into areas such as intermediate care and should consider if there is a need to incentivise such diversification or whether providers in particular areas will naturally diversify given the planned shape of the sector and/or based on demand.

Role of providers

Commissioning is not simply about procurement of services from external providers. It is about a mature relationship between different partners from across the public, private and voluntary sectors in a way which will help to achieve the best services for the population. Providers themselves will bring knowledge and experience of their services and the outcomes they are delivering. Every partner has a role to play in joint commissioning, and that is why it is important that local arrangements promote mature relationships and constructive dialogue. Those involved in the joint commissioning process need to develop their skills in working with a range of partners including the private and third sector, along with service users and their carers to build and implement commissioning priorities. Clinicians and care professionals in locality groups also play a key role in ensuring that local needs are understood, and that they inform the overall priorities.

Role of others

Health and care support for older people is not only funded through public sources or always managed directly by public agencies. Many people buy some of their care, make use of family, informal voluntary and community services, or use self-directed support. It is increasingly important that the statutory bodies look to understand the contribution that these services make, ensure that they are taken into account when planning new developments, and that they are helped to make the best possible contribution to achieving good outcomes for older people – even if they are not funded directly.

These development areas for joint commissioning will be influential in the design, development and delivery of the whole care system. They will help to ensure that the balance of services are what older people want and need, and that they will be best able to meet the needs of the population into the future.

It is clear that the banks also have a key role, not least in supporting home owners in times of difficulties. Partnerships (and Government) will need to work with the banks to encourage such support be available but also to ensure banks are aware of local joint strategic commissioning plans, in particular the Market Position Statement. This should help influence funding decisions in the future so that inappropriate ventures are not supported against the wishes and needs of the local commissioning partners.

Discussion

It is worth acknowledging that no initiative will change the shape of the current market overnight. Indeed this wouldn't be desirable, given the impact it would have on providers and the likely unintended consequences that would arise. Any new measure(s) will need a 3-5 year period to shape a market which reflects population need and policy direction. In areas of under capacity it will take time to attract new entrants of the right calibre to the market. In terms of over-capacity, this will likely require the market itself to naturally shrink by homes either voluntarily closing or adapting their business model to address the reshaping care agenda and public expectations. There may be opportunities through the commissioning plan to 're-commission' or redesign some facilities or places as intermediate or specialist care.

In setting out the ideal level of care home provision for the future, it will be even more important for the statutory bodies to support third and independent sector care homes to drive up quality. This will be particularly important in terms of earlier intervention around poor performing homes in order to put support in place to prevent deterioration and ensure improvements.

The Scottish Care Home Census provides data on care homes from 2000 to 2012. This shows that the number of care homes for older people has reduced from 1,059 to 916 over that period. However, the closure of several smaller homes and the introduction of larger, purpose built homes has meant the number of places (beds) has remained relatively constant, reducing from 39,178 to 38,465. This 1.8% decrease compares with a reduction of 36% over the same period in learning disability beds where there is a clearly articulated policy to shift the balance of care from bed based models to housing and community based models. Older people's

care home provision in the statutory sector has reduced by 25% while the independent sector has increased by 7.7% (table 2).

The census also shows (table 14) a reduction in the rate of registered places per 1,000 population over 65, from 49 in 2000 to 43 in 2012, with a variation between local authorities from a low of 27 to a high of 53.

The average weekly charge for self-funders in care homes for older people was £698 per week (table 7). This varies from highs of £839 in Argyll & Bute, £829 in Aberdeen and £812 in Edinburgh to lows of £600 in East Ayrshire and North Lanarkshire.

The occupancy level across Scotland for older people's homes was running at 87% in 2012 (table 3), a level that has remained fairly consistent over the years. However, the occupancy levels show great variation between local authority areas with a high of 96% in Orkney (which has the lowest rate of places), 93% in Edinburgh and Highland (which are currently finding quality issues reducing even further the number of places available), and 92% in Midlothian (the 'Edinburgh effect'). The lowest occupancy levels are recorded in East Dunbartonshire (also with a very low rate of places) at 67% and Clackmannanshire at 72%.

It should be recognised that in some areas, the local authority is the default provider of residential care, as the independent sector may not be willing to engage. It is important that taking a strategic commissioning approach to the sector is not just about care purchased from the independent sector but includes that provided by the statutory bodies. Indeed, to take such an approach is not to treat the sector in isolation but to see it within the whole spectrum of care.

The Group discussed several possible ways of more directly managing the market.

Tendering

Since the inception of a care market in the early 1990s, local authorities have typically avoided using tender based solutions to procure care from the care home sector. This is partly because of the predominance of the free market paradigm, which is underpinned by statutory regulations (the Choice Directions) which outline the rights of individuals to select care homes of their choosing within the market place.

However, it is possible to envisage a role for tender based commissioning. Under this model, the commissioning partnership maps its future population need and - within a whole system context – specifies the local requirements for care home provision over the next 5 years and beyond in terms of quality, quantity, interface and pathways. The commissioning partnership enacts these preferences by selecting 'preferred providers' through a tender process. While the non-successful providers will remain registered and hence a viable care destination, social workers would advise new service users of those care homes that meet the council's specified requirements in terms of quality etc. The likelihood is that most service users would be content to work within this arrangement; but for the minority who are not, they would be entitled to choose a care home out-with the preferred providers list, so long as the other choice directions are met.

This would mean that commissioners would be able to shape the market in line with local circumstances and population demand. It would, under the right circumstances, develop a stronger partnership between commissioners and preferred providers, drive up quality and would potentially strengthen financial viability as occupancy levels of preferred providers improve.

We recognise that two important populations would not be covered by these arrangements: people already living in care homes (the presumption would be that they continue to reside where they are) and self-funders. Where self-funders exhaust their capital, they will be entitled to public funding – but may not reside in the care home of a preferred provider.

There are a number of variables that therefore have to be worked through. However, if there is interest from individual partnerships to run with this model, we may be able to use 2014/15 as an opportunity to learn from individual pilots. Glasgow City and Aberdeenshire are interested in taking forward this approach.

Licensing

An alternative possibility would be to explore the licensing of care homes/care home beds, which would give the local authority the power to define local capacity. We understand that this is the preferred approach in France, Canada and some other countries and some states in America. No new licenses have been issued in France in the last two years. Each bed is licensed so you can close a home and transfer the license to a new build or, alternatively, invest heavily in refurbishing an existing home with the confidence that new competition will not appear.

While this would help control the number of care home beds in each local authority area, consideration would need to be given to cross boundary flow and incentives for developers in areas of high property/land values. Introducing such a scheme may create a conflict of interest where local authorities are a provider as well as the licensing authority, although it could be argued that this conflict already exists in the current commissioner/provider roles the Council plays. Account would also need to be taken of EU directives.

Establishing a licensing scheme would be relatively easy, by amending the Civic Government (Scotland) Act 1982. A similar approach was taken in 1991 with the licensing of Houses in Multiple Occupation (HMOs). However, local authorities appear to have reservations about such an approach. Anecdotally, it has been suggested that local licensing authorities are reluctant to take on more categories. There tends to be a presumption against being unduly restrictive in granting a license, in other words licenses are granted unless there is a particularly strong reason not to. Any refusal would be open to challenge via the Courts.

An alternative route might be for the Care Inspectorate to become a national licensing body. While this would strengthen the regulatory role of the Inspectorate it would be more difficult for local partnerships to influence local capacity. Whatever route might be taken would need to address the links between licensing and registration.

The role of Planning

Members of the sub-group have explored the potential use of physical planning regulations and policies to define the conditions under which a new care home development would be supported. In particular, we have been discussing whether there is scope for the Scottish Planning Policy (SPP) to give more weight to the economic sustainability of such proposals, which could in turn create a hook for policies to be developed within Local Development Plans.

Informal discussions have taken place with Scottish Government planners to discuss this issue. The planners have indicated that there may be scope to amend SPP wording and have asked for some draft wording for further discussion.

Heads of Planning (HOPS) and the Society of Local Authority Chief Executives (SOLACE), however, are keen to stress that economic viability is not a planning issue and that other avenues should also be sought.

The following wording has been taken to Scottish Government planners for consideration:

> **Specialist Housing Requirements**
>
> 100. As part of the Housing Demand Needs Assessment, authorities should consider whether there are any new build requirements for particular needs including housing for older people, sheltered housing, care homes and other accommodation for residents requiring care. Where a need is identified, planning authorities should prepare policies to support the delivery of appropriate housing and consider allocating specific sites. The local development plan should also address any need for houses in multiple occupation (HMO). More information is provided in Circular 2/2012 Houses in Multiple Occupation.

Preferred providers

A local authority is entitled to operate a preferred provider list, detailing those companies/organisations with which it prefers to contract. This would most likely be on grounds of quality and cost. However, where a system of preferred providers is in place, it ought to remain open to an individual to opt for a home that is not on the preferred provider list and, as long as the conditions of the Directions on Choice are met, the local authority would be obliged to arrange such a placement.

The Choice Directions do not prevent an authority using a system of preferred providers, in particular in the small number of cases where people have no particular preference about a care home. Where people do have a preference the authority can still recommend the homes that it prefers to deal with. So if an authority operates a system of approved providers it will need to make clear that that such a list is merely the providers it recommends and contracts with because these care homes meet the council's specification, but is not an exhaustive list of the choices that may be available.

