RECOMMENDATIONS FOR THE FUTURE OF RESIDENTIAL CARE FOR OLDER PEOPLE IN SCOTLAND SUMMARY

TASK FORCE FOR THE FUTURE OF RESIDENTIAL CARE IN SCOTLAND
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COSLA

The Scottish Government
Riaghaltas na h-Alba

Recommendations for the Future of Residential Care for Older People in Scotland

Task Force for the Future of Residential Care in Scotland February 2014

Context

Residential Care in Scotland

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 local authority, of which the Office of Fair Trading was particularly critical prior to the establishment of the National Care Home Contract. We have therefore made considerable progress on the procurement of care in care homes over the last decade. We can also be generally satisfied that work undertaken since 2006 has improved outcomes for individual services users. The introduction of national care standards 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 system and care user's perspective. 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. There has been some shift towards personalised arrangements - we have considerably reduced shared bedrooms for example – but a wholesale shift to put the service user in control has not happened. What is more, residents continue to feel that there is a lack of clarity about funding – and that sometimes the funding system is unfair. There have also been isolated instances of instability and poor performance, which have contributed to calls for increased levels of scrutiny within the sector.

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.

Current Landscape

Demographic projections of recent years have presented a picture of a growing older population. According to the latest figures from the National Records of Scotland, the number of people aged 75+ 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 by 2037 – an increase of 86% over a 25 year period.[1] While analysis and debate is on-going in terms of the impact of population change on levels of demand, the over-arching message is clear: we will need new patterns of provision if we are to respond to the changing profile of need. More of the same will be simply unaffordable.

The most recently available Scottish care home census tells us that there are 916 care homes for older people in Scotland providing 38,465 places to 33,636 residents.[2] Of those residents, at the time of the census, 32,555 (97%) were in long stay arrangements.[2] We also know that care home residents' average age and complexity of need are increasing.

There are 115,410 people employed as carers in care homes across Scotland. All support workers in care homes will be compulsorily registered with the SSSC by 30th September 2015. Other professional groups are already compulsorily registered.

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:[3]

	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%**

One of the indicators of success in the future reform of the care home sector will be the extent to which we are able to eliminate poorer quality care.

[1] http://www.gro-scotland.gov.uk/files2/stats/population-projections/2012-based/2012-pop-proj-publication.pdf
[2] https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2012-10-30/2012-10-30-CHCensus-Summary.pdf?73347109557
[3] http://www.scswis.com/index.php?option=com_docman&task=cat_view&gid=537&Itemid=100182

Remit of the Task Force

Within the context of emerging legislation to integrate health and social care services, it is recognised that there is an opportunity for change in respect of the evolution of the residential care sector. As such, the Task Force on Residential Care for Older People, was commissioned by Scottish Ministers and COSLA's political leadership to set out a range of ideas and recommendations to underpin the delivery of high-quality, sustainable and personalised care and support in residential settings over the next twenty years.

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.

Vision

Early in its deliberations, the Task Force agreed a 'Vision' which captures the kind of care services we would like to see created as a result of our work.

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 all human rights are protected and in particular the 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.**

The Task Force met four times between July and December. Its work was mostly undertaken through six sub-groups, which focused respectively on personalisation, place-making, workforce, commissioning, regulation and funding. Membership of the Task Force is detailed at Annex A. A more extensive Task Force report, which contains the detailed deliberations of the six sub-groups, will also be published.

Part 1: People, Places and Personalisation

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. 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. 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 include taking a direct payment in lieu of services. **The practical application of the use of Direct Payments in care homes will shortly be tested by a small number of local authorities – and this is a development that the Task Force welcomes.**

The 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, JIT and a number of independent sector providers demonstrated that this approach is just as applicable to residential settings as to care at home. However, its success requires strong leadership, a commitment to cultural change and the pursuit of personalised care. In a similar vein, 'My Home Life'[4] is a collaborative movement focused on personalising practice within care homes for older people. It identifies best practice in care homes for older people in the 21st century and has a particular focus on personalisation.

