

**BEST VALUE REVIEW
ACCOMMODATION NEEDS OF THE FRAIL ELDERLY
IN DEVON COUNTY
(Joint Review)**

Vision for the Future Support of People in Own Homes

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EXECUTIVE SUMMARY

- Older People state clearly that they want to remain in their own homes.
- Support for people within their own homes requires improved strategic planning and joint commissioning between health, housing and social services.
- The rise in the number and proportion of older people will create increased demand on services until the middle of the century.
- The development of services over the past 20 years has been driven by cost.
 - (a) firstly, an unmanaged expansion of residential and nursing care in the early 80's which quickly went out of control;
 - (b) secondly, the 90's have been concerned with managing down the over-supply of residential and nursing care and re-directing resources into community services such as domiciliary care and respite care.
- Developments in NHS policy, in particular:
 - (a) the reduction in long-stay care for older people and,
 - (b) pressure to reduce time in hospital has shifted cost and responsibility onto local authorities.
- Social Services have been funded below the rise in cost and demand for over a decade. Local Authorities have filled the gap in Government funding by spending well above SSA on Social Services. The capacity of Local Government to fill the gap has been reached, with the consequence that there is a severe funding pressure throughout Local Government on Social Services budgets.
- The funding pressure is having an impact in:
 - the reduction of preventative services;
 - low fee levels for residential care which is leading to market instability and downward pressure on quality;
 - workforce retention, recruitment and quality.
- The national system in which health, housing, social care and benefits systems operate is complex and confusing.
- The existing pattern of service provision is not considered to be well matched to meet the needs of the frail elderly or to promote the aim of supporting older people in continuing to live independently as they become more frail and dependent.
- The Best Value Review makes recommendations which will provide a medium to long term strategy to change the pattern of service provision:

(a) that those elements of the system subject to local control and influence are made less complex and easier to use through:

- integrated system of information and signposting;
- single point of contact;
- single assessment system;
- multi agency assessment teams.

(b) integrated strategic planning incorporating health, housing, social services and relevant stakeholders to achieve:

- Investment in preventative strategies and programmes to reduce health morbidity;
- a greater emphasis on the role of housing in community care strategies;
- strategic development of extra care housing;
- development of integrated Community Resource Centres;
- stronger market management in respect of residential and nursing care.

(c) local authority residential resources should be focussed on providing:

- locations for Community Resource Centres;
- redevelopment as sites for supported accommodation;
- reablement and respite care;
- services for the confused elderly.

- Changes in patterns of residential provision which will impact on long-term care need to be carefully planned with residents, relatives, care providers and staff in order to minimise disruption.
- Public understanding and commitment to the strategy is important. It should be communicated and explained directly to interest groups, the public and through the media.
- The strategic shift is a medium to long term programme which must be supported by a robust medium and long term financial strategy. Funding streams to achieve the shift will come from:
 - disinvestment from high cost and/or over capacity services;
 - more efficient joint commissioning with health, housing and social services;
 - ensuring transferred funds, ie Supporting People, Preserved Rights and Residential Care Allowance are applied to services which meet current and projected need, rather than sustain historic patterns of spending.

THE CONTEXT

1. SCOPE

- 1.1 This review is focussed upon the accommodation needs of the frail elderly. The scope of the review covers demand and supply issues of residential and nursing care, both in the public and private sectors.
- 1.2 There is a clear message from older people that the majority would prefer to maintain their independence into their old age and frailty. This review examines how that might be achieved as efficiently and effectively as possible. The review has considered how frail elderly people can be supported in a range of different care settings. (See Table 1.1)

Table 1.1 – ‘Care settings explained’ - Royal Commission Report With Respect to Old Age

<i>Care is provided in a range of settings by the public, private and voluntary sectors. The explanations of each are general as there is a wide variation in practice and form within each, and increasing overlap as innovative approaches are developed.</i>	
Care at home	Personal care and practical help provided to older people in their own homes.
Adult placement	Placing older people with selectively matched carers in the carer's own home.
Day care	This includes NHS day hospitals, Local Authority, and independent sector day centres.
Sheltered Housing	Individual housing within a setting which offers different degrees of monitoring, protection or support. It can be owned or rented. Within this there are the following variations: Very sheltered housing or housing with extra care Retirement communities/Care Villages
Residential care	Care for older people in an institutional setting, that is, either in a residential or nursing home
NHS continuing care	In nursing homes, hospices and hospitals
NHS Acute services	In NHS hospitals

2. COMMUNITY CARE POLICY

2.1 As such, the review has dealt with matters which are the heart of the national strategy of Care in the Community. The initial impetus for community care came

“as new treatments reduced the need for places in long-stay hospitals throughout the 1970’s and 1980’s. Social Services departments made significant contributions developing a range of community-based services”.