Revise the Directions on Choice

Irrespective of the innovation that can be delivered via practice based reform, the commissioning sub-group queried whether the commissioning approach will in the long term conflict with the regulations and that therefore it is appropriate to ask whether the regulations need to be updated to deliver a better fit with commissioning-based practice. In particular, it was felt that the Choice of Accommodation Directions could be amended to ensure that commissioning practices are allowed to flourish and that the choice individuals make is situated within a higher quality market.

The Directions currently require authorities to give effect to the choice of accommodation of the individual so long as:

- the accommodation is suitable to the person's needs as assessed by the Local Authority;
- it will not cost the authority more than it would usually expect to pay;
- the accommodation will be available within a reasonable period; and
- the person in charge of the accommodation is willing to provide the accommodation subject to the authority's usual terms and conditions.

Current guidance is being revised to clarify what these Directions mean in practice, for situations where people are choosing a care home place following hospitalisation (most placements are following an episode of in-patient care).

It could be argued that these directions already shape the choices that people can make. For example most authorities will not offer poorly graded care homes as they would not be deemed 'suitable to the person's needs'. Likewise, unless a publicly funded resident was willing to pay a top-up then homes would need to be available at the National Care Home Contract rate. However, others have argued that the Choice Directions still effectively debar partnerships from exercising a commissioning function over the care home sector – since they have no obvious levers to control market entry or exit. As such, should taking a commissioning approach not have the desired influence over the market, it might be necessary to revise the Choice Directions themselves to ensure that they fit within the context of Health and Social Care Integration. Once the Public Bodies (Joint Working) Bill is enacted, and partnerships have a statutory duty to produce a strategic plan, a further qualification could be added to say:

- the accommodation and model of care has been approved by the integration authority as meeting the requirements of its strategic plan.

The effect of this addition – or something similar – is that the exercise of individual choice would be framed in terms of the care homes that the Health and Social Care Partnership has endorsed in terms of quality, model of care and location.

Revised choice directions would lead to the rationalisation of care home provision, and it may mean some care homes leave the market. It could be argued that this will happen anyway as the reshaping care programme is delivered, only that instead of it being on a medium-term and planned basis, it would happen short term as a result of either financial instability or poor quality care, with a significantly greater impact on

residents. However, by strengthening the commissioning approach to make clear statements about future levels and range of provision this should evolve without the need for more stringent controls such as licensing or revising the Choice Directions.

The role of Self-Directed Support

In addition to the reforms outlined above, consideration also needs to be given to the impact of Self-Directed Support on the care home sector, and in particular, to the possibility of a Direct Payment being used to arrange care. Regulations on this matter are currently being drafted by the Scottish Government and the Task Force welcomes the news that a pilot of Direct Payments in Care Homes is planned.

If the status quo is changed to allow for the use of Direct Payments, it would potentially weaken the impact of reformed Choice Directions, inasmuch as the commissioning partnership would be less able to shape the market in line with its commission plan (since people using a Direct Payment would have the right to choose any care home, irrespective of quality and strategic fit).

On the other hand, a Direct Payments arrangement could open up choices within care home settings, to split off hotel costs from care and support elements and potentially bring the individual's preferred provider into a care home run by another operator. One question to explore here is whether the use of a Direct Payment requires the care home to be able to disaggregate or stratify its costs into constituent elements (e.g. rent, board, care etc.). This links to the broader debate about funding being advanced by the Task Force, and certainly it would seem that the recommendation to stratify costs would provide favourable conditions were Direct Payments to be rolled out nationally.

Jointly commissioned, locally delivered Intermediate Care

Intermediate care is an 'umbrella' term describing an approach involving a collection of professional disciplines working to common, shared objectives and principles. It provides a set of 'bridges' at key points of transition in a person's life, in particular from hospital to home (and from home to hospital); from illness or injury to recovery and independence; helping a person achieve their personal outcomes. 'Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland'[19] describes a continuum of integrated services to prevent unnecessary admission to acute hospital or long-term residential care, promote faster recovery from illness, support timely discharge from hospital and optimise return to independent living. It is visually presented on page 54.

By its nature in acting as a bridge between locations, sectors and personal circumstances, intermediate care must operate within mainstream pathways of care - crossing acute and community based services.

Intermediate Care should be accessed at times of "crisis" to complement existing care (where this is in place), providing a therapeutic, outcomes focused care plan. It can also form part of a range of planned interventions, this is particularly important for those with long term conditions. Wherever possible this will be provided in the

[19] http://www.scotland.gov.uk/Resource/0039/00396826.pdf

person's own home, but a range of locations may be appropriate, including care homes and community hospitals. Good practice would suggest that part of the suite of services provided in local areas should be available out of hours, with a fast, easy, single point of access to assessment.

The Reshaping Care for Older People programme[20] aims to support more older people to live well at home through scaling up delivery of anticipatory and coordinated care and support in the community. When people with complex multiple long term conditions with a combination of physical, cognitive and functional impairments experience a flare-up of their conditions they require urgent access to comprehensive multi-professional and multi-agency assessment. They are often admitted to hospital as an emergency, where they may be susceptible to healthcare associated infection, delirium and challenged to maintain adequate nutrition and tissue viability. These individuals statistically have longer stays, higher mortality, higher rates of readmission and increased risk of institutionalisation.

Intermediate care services can be provided in:

- Individuals' own homes, sheltered and very sheltered housing complexes;
- Designated beds in local authority or independent provider care homes;
- Designated beds in community hospitals.

Partnerships with comprehensive intermediate care services are showing accelerated reductions in rates of emergency bed days and delayed discharge compared to those which have been slower to implement hospital at home and other models of community based intermediate care.

The principles that underpin Intermediate Care are:

- Delivered at home, if safe and appropriate, or as locally as possible;
- Accessible, flexible and responsive through a single point of access that operates 7 days a week, and ideally 24 hours a day;
- Focused on rehabilitation, reablement and recovery;
- Targeted at those at risk of emergency admission, or re-admission, to hospital, or to avoid premature permanent admission to a care home;
- Based on holistic assessment to maximise independence, confidence and personal outcomes sought by the individual;
- Linked with and complementing local community and specialist services;
- Co-ordinated on site or in-reach support from multi-professional and multi-agency team with the required expertise to meet complex needs;
- Time limited, with anticipatory care and multiagency discharge planning from day one;
- Jointly commissioned by the partnership;
- Managed for improvement, gathering information on experience and outcomes and using this to inform service improvement.

[20] http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare

Level of acute need

 Individual becomes unwell. Primary care; District Nurse; Social Work; Home Care; NHS24; Ambulance practitioner; A&E attendance. Contact Single Point of Access Assessment Intervention as required: • Nursing • Therapy • Support Worker Timely diagnosis by GP Specialist input by: • Geriatrician • Community diagnostics • Rapid Response Team	 If too unwell to be cared for at home, step up to community facility. History / Examination / Diagnostics. GP, Nurse practitioner or Consultant review within 24 hours. MDT input with principle of care delivery at home when appropriate (as it may be in a care home).	 If too unwell to be cared for in a community facility, admit to acute hospital for comprehensive assessment. Transfer to community facility or home when medically stable and fit for transfer.

Level of need during recovery

 Timely comprehensive multidisciplinary and multi-agency assessment : Rehabilitative need identified. Referral to Intermediate Care Single Point of Access. Individual is medically stable and fit for transfer. Individual transferred to the appropriate setting: • Own home • Community based facility (such as a care home or community hospital)	 If the individual requires more care than can be delivered at home, step down from acute hospital to community facility. Regular MDT and GP / Nurse / Consultant review with principle of care at home to continue rehabilitation when appropriate	 Majority of users of Intermediate Care to receive their episode of care at home. MDT driven re-ablement to optimise recovery and promote independence.

A Home First default position promotes intermediate care at home where safe and appropriate. However some people, particularly those who live alone or require alternative housing arrangements or adaptations, may be unable to return directly home from hospital. Intermediate care can provide critical time and the right environment to recover confidence and independence, and avoid making premature life changing decisions. Each partnership has a cohort of housing / care home / community hospital beds that could be commissioned to provide Intermediate Care. The appropriate number of beds and provider(s), their location and the required support will evolve through Joint Strategic Commissioning. The critical path for bed based intermediate care would involve:

- Care staff promote a reablement approach;
- GP support for General Medical Services;
- In-reach by aligned specialist practitioners to support rapid assessment and diagnostics for 'step-up' and rehabilitation;
- In-reach by aligned community nursing, pharmacy and home care team to ensure effective communication, discharge management, anticipatory care planning and medicines reconciliation;
  Single Point of Access – for step-up (e.g. emergency referral centre) and step-down (e.g. discharge coordinator / discharge Hub);
- 'Pull' system to enable people who require continued inpatient rehabilitation or are unlikely to be able to return home within two weeks of being clinically ready for discharge to move to a community bed.

The Joint Improvement Team (JIT) has established an Intermediate Care Group (ICG) to scale up the adoption of intermediate care across Scotland. The ICG has asked that principles be agreed for local step-up/step-down intermediate care to involve housing, independent sector care homes and community hospitals.

A survey of local partnerships, 'Intermediate Care: Readiness to Scale'[21] was conducted by the Joint Improvement Team in April 2013. Intermediate care was provided in care homes by 21 partnerships – 13 in council owned homes and 11 in independent homes, with 3 of these providing it in both.