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.[5,6] New developments around guardianship and the embedding of the Mental Health Act are seen as high priorities to further the Personalisation agenda.

[4] http://myhomelife.org.uk/
[5] http://www.mwcscot.org.uk/media/53179/CC__MWC_joint_report%20Remember%20Still%20Me.pdf
[6] http://www.scottishhumanrights.com/careaboutrights

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 DWP benefits.**

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 choose 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.**

From the perspective of engendering a personalised approach, we advocate an approach which would allow an individual to build a matrix of support with the relevant input from family and providers, which offers the right balance between residential and home life. It would mean enhanced access to care at the right times in the right way.

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.**

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 individuals' 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. **The Task Force believes that the best way to test the practical application of these recommendations is through pilot activity.**

Part 2: Home and Environment

Personalised care requires a setting and physical environment that itself supports individual preference. This will involve the idea of 'Place Making' – residential facilities should not be developed in isolation from the communities they serve. It also requires thought to be given to the workforce that underpins the delivery of care and support arrangements.

Place Making

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 personalised support and community involvement.

The Scottish Government and COSLA's vision is to support older people 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.

Forward planning will be 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.[7] 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.

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.**

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

[7] www.dementia.stir.ac.uk

than as institutions for the elderly. **One way to create greater community ownership would be to establish community engagement arrangements for care homes, similar to those employed by some schools**. This would allow greater community involvement in the day-to-day activities and management of the facility - and it would connect the care home to wider community initiatives. It would also encourage greater participation in volunteering in care homes.

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.**

As part of this work, there is a need to determine the extent to which 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. We should ask some key challenging questions in respect of existing provision:

- 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 this is correctly the responsibility of Local Partnerships to carry out, in order that it reflects 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.

Residential care facilities are not evenly distributed across Scotland at present. There are areas of under-provision, as well as areas with excess capacity, and although this partly reflects an urban / rural split, that is not always the case. For example, much of the development of care home provision in Glasgow has been in the east of the city where land and build costs have been lower.

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. Smaller units within core and cluster arrangements may provide a way of balancing the provision of targeted accommodation with shared services and some economy of scale.

In short, the long-term planning of the physical estate, to ensure that it responds to future needs and connects with our communities, is a matter of primary importance.

Workforce

The communities that offer the context for place-making will be the same communities which provide the workforce. The anticipated changes in Scotland's demographics, and the increase in the number of people with 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 current care workforce is ageing, with the average age in the sector currently 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 potentially reduced physical capacity.

Part of this will involve investing in skills and training. In addition to possessing the core qualifications to practice, currently defined through workforce development bodies like the SSSC and NES, there are a wide range of training and development requirements needed in the sector. Depending on the role, this may include **skills and knowledge relating to administration of medications, falls prevention, nutrition, anticipatory care planning, first aid, tissue viability, rehabilitation, moving & handling, and health & safety. It is important that core training provision on these elements is maintained. We also need to future-proof skills against the demands of a changing profile of need, particularly in respect of increasing frailties and long term conditions; dementia care; intermediate care skills and techniques, including promoting self-management; the use of technology; palliative and end of life care; and skill mix and staffing numbers across the totality of the care home workforce. Effective training is at the heart of quality care.**

Increasingly, there will be a need to provide and secure highly specialist care and support for those with the most complex needs and behaviours, for example we know that there is a growing population of people with dementia. 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.
- **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.** Where not already established, the Joint Strategic Commissioning Plan is a potential vehicle to ensure that the planning of these services spans independent and third sector care homes, adding real value to the services that they already provide and maximising the impact of the whole system's resources.

All of this is affected by perhaps the *greatest single challenge for the delivery of a high-performing workforce into the future*: terms and conditions. Care remains a low wage economy. 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. Career progression in the sector remains challenging, 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 a 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. Levelling up the terms and conditions in the care sector to the Living Wage should be our goal. 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 and 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.

It is also the case that due to the increasing 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. The essence of good care 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 need to be at the heart of care provision into the future.

Part 3: Supporting Sustainable, Quality Care Services

Commissioning

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. 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.