(Home Alone – Audit Commission pg 5).

2.2 During the 70’s and 80’s the NHS made significant reductions in its provision of long-term care for the elderly, mentally ill and people with learning disabilities. This was partly in relation to a recognition that an improved quality of care could be provided within the community but partly in relation to financial pressures and new performance targets for NHS.

*“During the 1980’s the NHS became aware of its costs for the first time, and was subject to measured performance targets. The perception was that an old person on a ward consumed resources without an easily achievable and identifiable point of recovery. Given the **existence** of the uncapped social security benefits, residential and nursing care provided one ‘exit’ from the NHS for many patients”. (With Respect to Old Age – Royal Commission on Long-term Care pg 38).*

2.3 The 1990 NHS and Community Care Act, which was implemented in 1993, set out the core principles of community care based upon the White Paper, ‘Caring For People’, written by Sir Roy Griffiths.

These principles are:

- to enable people to live as normal a life as possible in their own homes or in a homely environment in the community;
- to provide sufficient care and support to help people to achieve maximum possible independence and, by acquiring or re-acquiring basic living standards, help them to achieve their full potential as individuals; and
- to give individuals a say in how they live their lives and what services they need. (from Audit Commission pg 5).

3. THE ECONOMIC SCALE OF THE CARE SECTOR

3.1 Providing care for the frail elderly is a significant part of the economy of Devon, both in terms of financial turnover, capital investment and workforce. Devon County Council spends £79m per annum on services for older people, of which £52m is on residential and nursing care, £20m on domiciliary care and the remainder on community services. (Source: Fair Access to Care Services: Report to SMG Feb 2002). While we do not have exact figures for numbers of people employed on the social care

workforce we estimate that there are at least 8-10,000 full time equivalent jobs in the social care sector in Devon in support of the frail elderly. We base this calculation on the Local Authority's employment returns to the Department of Health (SSD 5001) which shows there are approximately 1,200 (fte) people directly employed by Social Services in Devon in support of the elderly. There are approximately 600 fte posts in residential care, which would suggest at least 6-7,000 employees in the independent residential and nursing care sector. Approximately 600 (fte) people work in our in-house domiciliary care and day care services which suggests there are at least 1,400 posts in the independent sector. These figures exclude those people working in health care and housing. Given the size of the workforce and its contribution to the Devon economy it is essential that there be a planned, strategic workforce strategy..

3.2 The Best Value Review team was aware of the positive extension of the NHS Workforce Development Strategy to include the social care workforce in the public and private sectors. This approach is commended as being the way forward to jointly plan to meet the workforce and skill requirements of the health and social care workforce in both the public and private sectors. The Best Value review noted recent joint recruitment initiatives inviting health, social services and the independent sectors, and that it was planned to repeat and develop further this joint approach. The Best Value Review recommends that the joint workforce strategy be progressed with the framework of the NHS led Workforce Confederation.

4. POLITICAL SENSITIVITY

4.1 There are strong feelings about the relationship between residential care provided by the Local Authority and that provided by the independent sector. To some extent these issues run through the national care system. There tends to be a differential between the cost of residential care provided directly by the Local Authority and the price paid to purchase the same service from the independent care sector. Since 1993 and the implementation of the NHS and Community Care Act there has been a need to rebalance the care market away from an over reliance on residential care. Under funding of Social Services throughout the past decade has resulted in significant financial constraints being applied to services for older people and a subsequent downward pressure on fees for supported residents in nursing and residential care.

4.2 Within Devon there is an additional sensitivity because of different political strategies in the past in relation to the role of local authority residential care. It is now time to undertake a fundamental review of strategy in the context of needs, users preferences, new service opportunities and national programmes. These issues are examined in more detail in the body of this report.