The Delayed Discharge Expert Group report[22] (October 2011) stated that "care home providers have indicated a willingness through their involvement in the reshaping care programme to redesign their services to take shorter term residents. This could be providing more intermediate care services, step-up and step-down care."

It went on to say: "COSLA is currently undertaking a review of the National Care Home Contract. It is clear that the current contract does not deliver the flexibility of responses that local authorities and Health Boards will increasingly need from voluntary and private sector care providers into the future. We are therefore working towards a future contract and service specification that provides a stronger sense of

21 http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4034939/Intermediate%20Care%20%20-%20Readiness%20to%20Scale.pdf

22 http://www.scotland.gov.uk/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets/Delayed-Discharge/Expert-group-report

the outcomes we want to drive, and the pathways we want to exist at the interface of health and social care.

“Part of that work will involve the development of service specifications to prevent hospital admission and facilitate hospital discharge. Our aspiration is to encourage specialisation within the residential sector so that care homes can accommodate emergency admissions (as an alternative to A&E) and rapid discharges (where a return home is not possible in the short term). In respect of the latter, our work will look at a number of issues, including how to incentivise care homes to provide a rehabilitation service, such that the care home does not become a final destination but a stop-off point on a care journey which leads back home.”

It recommended “where a local partnership has identified a local need for residential step-down care, dedicated care home places could be identified and developed to provide specialised rehabilitative care. This will be developed within the context of a revised National Care Home Contract. COSLA and care home providers will advance this work with a range of partners including ADSW, Scottish Government, and NHS Scotland.” COSLA issued a resource pack on developing intermediate care in care homes in November 2012.

The choice guidelines apply only to permanent placements and are not applicable to intermediate care or respite care.

Strategic Plans

Partnerships will have a legal duty from 2015 to develop a Joint Strategic Commissioning Plan (JSC).

The Joint Strategic Commissioning Plan will specify the nature, scale and locality of provision a partnership intends to establish locally based on a strategic needs assessment. This will include plans for intermediate care, specialist dementia, end of life, respite and long-term care provision for older people.

This on its own will not define the market. However, independent sector providers and their investors will be expected to take account of the JSC Plans. Where there is an expressed need for provision in areas of undercapacity it should attract new investment and new builds because of the clearly articulated need. This will not immediately sort out the problem of over provision as it will be difficult to disinvest or decommission under current guidelines. However, it should deter any speculative new entry to the market as banks will be unlikely to lend in an area where the JSC Plan makes clear it is looking to reduce or stabilise the number of places. While this might deter specific lending, banks are looking to increase exposure to the care home sector as it is seen as a low risk profile. They are more likely to be willing to lend for larger older people’s homes. Another problem is the increasing use of ‘Opco/ Propco’ deals, where a company splits in to a property company (propco) and an operating company (opco). The Propco would own the real estate, have much more collateral and thus support more debt. In this situation the bank would take security of the property, reducing the risk to itself. However, this leaves the Opco as the registered provider being hopelessly exposed to a downturn in profitability.

The JSC process will involve providers at every stage. It should therefore seek to engage providers in dialogue to shape and develop services to meet changing patterns of service demands.

Further details about how commissioning for the care home sector could work in practice are provided at Annex B.

If we consider what has become a standard expression of the commissioning cycle, it is evident that the 'analysis' and 'planning' stages are immediately affected by the choice directions. That is to say, in giving due regard to the legislation, partnerships' desire to shape local markets will be subordinate to the individual's right to choose a home. These constraints impact most significantly in the 'delivery' phase, where the primacy of choice will dictate the nature and capacity of provision (as opposed to a strategic needs assessment of local population need driving that process).

Recommendations

The Group agreed the following commissioning vision:

We want to move to an arrangement where local health and social care partnerships form the bedrock of the commissioning agenda and that these include the third and independent sectors. We want to ensure that the care home sector responds to local population need/demand and make sure that local partnerships have the powers and levers to commission the desired type, volume and quality of care home provision in their area. The commissioner would have a more prominent role in establishing the conditions of market entry and exit. In other words, there would be a subtle but important shift away from free market principles towards a planned economy of care.

It further recommended:

- Partnerships should be helped to develop the necessary skills to develop a commissioning approach to the care home sector.
- Providers themselves should be an integral part of the commissioning process, fully involved in the planning of future provision.
- Strategic commissioning plans should be based on a Joint Strategic Needs Assessment in order to plan future capacity for its ageing population, including hospitals, care homes and housing with care.
- Partnerships should produce Market Position Statements to direct future care home supply.
- If the Task Force is in agreement with the proposals outlined to take a commissioning approach to the care home sector, to involve active market facilitation and the production of a Market Position Statement then we can build that in to the guidance for the statutory requirement for partnerships to produce a strategic commissioning plan, clearly stating the number of, and the type of facilities required.

- Alternative types of provision are explored and promoted within care homes. This should include intermediate care (the use of step-up/step-down beds), increased respite provision, Elderly and Mentally Infirm (EMI) beds and use for end of life care. This will raise issues of flexibility around registration and charging.
- Commissioners will need to have clear information on the dependency levels of the current care home population. Tools, such as the Indicator of Relative Need (IoRN), should be promoted in order to obtain a better understanding of the needs of current care home residents to inform the alternative uses described above.
- Partnerships should also liaise to include in their JSC Plans requirements for more specialist provision by client groups, on a regional basis if required.
- Concurrently, we should test a tendering approach that is based on quality.

Funding

Background summary – Why is funding such a problem?

The independent care home sector in Scotland currently provides care and accommodation to approximately 33,000 vulnerable adults and represents 88 per cent of the total provision of residential care.[23]

It currently employs 47,000 staff directly and is a major purchaser of local goods and services. Local government currently spends a total of £637 million buying care for older people through (a) the National Care Home contract for publicly funded residents, and (b) paying out £111 million on Free Personal and Nursing Care (FPNC) payments for self-funders[24].

Over time, and especially over the past 2/3 years, there have been significant and growing financial pressures on the sector from rising fuel, food and staffing costs – this strain has been experienced by local authority providers as well as the independent sector. The property boom and subsequent collapse in the property market has left many care home providers with onerous debt obligations which are set to worsen if interest rates rise in the near future. Funders continue to support care homes due to a perception of future guaranteed income, as a result of an ageing population, but meeting these obligations will require high occupancy rates.

A further source of cost pressure on care providers has been increasing expectations of users and scrutiny bodies, translated through regulation into higher specification for physical environments and rising staff training costs.

At the same time, Local Authorities have been trying to manage their budgets in a period of fiscal pressure. Some local authorities have even been pushed into only placing new residents when funding has become available, which is placing pressure on health boards as a result of delayed discharges from hospitals. This trend, along with the strategic shift to allowing older people to stay in their own homes for longer, has caused downward pressure on occupancy rates in some areas of the country, and south of the border has caused major instability in the sector, as shown by the collapse of the Southern Cross Care Group in 2011.

In Scotland, the national care home contract fee rate is negotiated annually between COSLA and Scottish Care. Over the past few years these negotiations have run into significant difficulty, largely associated with local government funding pressures, and a split in the negotiating stance of local authorities.

Care home providers accepted a freeze on payment rates in 2011-12 on condition that, in subsequent years, the sector would diversify and joint commissioning with NHS Boards would bring more resource into the overall funding envelope. This has not happened yet, and the providers have intimated that lack of investment impedes their capability to train staff and upgrade facilities.

[23] http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Previous-Publications/index.asp

[24] Scottish Government Free Personal and Nursing Care Expenditure, Scotland, 2011-2012 http://www.scotland.gov.uk/Publications/2013/07/1907/4

Providers argue that at least 4 to 5 per cent increase in fees is required to stand still and make improvements in quality. COSLA have asked Scottish Ministers to intervene in this impasse. Since the collapse of Southern Cross negative media coverage infers that standards of care are falling and that the focus of private providers is profit, not care. The implications of failing to provide adequate funding might include: (i) heightened risk of care home providers going into administration; (ii) still higher care fees for self-funders; (iii) a decrease in the level of quality of provision and services; (iv) an increased level of delayed discharges from hospitals; and (v) increasing difficulties in the recruitment and retention of care home staff at all grades.

Any reduction in investment in the sector as a result of fee increases not keeping up with inflationary pressures will also have an impact on the Care Inspectorate working to an agenda of care improvement. When improvement notices are served, and moratoria on new admissions to a home are applied, care home providers may simply not have the funds to finance required improvements. Many large scale providers are now making a strategic decision to focus on the self-funding market exclusively, with new builds in an attempt to increase the proportion of self-funders in their care home portfolios to mitigate their financial risk and attract investors. This will limit the choice for local authority funded new residents.

The recently introduced Public Bodies (Joint Working) (Scotland) Bill aims to establish person-centred planning and delivery of services by focusing on improving outcomes for people. The Bill makes provision for Integration Authorities who will be accountable for delivering new Health and wellbeing outcomes. NHS Boards and local authorities will put in place integrated budgets to ensure better, more effective use of their total resources. Whilst this development may ultimately ensure a more effective use of local resources, and ultimately provide a greater funding envelope for the care home sector, this is yet to be seen, and may not happen quickly enough to mitigate the most immediate funding issues for the care home sector.