There are a number of reasons that explain why we have been unable to move beyond the purchaser-provider paradigm. In part, this has been due to perception 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 and individuals 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, the power of 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 freedom of choice. And even in those circumstances where business failure does happen, there are significant political and professional reasons to prevent 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 has never developed. But precisely because of the deficits outlined above, now is the time to develop this thinking. 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 to 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 be required to develop commissioning plans by law.

The Task Force has reviewed the effectiveness of commissioning levers. We believe that three central options are available to us to better support commissioning practice into the future:

- Develop and strengthen partnership working, to ensure that there is a common understanding of what type of services will be required into the future and at what volumes. This is implicit in the commissioning process, but can also be advanced through the use of Market Facilitation Plans;
- 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. While the non-successful providers will remain registered and hence a viable care destination, social workers would advise prospective service users of those care homes which meet the Partnership's commissioning requirements;
- Regulatory or legal controls over capacity. This could involve the introduction of a licensing regime, whereby the integration authority has a power to define local capacity. This is the model used in France, Canada and some parts of the US. It might also involve the use of physical planning regulations and policies to define the conditions under which a new care home development would be supported. Or finally, the Choice of Accommodation Directions could be revised once the Public Bodies (Joint Working) Bill is enacted, to ensure that care homes have been approved by the integration authority as meeting the requirements of its strategic plan.

In the end, the Task Force has come to the view that it is premature to take a more aggressive regulatory or legislative approach to controlling capacity – mainly because of

possible unintended consequences / undesirable outcomes - and therefore recommends that Partnerships explore different procurement options within the context of their Joint Strategic Commissioning Plan. However, legal and regulatory reform should not be ruled out and the issue should be revisited within five years to ensure that local markets are responding to commissioning plans.

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 and specialist long-term care provision for older people. **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 under-capacity it should attract new investment and new builds because of a clearly articulated need. The use of a Market Facilitation Plans will be crucial in working with private and voluntary sector providers. It is important that such statements are developed with a wide range of partner organisations, including financial institutions like the banks.**

Commissioners will also need to develop 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 service development.** Further work should be undertaken around care pathways, especially if we are to realise current policy goals such as the presumption against discharging direct from an acute bed direct to a care home.

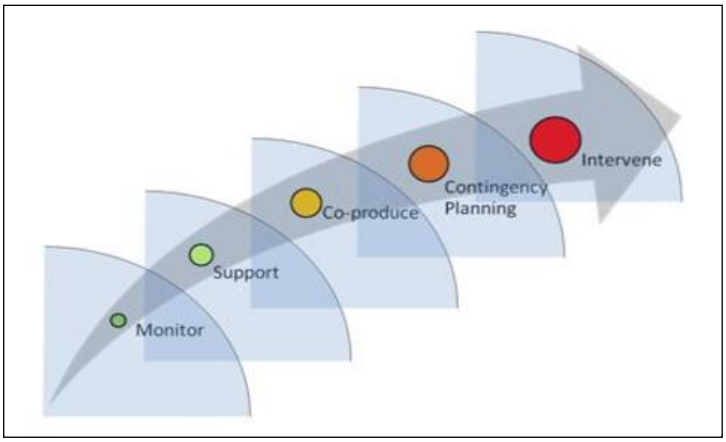
Contingency Planning

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 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, 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 good contingency planning arrangements in place nationally and locally.

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 therefore 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. An example risk register is set out in Annex B.**



It is important to point out that this register should not function primarily 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 and existing 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), the 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.

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.