5. MARKET CHANGES

- 5.1 Over the past decade there has been a shift in the shape of the market nationally. Between 1996 and 2000 there was a reduction of 23,000 (-10%) nursing care beds; a reduction of 16,000 (-24%) Local Authority residential care beds but an increase of 9,000 (+4%) independent and voluntary sector care beds. (Source: Healthcare Market Review 2000-2001, Laing and Buisson 2000).
- 5.2 In Devon the number of registered nursing beds has fallen in line with the national trend. In contrast, however, the number of residential care beds in the independent and voluntary sector reduced by 945 (-14%) between 1999 and 2001. The Local Authority supplies 721 beds in total, a number which has remained constant over the past decade, albeit there has been a change in function of a proportion of that bed provision.
- 5.3 This review examines the appropriateness of the mix of the market to meet the expectations and needs of the frail elderly today and in the future. The review draws conclusions about the balance between residential and non-residential provision; it makes recommendations in relation to strategies to support the frail elderly within the community; it recommends a strategy for the development of the Local Authority and residential care service and deployment of its skilled work force.

6. BEST VALUE REVIEW – PRINCIPLES

- 6.1 The duty of Best Value applies to all Local Authority services. The principle is that services should be subject to periodic, fundamental review with decisions about the effectiveness and efficiency of services based entirely on judgements about best value and optimum outcomes for individual users. The balance between quality cost is very important.

“Major expenditure constraints that have forced local authorities to systematically drive down costs are now biting into the quality of services that can be provided. The conclusion is unmistakable that the requirement to bear down on costs has led to a damaging preoccupation with price at the expense of quality. We accept that the concept of Best Value is intended to address both cost and quality issues. However, the evidence to the Inquiry demonstrated repeatedly that cost control has left virtually no room for further efficiencies. In some instances, the impact on service quality is threatening the continuation of the social care market”
(M Henwood –Future Imperfect Report of the King’s Fund Care and Support Inquiry, 2001 pg 143).

- 6.2 The Best Value review agrees with this analysis and has been concerned to address both the quality as well as the cost issues. The Best Value

review endorses the conclusion of the King's Fund Inquiry that cost pressures are placing an enormous strain on staff in all care sectors (as well as on carers and service users) and that a radical change in strategy, partnership and commissioning is required. (c.f. DH, Social Care Group 1999. "That's the way the money goes: inspection of commissioning arrangements for Community Care Services").

"Care staff provide a highly valued and essential service for millions of people and the commitment and dedication of many staff cannot be faulted. The pressures on care and support staff are enormous. Many provide an excellent service, often far above and beyond that which might be expected. However, there are grounds for believing that, without radical change, there is potential for a major deterioration in standards of care"
(M. Henwood – *Future Imperfect*, 2001 pg143).

7. THE REVIEW PROCESS

7.1 The Best Value Review was undertaken between Autumn 2000 and Spring 2002. Membership of the team included representatives of older people's interests, housing interests, the NHS, independent providers, social services staff, trade unions and Elected Members. Links to the parallel Best Value Review of Domiciliary Services were maintained and also to the NHS led older People's Modernisation Programme. Review Team membership is shown in Appendix 14.

7.2 The project plan was agreed in November 2000 as follows:-

- To establish current and projected demand in the frail elderly population;
- To map existing services provided or purchased through the County Council, District Councils and NHS
- To establish current care and accommodation costs to the County Council, District Council and NHS
- To establish consumer views of current and preferred pattern of service provision
- To identify and examine models of good practice
- To appraise options and recommend a course of action to the Executive Committee.

7.3 To achieve these tasks the team met on a number of occasions, took evidence from a range of interested parties, visited sites locally and elsewhere where good practise had been identified, held three day long workshops with wider representation (including a challenge day) and concluded with a series of specific consultations with key stakeholder groups.

7.4 In the course of the Review evidence was taken from representatives of older people, independent providers of residential and nursing home

care, providers of alternative types of accommodation for frail older people (Registered Social Landlords). The County's senior statistician, Performance Review Team and Supporting People team provided demographic and service mapping information.