As we begin a new year, nobody seems particularly content or comfortable with the way residential care is funded. The following sections take a deeper look at the issues from the viewpoint of (1) Service users and their families; (2) Providers of residential care; (3) Public bodies who have a duty of care to ensure the health and welfare of their citizens.

Care Home Residents and Their Families

Current framework

Under the Social Work (Scotland) Act 1968, Scottish local authorities have a duty to provide community care services within their area. Eligibility for such services arises from physical presence in the local authority area and from the individual being assessed as having a need that calls for the provision of a service.

If assessed as needing residential care the local authority will carry out a financial assessment to determine the appropriate level of local authority funding. The

National Assistance (Assessment of Resources) Regulations 1992[25] and associated Charging for Residential Accommodation Guidance (CRAG)[26], provide the framework for local authorities to charge for the residential care that they provide or arrange. The CRAG is due for review in 2014/15 following welfare reforms and the UK Care Bill reforms.

Since the Scottish Government introduced free personal and nursing care (FPNC) for people aged over 65 in July 2002, the local authority will pay a contribution towards these elements of the care for all those assessed as needing them, regardless of their assets. Under the financial assessment anyone with capital, including property worth £25,250 or more, must meet his or her accommodation costs (over and above any assessed entitlement to free personal and nursing care) in full. Where capital falls between £25,250 and £15,500 a resident will be expected to contribute a proportion of his or her assets towards the cost of care. Capital of £15,500 or less is not taken into account in assessing a contribution, although the individual will contribute to the accommodation cost from any income e.g. pensions and benefits, with the local authority funding the balance.

However, as all councils are expected to ensure that the resources available to them are used in the most effective way to meet individual care needs, this therefore means that the care package that a council is willing to provide may differ to that preferred by an individual. For example, a growing number of providers will no longer accept local authority placements.

The local authority will contract direct with the care home for the free personal and or nursing care elements of the residential fees for those with sufficient capital to pay for the accommodations costs, and will contract for the full cost of the placement where the individual's capital assets fall below the capital limit.

This current overarching framework has been in place since the National Assistance Act 1948, updated by UK regulations, the National Assistance (Assessment of Resources) Regulations 1992. Whilst both these are Acts of the UK Parliament, the Scottish Regulations mirror those in place through the introduction of the CRAG.

The current framework (as outlined in Table 1, Annex B) is perceived as unfair by those with capital and assets greater than the upper limit because:

- It requires families to sell homes to pay for care – and those who have not saved for old age and retirement get all their fees paid by the state;
- The upper capital limit catches more older people, many of whom had exercised their right to buy their council homes – so, even families of modest means are surprised to find themselves liable for care home fees;
- Individuals have to negotiate their weekly fee rates directly with providers and do not have the benefit of bulk purchase negotiation – so invariably pay a higher (often significantly higher) fee rate;

[25] http://www.legislation.gov.uk/uksi/1992/2977/part/IV/made?view=plain
[26] http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Financial-Help/Charging-Residential-Care

- While the right to choice is enshrined in regulation, often families are restricted in their choice of care home;
- The current system of charging is complex and difficult to follow, and families are often unaware of all the options to fund their care;
- Once in a care home, a resident has few rights of tenancy and can be moved from one room to another or into a different care home. When providers go into administration, residents have to be moved from their homes with few options or choices.

Provider perspective

From the perspective of providers of care, funding issues are a complex mix of rising demands and costs along with increasing uncertainty about occupancy. Depending on the nature of a care home business (family run one or two care homes) up to large corporate bodies, pressures and issues around funding are different. The following attempts to capture some of the common issues.

Breaking even is currently difficult as:

- Current contract rate for publicly funded residents does not cover running costs for small and medium sized care homes;
- Without higher income from self-funders, many care homes would not be viable. Self-funders are cross-subsidising publicly funded residents with no discernible difference in the quality of service;
- Over time, new residents entering long term care tend to be frailer or have more challenging behaviours than previously, and those with higher needs are making up a greater proportion of the population in care homes, these higher needs have higher care costs;
- Variable occupancy rates have an impact on viability, and the current contracting framework does not guarantee any level of occupancy;
- The national contract framework currently does not differentiate between different client group needs – such as those with dementia, or requiring palliative care;
- Operating costs have increased, in addition to rising staffing costs, there have been sharp increases to utilities and food bills;
- With increased scrutiny and rising expectations for care home standards of care and environment, greater investment in training and buildings have had an upward pressure on running costs;
- The costs of capital and property have also changed with a rise in the number of care homes who “rent” their property from a landlord; and
- The property boom and subsequent downturn has left many property owning companies with negative equity and significant debt to service. The continuing operation of the care homes they own and associated income stream is essential to stave off the demands of their creditors and many are forced into increasingly complex financial restructuring to avoid realising the massive loss in property values. Pressure in this area would increase significantly should the interest rates go up as planned in two years’ time.

Changes requested from providers include:

- Over the past few years, providers have argued for increases of between 2-5% in the headline NCHC rate to cover increased running costs;
- Greater recognition of the needs of different specialist groups in the fee rates; and
- Greater certainty over occupancy levels – or some recognition of fixed running costs that need to be covered when there is a high turnover of placements.

From Local Government Perspective

There is a strong sense that introduction, and development of the National Care Home Contract from 2007 has provided stability in the market for care, as well as significant benefits in advancing the quality agenda for the care home sector. In addition, there has been an added benefit of greater partnership working with the sector through Scottish Care and the Coalition of Care and Support Providers in Scotland. Some in Local Government perceive that over the last few years, that commitment to partnership, alongside the fact that there are 32 councils with different local markets, has meant that in relative terms, care homes have received more generous uplifts compared with other social care providers, especially in care at home (many of whom have not had an uplift for several years). Indeed, care home providers have typically received a higher settlement than the Scottish Government has passed to local government:

	Local Govt. Settlement	NCHC Settlement
2011/12	-2.6%	0%
2012/13	0%	2.75%

However, even with this investment, most local authorities recognise that the last couple of years have been very difficult for the care home sector, with more than one high profile closure. Most notably, the collapse of Southern Cross – a corporate care provider with almost 100 services in Scotland – led to widespread condemnation of the way in which that organisation was run and generated a push to tighten financial regulation within the sector.

Given the pressures on local authority budgets, it is now more important than ever that those contracting with providers properly understand the investment needs of the care home sector in Scotland: invest too little and the quality of care will suffer and greater market instability could ensue; invest too much and our tax-pounds will stretch less far in terms of the volumes of care we can procure – an important consideration in an era of demographic change and increasing levels of need among the 85+ age group.

The main concerns of Local purchasers and commissioners are:

- Most care in care homes is procured through a nationally agreed contract with standard fees, used locally to spot-purchase care. There is little scope to negotiate differential fees if local market conditions could accept a lower fee. In some areas, particularly where there are labour market problems, and the NCHC level is perceived to be too low, partnerships could increase fee levels to help solve some of these issues;

- Placements are made in response to levels of need and the commissioning role of the authority is limited to purchasing care from a local 'market' – the tools to fully commission care and shape the local market are weak and underdeveloped;

- Providers are often granted planning permission for new developments without regard to the market conditions for residential care in a geographic region – often leading to over-supply in areas where development land is more available and less expensive; and a lack of capacity in remote areas or where land is expensive;

- Little flexibility to develop personalised packages within the rigid framework of the NCHC;

- Recognition of the public policy question for national and local government around the extent to which we are prepared to preside over a drift between the rates paid by publicly-funded and self-funding residents;

- Lack of transparency over the financing arrangements of care homes. The split between property ownership and the provision of care has at times led to complex financial arrangements that make it difficult to determine where risk lies in business continuity terms. This in turn can fuel suspicion that paying higher rates to independent providers will only increase shareholders' profits, not increase the quality of care;

- A general concern that demand for residential care – and community care more broadly - cannot be accommodated within projected budgets.

Wider Societal issues

People in Scotland are living longer – if current trends continue we expect that **by 2033 the number of people who are over 60 will increase by 50%**[27]; this is a **good thing** and reflects improved standards of living, public health activity and the success of health improvement initiatives; (though even with this change, life expectancy in Scotland will still be lower than in many European countries); growth in the elderly population is not steady over time and is driven by health gain and birth rates (which reduce after the late 1960s, suggesting perhaps fewer elderly people after 2033).

[27] GROS (2010) Scotland's Population 2009; based on 2008 population

The age balance of the population is changing across the UK, with there being an increasing proportion of the population who are elderly (the rise in Scotland is from 19.7% of the population to 24.1% by 2033[28]; similarly there is a fall in the proportion who are under 16 from 17.7% to 16.2%; these changes are more pronounced in Scotland, Wales and NI than in England). In Scotland the change is significantly most pronounced for the most rural areas with a number of rural local authorities having around a third of their population being over 65.[29]

The changing demographic brings a range of **public policy and finance challenges** related to:

- the reducing ratio of working age people to non-working age people (**the dependency ratio moves from 60 per 100 to 68 per 100;**[30]); at a local partnership level there is a wide range of dependency ratio; and
- the simple increase in people living to an age where they are more likely to access health and social care services (the 50% increase in elderly people by 2033) due to frailty, cognitive disorders or other long term conditions.