As we move towards greater integration of health and social care, the Care Inspectorate is working more closely on developing a joint inspection regime covering health and social care services in partnership with Healthcare 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 key service types under regulation, which we believe require either review or greater flexibility, include care home services; housing support services; support services; and adult placement services. **The Task Force is clear that flexibility should be given to providers to innovate and provide different service design or delivery options - for example, more community outreach services. The Care Inspectorate's view is that variations (from the standard service template) that are reasonable, specific and justified, are 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. The Care Inspectorate has signalled a willingness and strong support for the adaptation of approaches to registration and the process of agreeing conditions to registered services, to facilitate greater innovation in older people's care services.** In terms of more specific reforms, the Task Force is recommending:

- **a discussion on a new definition for housing support services within secondary legislation, to allow for more flexible service design and registration;**
- **further discussion on registered care home services adding to their functions (e.g. day care/respite; laundry; meals; activities) to provide an outreach service to non-residents in the local community. In addition, regulations may need to be reviewed to facilitate greater flexibility;**
- **the use, recruitment and training of volunteers. It is recognised that volunteers are an under-used resource. There is an incorrect assumption by some that volunteers and unpaid carers are prevented from 'working' in a service by the Care Inspectorate. As such, new protocols and toolkit materials should be developed to combat these misperceptions;**
- **further work should be undertaken to establish the regulatory implications of moving to a tenancy based model within some care homes – this might be explored through a pilot; and**

- **the implementation strategy being developed on the back of the Task Force report 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.**

Part 4: Sustainable Funding

Changing demographics – both for older people and for other age-groups – will impact on public finances. The need for a radical shift towards collaborative, outcome-focussed service planning, pooled funding, and pre-emptive, community-orientated preventative services is widely recognised. Even so, funding this shift remains very challenging.

The financial impact of demographic change is already here, and has been for some years, although not necessarily at the levels previously projected. Nonetheless, many councils have not been able to increase spending on social care in line with increasing demand, resulting in tighter application of eligibility criteria. The best evidence available is that the need to spend more on health and social care will continue at an accelerated pace into the future. As the Office of Budget Responsibility points out, "demographic change is a key long-term pressure on the public finances."[8] The recommendations of the Task Force therefore need to be set within this wider strategic challenge around demographic change.

Care Home Funding

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[9].

Over time, and especially over the past 2 to 3 years, **there have been significant and growing financial pressures within the care home sector from rising fuel, food and staffing costs – this strain has been experienced by providers within the private, voluntary and public sectors. The property boom and subsequent collapse in the property market has left many private sector care home providers with onerous debt obligations which are set to worsen if interest rates rise in the near future.**

At the same time, Local Authorities are having to manage their budgets in a period of fiscal pressure. 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.

[8] Office for Budget Responsibility (2012): Fiscal sustainability report 2012. July 2012, page 6
[9] Scottish Government Free Personal and Nursing Care Expenditure, Scotland, 2011-2012 http://www.scotland.gov.uk/Publications/2013/07/1907/4

These pressures have been given expression within the context of the National Care Home Contract fee negotiations, which are taken forward 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. 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. Despite subsequent uplifts of 2.75% and 2.5% for the period 2012-14, many providers continue to operate at the margins of viability.

It is the view of the Task Force that there is currently insufficient funding for investment in the care home sector. Publicly funded residents are generally being cross-subsidised by self-funding residents and many providers are relying on expensive and more complex debt packages to stay viable. New build properties are often being targeted exclusively at self-funders. None of these developments are in the interests of the majority of current and future residents. **The implications of failing to provide adequate funding include: heightened risk of care home providers going into administration; still higher care fees for self-funders; a decrease in the level of quality of provision and services; an increased level of delayed discharges from hospitals; and increasing difficulties in the recruitment and retention of care home staff at all grades. In short, the funding of care is at the heart of building a high quality and sustainable sector into the future.**

The view of the Task Force is therefore that there is a need to review funding levels within the sector and that the main vehicle for this should be around a separation of the accommodation, hotel and care costs. This will help to make it clearer that the individual's responsibility (where he or she has the means to do so) lies in covering living costs regardless of whether they are living at home, in extra care housing, or a care home, whilst the costs of care (personal and nursing) remains the responsibility of the state. This will necessitate a review of the current rates for Free Personal and Nursing Care. When we stratify the care home fee structure into its various strands, it raises questions about the costs of providing care and support arrangements within a homely setting. Work undertaken by Laing and Buisson indicates that FPC payments are unlikely to cover the true cost of nursing care. There is general consensus in Scotland that the "care" element of residential care fees should be fully funded by the state. As such, 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. Furthermore, the Task Force holds the view that any additional investment in the sector through an uplifted FPC rate should be offered in the expectation that it delivers a quality dividend.