- 7.5 In the course of two separate day long workshops, evidence regarding services were provided by Exeter University Centre for Evidence Based Social Services and Peter Whittingham Associates, and for dementia sufferers by Dementia Voice.
- 7.6 Visits or other extended contacts were undertaken with: Douro Court (Guinness Trust); Anchor Housing, a number of Local Authority and independent homes in Devon; Bournemouth Social Services; and Wolverhampton Social Services.
- 7.7 The challenge day received and considered presentations from members of the team on the work which had been undertaken. A series of 'focus group' consultation meetings were held with representatives of the main interest groups in order to discuss the main conclusions and to help in formulating the final Action Plan.

8. BEST VALUE – INTERFACE WITH OTHER REVIEWS

- 8.1 New guidance on the conduct of Best Value reviews has recently been published (Reference – Statutory Instrument + No 2002/ 305). It recommends that reviews should be strategic and cross cutting “to enable authorities to focus Reviews more effectively on national and local priorities, and on areas of weakness and opportunity identified as a result of the reassessment process.” This raises the question whether we have been sufficiently strategic and conclusive in our approach.
- 8.2 We believe we have taken a strategic overview of the accommodation needs of the frail elderly. We have tried to work on the big picture as we think it will unfold over the next ten years; at the same time we have tried to gather information on quality and costs as they relate to existing services. One of the major challenges we faced was how to address aspects of the review which are beyond the remit of a Social Services authority, in particular health and housing matters.
- 8.3 The Review dealt with these matters by working closely with the NHS Modernisation programme, in particular implementation of the National Service Framework for older people. This was facilitated by cross membership between the Review group and the NSF implementation group.
- 8.4 In relation to supported housing, the Review group benefited considerably from the initiative of District Housing colleagues in promoting a review of new housing and service initiatives for older people. Furthermore, the Supported People programme, which is administered through the Social

Services authority, has broadened considerably the scope, information and knowledge available to the Best Value review team.

8.5 Another major and related Best Value review into Help at Home has been undertaken in parallel with this review. There has been regular interchange of information between lead and support officers of each review. There is considerable overlap between the two reviews, particularly in respect of ways of supporting people at home. While in retrospect it might have been better to have merged these reviews, on the other hand it could be argued that the consistency of the conclusions of these parallel processes is, in itself, a strength.

9. NATIONAL POLICY CONTEXT

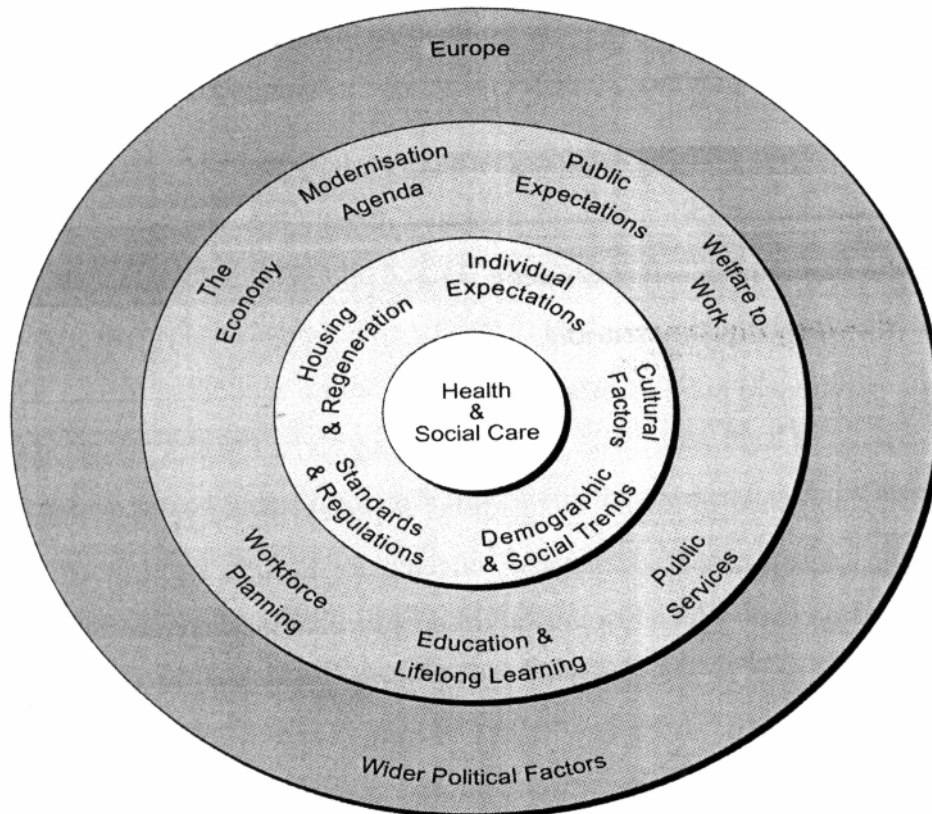
9.1 The review has been undertaken in the context of the Governments modernisation agenda for public services in respect of Local Government, Social Services and the NHS. A new, more positive national framework is emerging which may provide the opportunity for radical change if there is the vision and will to take up the challenge.