The key challenges are as follows:

- **Money In vs. Money Out.** A reducing **tax base** (UK Gov issue) relative to expenditure on **pensions**[31] (UK Gov issue) and expenditure on **health and social care services** for the elderly (SG and CPP level issue – the level of revenue generated by a LA reduces as older people receive discounted council tax, and are eligible for free services). Changes to the state pension age are intended in part to address this issue. At UK level **expenditure on services and pensions for the elderly are expected to each increase by 2% of GDP over the period to 2057**;
- **Workforce challenges.**[32] There are likely to be fewer people of working age relative to those who we would (currently) expect to be retired (though see below); we would also potentially see an increase in the proportion of the workforce engaged in providing publicly funded health and care services (an economic 'drag' factor that potentially reduces productivity growth over time);
- **Social change.**[33] Social structural changes related to the family (more people living alone), geography (people living far away from relatives) and solidarity (people not actively engaged in mutual support) reduce the overall capacity for informal care.

There is a perception coming from responses to the first set of public engagement events and surveys on Reshaping Care in 2009-11 that around a third of all respondents thought that all care should be paid for by the state (Local Government) and around a half thought that a mixture of individual contribution and state

[28] GROS (2010i) Statistical bulletin (2010) Health Life Expectancy at Birth and at age 65 in the UK, 2005 – 2007, ONS
[29] GROS (2010i) Life Expectancy for Administrative Areas in Scotland, 2007-9
[30] GROS (2010) Scotland's Population 2009
[31] HM Treasury (2008) Long-term Public Finance Report: An Analysis of Fiscal Sustainability
[32] Fraser of Allander Institute (2008) Report to GROS: Economic Impact of Scottish Demographic Change, University of Strathclyde
[33] GRO(S) Household Projections for Scotland

contribution was fair. There is a need to undertake more public consultation on the views of people about what it is fair to ask care home residents to contribute towards their costs.

The UK Government has recently accepted some of the reform framework as set out in Andrew Dilnot's independent report in 2011. In summary, the UK Government will:

- introduce a cap on the costs which defines the level people should have to pay to meet their eligible needs (from April 2016):
    - a cap set at £72,000 in April 2016 for people of state pension age and over;
    - people who develop eligible needs before state pension age will benefit from a cap lower than this amount;
    - people who turn 18 with eligible needs will receive free care and support to meet those needs;
    - **people receiving residential care will remain responsible for a contribution to daily living costs. This contribution will be set at around £12,000 in April 2016, where they can afford to pay;**
    - the total cost of meeting the person's eligible needs will count rather than their financial contribution.
- target additional financial support to those people with modest wealth to help them with care costs of meeting their eligible needs by extending access to financial support:
    - the financial limit used in the financial assessments for people in **residential care increases from £23,250 to £118,000 when the value of their home is considered as part of their capital (from April 2016);**
    - combination of the increase in the financial limit and the state contribution towards costs of care counting towards the cap means many people will not have to contribute the full cap amount;
- give people the right to defer paying care home fees, so they are not forced to sell their home in their lifetime to pay for their residential care costs (from April 2015).
- Everyone will have this reassurance, not just the 16 per cent of older people needing care currently facing care costs of £72,000 or more. This will empower people to take responsibility for their care in line with what they can afford. Everyone will be protected against unlimited care costs. And state support will be targeted for the people who need it most.
- In advance of this, from April 2015, people needing residential care will have access to deferred payment agreements in every local authority in England. This means people will no longer face the added stress of having to rush into selling their home to pay for care home fees and will have the flexibility to avoid selling their home within their lifetime.

- Protecting families from selling their homes;
    - For the first 12 weeks in residential care, no-one will be expected to use the value of their home to pay their fees.
    - For the first time (in England) all local authorities will offer people the option of a deferred payment.

Conclusions

There is general acceptance that there is insufficient funding for investment in the care home sector. National Care Home Contract funded residents are being cross-subsidised by self-funders and many providers are relying on expensive and more complex debt packages to stay viable. New Build properties are being targeted exclusively at self-funders, and this is another example of how providers are managing their financial risks. None of these developments are in the interests of the majority of current and future residents.

The general lack of investment is also causing a variety of problems such as a lowering of public confidence in the sector[34] as evidenced by the media attention on a number of high profile closures and failures of care, and growing sense that care homes are struggling to recruit and retain qualified staff.

The National Care Home Contract has served and achieved a range of positive outcomes for residents, providers and local authorities over the years since its introduction in 2007. However, its flaws are starting to become more evident. From the provider and commissioner perspective one contract does not adequately reflect the current range of services provided in care homes such as step-up/ step-down care; respite care, specialist dementia care; palliative care. Nor does the current rate structure reflect the range in costs of providing care which are dependent on labour market conditions; property costs; or the size and age of the current estate of care homes.

However, despite the flaws outlined above, both care providers and commissioners want to see some form of standardised contract and fees grading to avoid every new resident's care package being individually priced and purchased.

There is a general acceptance that it would help to separate out care costs into accommodation, hotel, and care costs. However the methodology for doing this should be as simple and easy to administer as possible. The main arguments for taking this route are to help merge some of the boundaries between housing and residential care; making it easier to personalise care packages; help identify the personal contribution that individuals have to make for accommodation and living expenses. Work carried out by Laing and Buisson has split care home costs into their component parts (see table below) for a care home meeting all the latest physical and other standards. This is detailed in Annex B.

There is general consensus that the "care" element of residential care fees should be fully funded by the state; and that the Free Personal and Nursing Care contributions should be reviewed to more accurately reflect the costs of personal and nursing care in a residential setting.

[34] http://www.communitycare.co.uk/2013/11/13/care-homes-more-associated-with-abuse-than-with-safety-finds-opinion-poll/#.Up2rI8RdVZc

There are significant issues about the recruitment and retention of care assistants given the pay differentials between private and public sector, and between care home employment and the retail and catering sectors. It would therefore be helpful to look at how much additional funding would be required to bring care workers' pay up to the "living wage" standard.

Not everyone will be able to afford to make their personal contribution, and those currently just outside the eligibility for means-tested help are not adequately protected. To address this, means-tested support should continue for those of lower means, and the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23,250 to £100,000. When the Dilnot recommendations were published, Scottish Ministers were clear that whilst the report was aimed at reforming the English system of paying for care, there may be aspects which would fit with the aspirations of the people of Scotland. The relevant recommendations that a future work may wish to consider focus on the upper capital limits, and the current regressive effect of the existing capital limits. Given more time, there should have been more analysis undertaken on the differing costs and benefits of housing with care and support and its impact on individuals, and the spread of costs between state and individual.

Recommendations

- Review and re-prioritise funding for the residential care sector overall.
- Develop an objective assessment of needs which is capable of categorising care needs into 4 or 5 broad categories of care package grouping. The IoRN may be a useful starting point.
- Undertake further work to incentivise more specialised case contracts to better reflect different services that care homes currently provide, and look to more accurately cost the care and support element of these specialised care packages.
- Separation of costs - look to explore robust and economically feasible ways to separate out the accommodation, hotel and care costs – with a view to ensuring that "care" is free to the individual, but all other costs are means tested.
- Undertake modelling work to the current capital limits to ascertain the cost effect of raising capital limits in Scotland, both in terms of public funds, and the possible regressive effect on households of the current limits and potential changes. This work could effectively be remitted to the CRAG Review Group.
- The Free Personal and Nursing Care contributions should be reviewed to more accurately reflect the costs of personal and nursing care in a residential setting.
- Further work should be undertaken to examine how much additional funding would be required to bring care workers' pay up to the "living wage" standard.
- Consideration needs to be given on how (and who carries out) monitoring of providers' financial issues and risks is carried out in such a way as it does not jeopardise the service or the provider's sustainability.

- Further analysis of the distribution of costs in the provision of housing with extra care needs to be undertaken to better understand the comparative costs between residential care and housing with support.

Regulation

The Care Inspectorate is Scotland's independent scrutiny and improvement body, and is responsible for providing assurance and protection for people who use social care services, their families and carers and the wider public. It also plays a key part in improving services for adults and children across Scotland, acting as a catalyst for change and innovation and promoting good practice. It currently regulates over 14,000 care services, including care homes, care at home, housing support, daycare of children, adoption and fostering, secure care, school accommodation, nurse agencies, offender accommodation and child-minders.

It registers all new care services to ensure that they meet legal requirements, evidence their ability to provide good quality care and take into account the National Care Standards. It can also make variations to any conditions of registration at the request of the provider or through taking enforcement action. When a service cancels its registration or is faced with a sudden closure through the financial collapse of the provider, the subsequent registration cancellation aims to safeguard the people who are using the service by working with the provider, local authority and others to ensure changes are planned and uncertainty is minimised.

As we move towards greater integration of health and social care, the Care Inspectorate is developing a joint inspection programme covering health and social care services, with a focus on older people, in partnership with Health Improvement Scotland (HIS). This is a positive move for care homes and housing support providers whose clients often also require complex health care.

In terms of the scope of this report, the currently regulated key service types under discussion, which we believe require either review or greater flexibility are:

- Care home service
- Housing support service
- Support service
- Adult placement service

In terms of the flexibility for providers to innovate and provide different options in terms of service design or delivery, for example more community outreach services, conditions of registration can be applied for each new registration. Variations (from the standard service template) that are reasonable, specific and justified, are also possible. For example, conditions about numbers of service users, for specific service types, and conditions unique to the service at the point of registration are agreed with the service provider. Some of the issues raised by providers in the course of the task force discussions have been about the rigidity of the registration regime. However, the Care Inspectorate maintains that conditions and variations should allow services to be innovative, whilst ensuring that the process of registration remains a protective measure.