Charges to the Service User

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 and associated Charging for Residential Accommodation Guidance (CRAG), provide the framework for local authorities to charge for the residential care that they provide or arrange.

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.

The current framework is often perceived as unfair by those with capital and assets greater than the upper limit because:

- it often requires families to sell homes to pay for care;
- a significant proportion of people accessing care homes for the first time will have assets greater than the upper capital limit;
- Self-funding 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 significantly higher fee rate; and
- The current system of charging is complex and difficult to follow, and families are often unaware of all the options to fund their care.

The UK Government has recently chosen to reform capital limits in England, following Andrew Dilnot's independent report in 2011. The financial limit used in the financial assessments for people in residential care will increase from £23,250 to £118,000 when the value of their home is considered as part of their capital (from April 2016). **The Task Force recommends that work is undertaken to fully explore the opportunities and costs of amending the capital limits in a Scottish context.**

Pooled Budgets

The formal integration of health and social care services through the Public Bodies (Joint Working) Bill provides an opportunity for local Health and Social Care Partnerships to pool

resources. This is especially true with respect to the resources that partnerships deploy in support of older people with highly complex long-term care needs. For example, as mentioned above, councils currently spend in the region of £640million on this population while the NHS also has a significant expenditure on continuing care patients, most of whom are older people with complex needs. **There is therefore an opportunity to rationalise this expenditure to deliver a consistent approach to care and support across this care group. It is recommended that Heath and Social Care Partnerships scope out this potential in their joint commissioning plans.** Many NHS Boards already make use of the sector and this is a practice that we would like to see increase under integrated arrangements. More generally, the Task Force is aware that the Scottish Government has commissioned a separate review of NHS Continuing Healthcare and we await its conclusions.

Part 5: Conclusion and 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-up / step-down 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 on-going 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, Care Inspectorate, 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, CCPS, Scottish Care 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 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, Scottish Care and CCPS 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, CCPS 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. The Care Inspectorate should devise new protocols and toolkit materials to support the involvement of volunteers and unpaid carers in care home environments.

- 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 opportunity to rationalise health and social care expenditure on older people with highly complex long-term care needs.

Managing Risk

- A compulsory risk register should be devised by COSLA, ADSW, Scottish Government CCPS 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 and Quality Assurance

- The Scottish Government, COSLA, CCPS and Scottish Care 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, CCPS and Scottish Care 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 regression 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, CCPS, Scottish Care, 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

Co-chairs	Douglas Hutchens (Non-Executive Director of Scottish Government) Cllr Peter Johnston (COSLA Spokesperson for Health and Wellbeing)
Ranald Mair	Chief Executive, Scottish Care
Gillian Barclay	Head of Older People's Unit, Scottish Government
Brian Slater	Joint Commissioning Lead, Scottish Government
Alan Martin	Policy Advisor, Scottish Government
Ron Culley	Chief Officer, Health and Social Care, COSLA
John Urquhart	Policy Officer, Health and Social Care, COSLA
Judith Proctor	NHS Directors of Planning
Rob Harper	Managing Director, Scotland & North East England, Four Seasons
Jim Hayton	Association of Local Authority Chief Housing Officers (ALACHO)
David Williams	Association of Directors of Social Work (ADSW)
Dorry McLaughlin	Coalition of Care and Support Providers in Scotland (CCPS)
Derek Young	Policy Advisor, Age Scotland
Colin Mackenzie	Society of Local Authority Chief Executives (SOLACE)
Rachel Cackett	Policy Advisor, Royal College of Nursing
Amanda Britain	Associate, Joint Improvement Team
Robert Peat	Director of Inspections, the Care Inspectorate
Brian Logan	Chief Executive, Bield Housing Association
Harry Stevenson	Executive Director of Social Work, South Lanarkshire Council
Donald Forrest	Local Authority Directors of Finance

Annex B: Example 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.

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