9.2 The review has acknowledged the opportunities for radical change inherent in the NHS Plan with the emphasis on a primary care led NHS through PCT's; the priority which will be given to health promotion and compression of morbidity signalled by the requirement for each PCT to appoint a Director of Public Health at Board level. The Health Act creates new opportunities for partnership by introducing a range of flexibilities including integrated services, pooled budgets and lead commissioning,

- Integrated strategy planning should become more robust as a consequence of the requirement for Local Authorities to establish Local Strategies Partnerships (ref Local Strategic Partnerships: Government Guidance, DETR, 2001). Consistency of service provision between health and social services will be promoted through the introduction and implementation of the National Strategic Framework for Older People.
- A new Single Assessment Process bringing together health, social services and housing will be introduced in October 2002.

9.3 The inter-relationship of the wider external environment on health and social care services is illustrated in Table 9.1.

Table9.1 – The external environment influencing the quality of care and support (Source: Future Imperfect? M Henwood)



10. TACKLING THE LEGACY OF UNPLANNED EVOLUTION

10.1 Significant changes have taken place over the past 20 years which have had a marked impact on the system which exists today. Changes in national policy and provision have not been well planned or co-ordinated. The report addresses these matters in some detail but in summary the existing national system of care for the elderly has been formed by;

- a change in the funding regime in the early 80's which allowed uncontrolled access to residential care funded by social security;
- this led to a national funding crisis in meeting the costs;
- residential care grew at an uncontrolled rate – a legacy still with us today;
- this drained resources away from preventative community services such as domiciliary care;

- it led to the consequent implementation of the NHS and Community Care Act in 1993 aimed at redressing the balance, controlling the unregulated expenditure and returning the market to a better balance
- a decade of chronic and significant under funding of Social Services;
- a shift in responsibility for long-term care from the NHS to Local Authorities without a compensating shift in resources;
- naive and politically motivated performance indicators in relation to NHS acute sector bed occupancy which have a perverse impact on investment in services within the community;
- rising expectations of older people;
- increased regulation;
- changing public sector housing policies and a mismatch between supply (as in sheltered housing) and consumer expectations;
- a national funding regime described by the Royal Commission as:

“Characterised by complexity and unfairness in the way it operates. It has grown up apparently haphazardly over the years” (ibid pg 33).

And

“Confusion and uncertainty exist as an intrinsic part of the current system. Looking at its development in this historical context shows how problems have become compounded over the years” (ibid pg 38).

10.2 The current system has evolved in an ad hoc, often contradictory way over the past 20 years. It is not a system devised by Local Government, let alone Social Services. In respect of the frail elderly it is social services staff who are faced with the complexity of trying to make a flawed and contradictory system work. It is a system which, in the view of the Royal Commission is tainted by a lack of trust and belief that there has been a breach in the contract between the Government and the people in terms of its funding. (c.f. Royal Commission ibid pg 33ff).

This summarises the context of the challenge for the Best Value process, and also defines limitations. The Best Value review is able to recommend a number of changes which we believe will result in an improved service for the frail elderly. We welcome the opportunities inherent in a Government led modernisation programme, but we are equally aware of the limitations of what can be achieved within a flawed and contradictory system; added to which is the ongoing, chronic under funding of social services which threatens to undermine the range and quality of the services which exist. The Best Value review makes its recommendations within the limitations of the wider economic, social and political context.

OLDER PEOPLE LED SERVICES WHAT DO PEOPLE SAY THEY WANT?