Under section 60(2) of the Public Services Reform (Scotland) Act 2010 the Care Inspectorate can grant the registration of a care service subject to such conditions as it thinks fit, and have signalled their willingness to adapt in their approach to registration and the process of agreeing conditions to registered services, to facilitate greater innovation in older people's care services.

The quality of provision, in the main, continues to be at a good or high standard. The Care Inspectorate reports in its 2012-13 annual report that almost 75% of care homes received a grade of 4 or 5 out of 6 in the Quality of Care and Support. At the same time, there is a consistent proportion of providers – around 5% of the market – operating at grades 1 or 2, which is higher than for other service areas, as evidenced by the following table:[35]

	1	2	3	4	5	6
Adoption	0.0%	0.0%	5.1%	38.5%	53.8%	2.6%
Adult Placement	0.0%	0.0%	5.6%	30.6%	58.3%	5.6%
Care Home	0.8%	4.4%	14.7%	34.9%	40.0%	5.2%
Childcare Agency	0.0%	0.0%	10.0%	33.3%	40.0%	16.7%
Childminding	0.1%	0.6%	4.3%	24.8%	59.4%	11.0%
Daycare of Children	0.2%	1.2%	5.4%	27.2%	57.6%	8.5%
Fostering	0.0%	1.7%	1.7%	35.0%	58.3%	3.3%
Housing Support	0.2%	1.8%	5.2%	31.3%	52.3%	9.2%
Nurse Agency	2.9%	2.9%	5.7%	28.6%	54.3%	5.7%
Offender Accommodation	0.0%	0.0%	0.0%	22.2%	66.7%	11.1%
School Care Accommodation	0.0%	3.1%	3.1%	33.8%	41.5%	18.5%
Secure Accommodation	0.0%	0.0%	0.0%	40.0%	40.0%	20.0%
Support	0.2%	2.0%	5.2%	31.7%	50.9%	10.1%
Grand total	**0.2%**	**1.4%**	**5.9%**	**27.9%**	**55.1%**	**9.4%**

Review of the National care Standards in 2014

With 23 sets of care standards currently in use and being used for registration and inspection of regulated care services, there is a significant opportunity to support improvement in care at the same time as reviewing and updating the existing standards and regulations. At the time of writing, it is recognised that there is a real chance to take a more innovative approach to describing what really matters to people about their care and to reduce the complexity that surrounds setting up and providing world class care in Scotland. In the context of the review of care with accommodation, this could make it much easier to narrow the difference between housing and care homes.

The current 23 service related standards have served us well. However, the current standards do not reflect the changing landscape in care, nor the commissioning of more flexible, integrated care services. The Care Inspectorate use the standards as an entry point for providers wishing to deliver a care service and they form a good gate keeping role in this regard. They do not however, readily lend themselves to describing, in a more progressive way, an aspirational standard to the quality of care. They do not fully address those areas which, when added together, form the totality of people's experiences of their care or the care of their family and friends.

[35] http://www.scswis.com/index.php?option=com_docman&task=cat_view&gid=537&Itemid=100182

The care standards and their relevant regulations are also now becoming out of date with regard to the flexibility needed to provide more innovative and creative approaches to developing care that enables people to live as independently as possible. The task force are supportive of a human rights-based approach to developing standards, guidance and regulations which will enable safeguarding whilst allowing for alternative types of service provision and individualised care pathways. There is strong support for this direction of travel across many of the recommendations in this report. It will therefore be important to feature the development of the rights-based standards in the next stages of developing a strategy for residential care in Scotland.

Greater Flexibility in service design

Housing Support is defined as providing a service to people with assessed needs living in their own homes (all tenures). SSI 2002/444[36] prescribes housing support services (i.e. definition of the 21 tasks). However, the definition of housing support services in the Public Services Reform (Scotland) Act 2010 is at a much higher level. As the 2010 Act does not link back to SSI 2002/444, the need to keep SSI 2002/444 has been questioned. As part of the on-going work of this group, this anomaly should be addressed, starting with a discussion on a new definition for housing support services.

Community Asset approach

Potentially a care home that is performing well could branch out and provide a range of other services to the community. However there would need to be some way to safeguard the standards of care for those receiving the service as well as the residents who represent the core business. For example, there is no reason why a care home could not add to their functions to incorporate the following services:

- Day care / respite
- Laundry
- Meals
- Activities
- Garden – allotments etc

By increasing services to the local community, a number of factors would need to be considered eg how to keep a degree of privacy for the residents while welcoming members of the community. However, in actual fact many of the residents would benefit from the attendance of others into the service. These types of additional services would require a variation of registration only.

36 http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4034939/Intermediate%20Care%20%20-%20Readiness%20to%20Scale.pdf

Care Home Governance

There is good practice to be learned from the way that social landlords engage with both their tenants and the wider community that could be transferred to the care home sector through the development of Care Home Boards/Resident and Community Interest Boards. The purpose of such groups would be both to provide support to the care home management in the daily running of a care home in representing the interests of resident, in helping to raise funds and arrange activities that include wider community groups, and being a sounding board for service improvements, operating in a similar way to school parent councils. By opening up care homes to wider influence from within communities, care homes have a greater chance of being identified and used as community assets.

Volunteers

A related issue to governance is the use, recruitment and training of volunteers. It is recognised that volunteers are a significant untapped resource that should be explored further by care providers. There is often an assumption that volunteers and informal carers are prevented from 'working' in a service by the Care Inspectorate. However, as long as this is done sensitively and with appropriate safeguards in place, the opening up of a care setting to other people from the community should also increase transparency and help improve standards of care. It may help to develop protocols and toolkit materials at a later stage in this work.

Tenancy-based model

The suggestion that care homes may move towards a tenancy based residency, and such a move may enable more couples to decide to move into a home together, with different monetary rates being applied, depending on need. For people with dementia this may alleviate separation anxiety and subsequent agitation that often follows a move into a formal care setting. Rooms however would need to be larger with the option of a sitting room. It is at this point where the lines between residential care and very supported housing become blurred and discussion needs to be had to determine the role and function of supported housing.

A rights based model may provide more flexibility and protection for people receiving care, but questions as to how this type of service would be effectively regulated would have to be factored into service and contractual arrangements. For example, would accommodation need to be licensed separately as suitable for care provision? How would the regulator enforce improvements without any extra cost being directed by the landlord to the tenant? Would it increase our bureaucratic workload dealing with different providers for the same service?

On the flip side, where we have a failing provider, a license to provide a care service attached to a property might increase the maintenance of a continuity of care and the chance of the property changing hands at an increased price.

Recommendations

The current regulation and scrutiny of all care services is going through significant change at this time and in moving towards a rights based approach to the new care standards will support many of the measures being recommended as part of this report. The specific actions that should be taken forward in this regard are:

- The strategy being developed for future care with accommodation services must be linked to the review of the National Care Standards to ensure that the reforms being recommended here are supported in the new standards.
- Providers should be encouraged to begin greater dialogue with the Care Inspectorate and Health Improvement Scotland about the innovations they want to take forward within their care homes or housing with support service.
- The Care Inspectorate and Care Providers should enter into pro-active discussions about developing care homes as community assets, but which continue to safeguard the safety and privacy of care home residents.
- The idea of care home governance / support boards should be developed in the next stage of this work, as should a protocol around the recruitment and training of volunteers.
- The definition of housing support as set out in SSI 2002/444 should be reviewed.
- Further work on developing a tenancy-based model might benefit from a pilot with a willing provider.

Contingency Planning

Context

The stability of the care home sector is of vital importance to the effective delivery of care and support to many older people in Scotland. Sadly, over the last five years, contingency planning has had to play a more prominent role in the management of the sector than we would have wanted. There are a variety of reasons that a care home may close, including: in response to unforeseen environmental factors, such as flooding or fire; as a result of enforcement action taken by the Care Inspectorate; or as a result of an organisation or business ceasing to operate. Our recent experience in Scotland has been of the latter example: a number of care home providers and/or owners have fallen into administration and have announced closure plans, sometimes at very short notice.

Inasmuch as the avoidance of a care home closure is not always possible or desirable, it is important that satisfactory arrangements are in place for the closure of an individual care setting and to ensure the safety and the continuity of care for the residents affected. In planning for the closure of a care home, the interests and the welfare of the residents affected are paramount.

A high-profile example of the importance of good contingency planning relates to the collapse of Southern Cross Healthcare in 2011. This episode illustrated the dependency that we have on non-statutory providers to deliver care and of the importance of all parties – providers, lenders, Local Authorities, Health Boards, the Scottish Government and the Care Inspectorate – collaborating in the management of contingencies. Southern Cross operated 96 care homes in Scotland, across 28 local authorities. While the subsequent transition from Southern Cross to HC1 and other providers was managed effectively, it underlined the importance of having effective contingency planning arrangements in place nationally and locally.

Yet there is also a tension in the execution of contingency planning, specifically in the steps that often lead up to a care home closing. It is feasible that once an intervention takes place (and indeed even after a moratorium on new placements has been lifted) that the damage done to the care home's local reputation places it in a very precarious position. This is particularly true in respect to self-funders in urban areas, who may have the luxury of choice and will make their decision based on local media coverage. Subsequent placements and funding decisions on the part of Local Authorities could then bring about further instability to the business and threaten the continuity of care for those resident within it. Establishing a mechanism of intervention that doesn't then escalate the problem is therefore an important issue to address.