1. STAY AT HOME

1.1 There is a consistent message from surveys of older people, and from groups representing older people that the majority of people want to stay at home. A survey, undertaken for Anchor Housing, is typical in finding that:

- 66% of older people wished to stay in their existing homes.
- 30% would prefer to move on, mainly to options involving smaller accommodation.

The same views expressed in national studies have been reflected by local studies, e.g. 'Better Governance of Older People', Devon; Ageing and the Future of Health and Social Care; Age Concern Exeter; Demographic Change; The agenda from the South West Region; Age Concern in the South West.

“Overall these older people were often asking for very modest forms of help in order to maintain independent and their sense of being ‘at home’ in their present accommodation” (Means, 1997)

1.2 The range of practical support required while not complex, is of a broad range of services. The Age Concern, (Exeter) millennium debate of the age survey identified that the majority (90%) of those surveyed agreed that a good social life and a mix of leisure activities is important in maintaining health in old age. It was recorded by 58% that leisure sports and fitness centres should gear their facilities more towards the fitness needs of older people. The most important factors in maintaining a varied social life in later life were seen to be family and friends (37% surveyed) and affordable transport (35%).

1.3 These findings are consistent with a range of other research surveys.

- The majority of older people wish to retain their independence in their own accommodation.
- The support they require while not necessarily complex, covers the whole range of health, housing and social care needs.

2. QUALITY OF LIFE

2.1 Irrespective of whether frail elderly people are supported within their own home or in a residential care home the quality of the personal support is very important. 'Future Imperfect' a report by the Kings Fund into Care and Support for the elderly and people with disabilities found;

“Consistency of the messages arising..... It is apparent that service users definitions of ‘quality’ focus not only on the material aspects of quality (such as the characteristics of it’s residential facility) but the nature of the relationship with members of staff and the quality of the interaction with service users” (Future Imperfect pg55)

2.2 The quality features most valued are:

- staff reliability
- continuity of care and staff
- kindness and understanding of care workers
- cheerfulness and demeanour of care staff
- competence in undertaking tasks
- flexibility
- knowledge and experience of the needs and wishes of the services user

2.3 Concerns about the relationships between service users and support staff is considered to be:

“fundamentally important, not least because they are indicative of many other actual or potential problems including;

- *Failure to treat service users as people first can lead to dehumanising treatment and actual abuse.*
- *Shortcomings point to wider problems with recruitment of appropriate care staff*
- *Vital aspects of service quality are undermined by cost pressures which limit the capacity of services to respond”*

(Future Imperfect pg 57)

Thus the quality of care is important and it is judged in terms of the personal interaction between the service user and care giver.

See Appendix 1 Views of Service Users identified from consultation meetings with Future imperfect inquiry (Future Imperfect)

2.4 These are important messages for workforce strategy in terms of recruitment, training and deployment of staff.

For example,

“The current practice of sending in numbers of different staff for short periods of time is generally regarded as disturbing by older people. It does not represent good quality care. Continuity of personnel will assume a greater importance if more care is provided in peoples homes”

(With Respect to Old Age: Royal Commission on Long Term Care, pg92 HMSO 1999).

2.5A report by the Office of Fair Trading, 'Older People as Consumers in Care Homes' OFT Oct 1998 found that;

- 75% of the respondents (care home residents) said they were very satisfied with the services and facilities of the care homes they were in
- but 41% considered that staff were too busy to sit down and talk
- Of those residents who had complaints or concerns only 67% had told anyone about them.
- The four most common positive attributes identified were;
 - kind and helpful staff
 - companionship
 - the care they received
 - friendly, pleasant atmosphere
- The four most common concerns were;
 - not enough experienced staff
 - deteriorating standards and maintenance
 - insufficient food
 - not enough staff to look after residents or take them out

3. PERSPECTIVES ON AGEING

3.1 We live in an ageing society.

"The most important policy challenge facing society in the 21st century is how to respond to an ageing population. The prize will be to transform the concept of 'healthy ageing' into the living reality for many older people" (Fit for the Future pg41 pub Continuing Care Conference 1998).