Work Underway

In response to the Southern Cross collapse, the Scottish Government and COSLA established a National Contingency Planning Group for Adult Care Services. The Group was set up to look at the overall preparedness of statutory agencies in addressing unforeseen circumstances that could lead to the disruption of adult care provision in Scotland. This includes any service disruption or cessation that arises from a business closure, an emergency situation or a public health matter. The

Group draws its membership from statutory bodies, including the Scottish Government, Local Authorities and the Care Inspectorate and is jointly accountable to COSLA's Health and Well-being Spokesperson and to the Cabinet Secretary for Health and Wellbeing in providing up to date information and quality assurance. The group continues to function as a standing committee, and it meets on a bi-annual basis, or whenever circumstances require it. It has a particularly important role where care home providers or owners operate across a number of local authority areas.

Allied to this, local partnerships have developed strong and robust planning arrangements to deal with contingencies. There are many excellent examples over the last few years of local partners coordinating remedial action between themselves, working with providers and lenders/administrators, supporting residents and families, and offering support to failing care homes to provide stability and rehabilitation. Local authorities (or Health Boards with delegated responsibility) have a duty of care for all residents in care homes in Scotland, including those whose care package is not funded by the local authority.

Ideally, the movement of older people from care homes as a result of closure should be planned over a period of time. The evidence currently suggests that the movement of older adults from care homes can be undertaken without adversely affecting their well-being if this is part of a planned and considered process over, say, a six month period.[37] COSLA has produced guidance[38] which provides an outline of the type of issues that should be considered as part of that process. Short-term movement – and especially repeated movement – can be more dangerous for the health and well-being of an older person in a care home.

Future Action and Recommendations

It is appropriate that the Task Force should take a view about how to deliver stability for the care home sector into the future, especially as the make-up and funding of the sector is likely to change. In particular, it is important that accurate information is shared across commissioning partners in relation to a number of key factors which the evidence tells us makes the difference between success and failure.

It is recommended that in Scotland we work towards a comprehensive risk register, to provide an early warning system for care providers experiencing operational or financial challenges – and an associated ladder of intervention for public authorities to co-produce solutions for exit or redesign of struggling services.

A number of factors will need to be considered as part of that work, and the table below sets out what we feel the core indicators of risk should be. Some of these are well-established (such as continuity of management support within a care home) while others have a less well developed evidence base (for example, the split between care home operators and owners). We are recommending that the latter is recorded in view of our experience of the last few years, where business failures operating under this model have been complex and more difficult to foresee.

[37] http://www.hsmc.bham.ac.uk/news/news/2011/6/care-homes-closures.shtml
[38] www.cosla.gov.uk

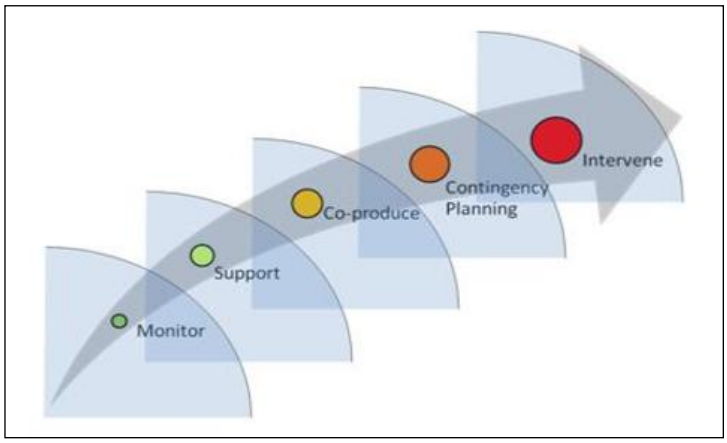
Standard Risk Register

Indicator	Impact	Exposure to Risk		
Stability of care home management	It is widely regarded that in the absence of an effective and established care home manager being in place, there can be a deleterious impact on staff culture and quality of care.	Manager in post for over 3 months	Manager in post for less than 3 months	Manager not in post
Use of agency staff	The absence of a settled staff group, operating within an established culture, can be an indicator of concern. That is not to say there is no role for agency staff, or that agency staff are inferior in any way. This is a commentary on how settled and established teams are.	<1% of weekly care hours delivered by agency staff	1-5% of weekly care hours delivered by agency staff	> 5% of weekly care hours delivered by agency staff
Occupancy	Industry and lenders have a sense of what levels of occupancy will be required in order to make a care home financially viable. While this will vary by geography and provider, occupancy levels below 85% are generally a cause for concern.	>90%	85%-90%	<85%
Profitability of care home	Partly a derivative of occupancy levels, EBITDAR (profit before rent) is also a signal of the financial health of a particular care home.	EBITDAR per bed of £8k	EBITDAR per bed of £6k-£8k	EBITDAR per bed of <£6k
Care Inspectorate Grades	Care Inspectorate grades offer an evaluation of the quality of the care home and are important in analysing risk.	Consistently achieve grades of 3+	Temporarily dropped below grades of 3+	Consistently achieve grades of <3

Additional Risk Factors

Indicator	Impact
Op-co/prop-co split	Where the property owner is different to the operating company, it doubles the number of parties who can choose, or who may be forced, to exit the market. It can also introduce complex contractual arrangements.
Location	Where the property is in a location that is inconsistent with the commissioning plan of the Health and Social Care Partnership.
Service-user feedback	Where there is soft intelligence about dissatisfaction in a care home, this should also be factored into the risk assessment process.

Ladder of Support and Intervention



It is important to point out that this register should not function simply to support punitive measures. Rather, it is intended to operate as a system of early intervention and prevention. It provides a ladder of support, to ensure that a standard monitoring of risk can be used to target support where care homes find themselves in difficulty, which in turn should lead the local authority or Health Board to work with the provider (and where appropriate the lender) to coproduce a solution that remedies the business failure. In the event that recovery is not possible, contingency planning and direct intervention may then be required.

It is also important that local partners give thought to the impact of risk assessment on the viability of a care home business, especially where the focus is on recovery. The use of tools to embargo admission can be helpful to ensure that prospective residents are not placed at risk and to provide an incentive for care providers to improve performance. However, they can also expedite business failure because of lower occupancy levels and therefore it is important that their use is carefully considered. It is important that the local authority (or Health Board), Care Inspectorate and provider communicate effectively where embargoes are used and that the same parties work constructively together when there are opportunities to lift these.

In terms of the other steps that can be taken to intervene, we have explored various contractual options such as compulsory step-in arrangements over the last few years. However, it is now recognised that neither local authorities nor providers feel that compulsory step-in arrangements would be effective in practice. The reality is that local authorities would rather avoid having to take control of a failing care home – and providers would prefer to see support and partnership rather than enforcement. That is not to say that step-in arrangements do not have their place.

Indeed, voluntary step-in arrangements have been very successful where these are coproduced and work to the advantage of all parties.

Conclusion

A market based care home sector, developed through a process of strategic commissioning, retains a level of insecurity. Market forces can force providers out of business. For this reason, it is important that we develop a robust system of support and contingency planning based on an ability to monitor risk within the sector.

Recommendations

- It is recommended that in Scotland we work towards a comprehensive risk register, to provide an early warning system for care providers experiencing operational or financial challenges – and an associated ladder of intervention for public authorities to co-produce solutions for exit or redesign of struggling services.

- It is recommended that the Scottish Government, COSLA, Scottish Care and CCPS operationalise this risk register by asking all local authorities to register information for their area and for this to be collated centrally through COSLA. Scottish Care and CCPS should work with their members to ensure that every care home in Scotland is recorded on the register and provides information on a quarterly basis.

- It is recommended that COSLA, ADSW, Scottish Care, CCPS, the Scottish Government and the Care Inspectorate more fully work up national guidance which articulates a ladder of support and intervention, the principles of which are outlined above.

Recommendations

The Residential Care Task Force is pleased to provide the following recommendations to help shape the future of residential care in Scotland:

Strategic outcomes and priorities for adult residential care for the next 20 years

- The development of the residential sector over the next period should see expansion in three directions: an evolution and expansion of the extra-care housing sector; a growth in the residential sector focused on rehabilitation and prevention (step-down / step-up care); and a smaller, more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs. We anticipate that in some areas, single facilities or hubs might provide all of these service types.

- The implementation strategy which will be developed by the Scottish Government and COSLA must be linked to the ongoing review of the National Care Standards to ensure that the reforms being recommended here are supported in the new standards.

Personalisation

- People living in grouped care arrangements should be able to exercise choice and control over their care, support and daily living arrangements. This will involve practical work through a proof of concept project, and will also require the Scottish Government and COSLA to carry out further policy development work.

- The Scottish Government, COSLA and ADSW should make sure that arrangements are in place to support well-informed decision-making for people considering residential care or supported housing. This will require effective information and advice being given to older people around the options that are available to them under the SDS legislation.

- Outcomes-based assessment and review within residential settings should become standard practice, learning from the initial 'Talking Points' pilot work undertaken in Scottish Borders.

Residency, Tenancy and Tenure

- The Scottish Government, COSLA, CCPS and Scottish Care should ensure that people are able to access the right type of tenure. For some, particularly within extra-care housing arrangements, this will mean an opportunity to enter into a tenancy or ownership arrangement; for others, it may mean a more flexible residency agreement. Further work on developing a tenancy-based model will benefit from a pilot project and discussion about possible reforms in regulatory practice.

- The definition of housing support within secondary legislation should be revised by the Scottish Government to allow for more flexible service design and registration;

- The Care Inspectorate and Scottish Government should ensure that registered care home services can add to their functions (e.g. day care/respite; laundry; meals; activities) to provide an outreach service to non-residents in the local community.

Capacity planning

- Investment in improving existing care accommodation and building future capacity should be managed through a coordinated planning and commissioning process at local partnership level. This should also seek to address the location and distribution of care home provision within a local area.

- Work should be undertaken by COSLA, Scottish Care, CCPS and the Scottish Government, along with local partners, to audit the physical infrastructure of the care home estate, to provide a sense of what type of future investment is required.

- Commissioners and developers should ensure that new builds should focus on 'person-centred' design, developing accommodation that is supportive of the care needs of residents/tenants.

- Further work should be carried out by local partnerships to determine the desired mix of accommodation across the housing with care and care home spectrum. This will require a comparison of the ranges of need and cost to help better understand the comparative costs between the residential care and housing with support.

- A national workforce planning tool for the care home sector should be developed by SSSC, NES and other relevant partners.

Commissioning

- A collaborative approach should be taken in the commissioning process, with providers themselves fully involved in the planning of future provision. Strategic commissioning plans should be based on a joint strategic needs assessment in order to plan future capacity.

- Partnerships should produce a Market Facilitation Plan to direct future care home supply. This should be incorporated in Joint Strategic Commissioning Plans, which should clearly state the number and the type of services required.

- Commissioning partnerships may want to explore new procurement methodologies, which would offer greater control over quality and capacity of provision in the market. For example, the commissioning partnership could enact preferences around quality, capacity and type of service by selecting

'preferred providers' through a tender process. Commissioning partnerships should take care to ensure that any such developments are consistent with the choice directives.

- The Scottish Government, COSLA, CCPS and Scottish Care should review partnerships' commissioning levers within five years to ensure that local markets are responding to commissioning plans.

- Dependency tools, such as the Indicator of Relative Need (IoRN), should be promoted by the Scottish Government, Scottish Care and ADSW in order to obtain a better understanding of the needs of current care home residents to inform the alternative uses described above.

- Local partnerships should develop volunteering and carers' roles in support of people that live in care homes.

- Joint Strategic Commissioning Plans should include, as part of their needs analysis, a scoping of the workforce issues in the care home sector in their partnership. This scoping should include an analysis of skills and training requirements and gaps, issues of recruitment challenge and gaps and opportunities for role and career development.

- The workforce should be adequately trained by employers to respond to the increasing levels of dementia seen in residential care home settings, by ensuring that the good practice set out in Promoting Excellence is enshrined in a formal qualification.

- Providers should enter into dialogue with the Care Inspectorate and Health Improvement Scotland about the innovations they want to take forward within their care homes or housing with support service. This might include discussion about developing care homes as community assets, but which continue to safeguard the safety and privacy of care home residents.

- The Scottish Government should work with professional bodies and education providers to ensure that nurses, GPs, Social Workers and AHPs in training experience high quality learning placements in the care home sector.

- Local partnerships should make effective links across community care and all health services (primary, community and acute settings, including mental health) to maximise the available support and expertise to care home residents and to the people who care for them in the home.

- It is recommended that Heath and Social Care Partnerships scope out the potential to disinvest in long-stay NHS hospital beds and use the cash released to invest in the care home sector. Any changes should be outlined in joint commissioning plans.

Managing Risk

- A compulsory risk register should be devised by COSLA, ADSW, Scottish Government and Scottish Care to provide an early warning system for care providers experiencing challenges to the continuity of care – and an associated ladder of intervention for public authorities to co-produce solutions for exit or redesign of struggling services.

- The Scottish Government should consider further revising and simplifying the regulation of care, to enhance openness and support service improvement.

- Research should be commissioned by SSSC and NES on the level of burn-out experienced by staff in care home settings, and models of supervision and support also developed to address this.

Care Home Governance

- The Scottish Government, COSLA Scottish Care, and CCPS should undertake policy development work to underpin a system of community engagement boards for care homes, to ensure greater continuity between the needs of the local community and the management of the service.

- The Care Inspectorate should undertake further work to establish if there are additional risks to continuity of care as a result of the separation of property owning companies from operating companies in relation to care home provision.

Fee structure and funding

- The Scottish Government, COSLA, Scottish Care and CCPS should undertake work to ensure that charging arrangements are transparent and stratified. Accommodation, hotel, care, and leisure and recreation costs should be separated.

- Modelling work should be undertaken to ascertain the cost effect of raising capital limits in Scotland, both in terms of public funds, and the possible regressive effect on households of the current limits and potential changes. This work should be remitted to the CRAG Review Group with subsequent recommendations put to Scottish Ministers and COSLA.

- The Free Personal and Nursing Care contributions should be reviewed by the Scottish Government to more accurately reflect the costs of personal and nursing care in a residential setting.

- Financial modelling should be undertaken by COSLA, Scottish Care, CCPS, the Scottish Government and other relevant stakeholders to establish the costs of implementing a national commitment to pay the Living Wage in the care sector. This would support a national debate on appropriate payment and reward in caring as a career.

Annex A

Task Force Membership

Douglas Hutchens	Independent co-chair
Peter Johnson	Co-chair (COSLA Spokesman for Health and Wellbeing
Gillian Barclay	Head of Older People's Unit, Scottish Government
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Stephen Fitzpatrick	ADSW (attending o.b.o David Williams)
Donald Forrest	Local Authority Directors of Finance
Rob Harper	Four Seasons
Jim Hayton	Association of Local Authority Chief Housing Officers (ALACHO)
Brian Logan	Bield Housing Association
Colin Mackenzie	Society of Local Authority Chief Executives and Senior
Ranald Mair	Chief Executive, Scottish Care
Alan Martin	Policy Advisor, Scottish Government
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Judith Proctor	NHS Directors of Planning
Brian Slater	Commissioning Lead, Scottish Government
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John Urquhart	Policy Officer, COSLA
David Williams	Association of Directors of Social Work (ADSW)
Derek Young	Age Scotland

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Personalisation sub-group

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Audrey Birt	Health & Social Care Alliance
Chris Bruce	Joint Improvement Team
Elaine Torrance	Scottish Borders Council
Belinda Dewar	University of West of Scotland
Sarah Grant	Self-Directed Support Branch, Scottish Government
Dee Fraser	CCPS
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Donald Macaskill	Scottish Care
Ranald Mair	Scottish Care
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Place Making sub-group

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David Rennie	Scottish Care
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Jacqueline Allan	Care Inspectorate
Donald Forrest	West Lothian Council

Annex B

Table 1 – Current Funding Arrangements Summary

Who Pays?	Type of funding arrangement			
	NHS continuing care	**LA-funded**	**Self-funded**	**Housing with Care (example)**
Resident	Resident pays nothing towards care costs or accommodation costs. They retain all income from pensions and benefits related to housing.	Resident contributes from pension towards Care Home fees and is left with £23.90 per week in personal expenses allowance (PEA).	Resident pays Care Home fees, on average: £ 698 for nursing £ 632 without nursing May be eligible for FPC / FNC payment.	
Local Authority (LA)	LA makes no contribution.	LA pays balance of care. LA pays NCHC rates: £ 580 pw for nursing £ 499 pw without nursing (less the DWP Pension of £143.	LA pays £166 per week for FPC and £75 per week for FNC if resident is eligible.	LA will make a contribution to the care costs such as personal care.
Health Board	NHS Health Board pays 100% of Care Home costs. Exact amount is negotiated with Care Home provider.	NHS will provide GP services, free prescriptions and district nursing care as required.	NHS will provide GP services, free prescriptions and district nursing care as required.	NHS will provide GP services, free prescriptions and district nursing care as required.
DWP	Resident loses AA/DLA/PIP benefits when resident in Care Home.	Resident loses AA/DLA/PIP benefits when resident in Care Home. Pensions at £145.70 pension credit, or £109.60 basic state pension.	Resident loses AA/DLA/PIP benefits when resident in Care Home.	If eligible, DWP will pay housing benefit to cover the costs of rent.

Table 2. Breakdown of care home fees £ per resident per week, England average

	Care Costs	*Accommodation Costs*	*Ancillary Costs*	*Operator's Profit*	*Total Costs and Profit*
Residential care frail elderly	£197	£151	£205	£44	£596
Nursing care frail elderly	£347	£153	£205	£59	£764
Residential care dementia	£221	£151	£205	£47	£623
Nursing care dementia	£356	£153	£205	£60	£774

On these figures, residents and their families would under the Dilnot proposals still have to pay £399 - £418 per week in care home fees on average, even after the state picks up the full cost of ‘care’. And in affluent parts of the country the costs to the individual will much higher. It would still be necessary post-Dilnot, therefore, for most private payers entering care homes to sell any house they own to pay for fees - either at the outset, or at death for those benefiting from deferred payment arrangements.

ISBN: 978-1-78412-277-5

ISBN: 978-1-78412-278-2 (ePub)

ISBN: 978-1-78412-279-9 (Mobi)

This document is also available on the Scottish Government website:
www.scotland.gov.uk

APS Group Scotland
DPPAS23595 (02/14)