3.2 The Royal Commission on Long Term care stated

"There is now a clear opportunity to see old age for what it is, a stage of life where we have the gift of time to be able to acquire knowledge and experiences.... In this age of opportunity.... People should not necessarily be assumed to be passive recipients of the goodwill of others or inevitably incapacitated, befuddled or redundant" (With Respect to Old Age – Royal Commission pg 4).

3.3 The risk as identified by the Royal Commission, is that old age is seen as a 'problem' and that;

"the problem will increase in intensity over time. Seeing old age as a 'problem' is of relevance to the provision of incomes in old age, healthcare, housing, transport, the facilities for daily life which

everyone take for granted in their youth and middle years” (With Respect to Old Age – Royal Commission pg 3).

See Appendix 2 for the set of values adopted by the Royal Commission.

4. USER EMPOWERMENT AND INCLUSIVE PLANNING

4.1 The Government’s modernisation programme for public services (Local Government, NHS, Social Services) emphasises service user and carer participation within open and inclusive planning systems. If the views and interests of older people are to influence service planning and provision then they must be involved in the planning process.

In a background Research Volume 3 for the Royal Commission it is stated that:

“the culture of services designed for older people has.... barely changed over the past ten years” (T Harding With Respect to Old Age. Research Volume 3 pg43).

4.2 The reasons put forward for this are:

- The financial pressures to get people out of hospital as quickly as possible.
- To target resources on those in greater need
- Not actively involving older people in discussions about service developments
- That services for older people remain low grade and low status activities.

4.3 Achieving the goal of supporting older people to live in their own homes and remain independent is wider than domiciliary, day and respite services.

“Income levels, accessible and affordable transport, comfortable housing, safe and accessible environments, access to adult education, libraries, cultural and sports facilities and so on are all significant factors which enhance or undermine independence and inclusion” (T Harding – With Respect to Old Age – Research Volume 3).

Thus participation by older people in inclusive planning processes must reflect the ‘whole system’ nature of the services.

4.4 The Royal Commission has identified that many people find the existing system confusing and “hard to navigate”. It suggests that independent advice and information is one of the most important factors on delivering a client centred approach to long term care provision and that this information should be available from a single point of contact, possibly centres of primary health care into which independent advice workers and advocacy services might be combined.

4.5 The development of simplified integrated advice, information and advocacy services would require the collaboration and commitment of the full range of statutory agencies.

4.6 At an individual, rather than collective level, there are examples of good practice involving service users in monitoring and reviewing service provision. The King's Fund, in the report 'Future Imperfect' gives examples of user involvement in service evaluation and inspection (see Appendix 4) and user-focused monitoring of mental health services (see Appendix 5).

"User involvement and empowerment are words that are in frequent use, but often with little consideration of what they mean in practice, either at the level of the individual or collectively.... The development of similar approaches to training should be encouraged. The direct involvement of service users is invaluable in raising awareness and understanding of the needs of service users. It also ensures staff training is better related to those needs" (Future Imperfect pg 142 – The King's Fund).

The existing formal joint planning structures, ranging from the Devon Strategic Partnership through to the locality Joint Investment Planning Groups for older people need to be inclusive bodies with representation from older people and relevant interest groups. Appendix 3 describes a framework which would link locality based strategic planning groups, local JIPs, to a co-ordinating Devon strategic partnership. The proposed Partnership Board would be modelled on that described in the White Paper 'Valuing People'. It is recommended that the existing structure of joint planning groups be developed to be inclusive of all main stakeholders, and that the structure ensure co-ordination between locality and County-wide planning groups.

5. MEETING THE EXPECTATIONS OF OLDER PEOPLE

5.1 There is no doubt that the current system of support for frail elderly people does not meet their expectations. This will be explored in more detail within the report. The Royal Commission on Long Term Care concluded that "the current system does not fulfil the reasonable expectations of old people (ibid pg 41). That it "appears at times to be designed around a service of different bureaucracies, rather than the needs on individual older people" (ibid pg 40).

"The Commission is clear about the strong lack of trust in the current system. There are pronounced feelings that Government was meant to underwrite the system in some universal sense through taxation, and it has not done so.... The feeling is that a contact with the people has been broken. The reality is that there never really was one and, incrementally, rules were changed

without people understanding what this meant. The result is a sense of betrayal, a lack of trust and a genuine sense of helplessness”

(With Respect to Old Age – Royal Commission pg 40).

5.2 The overall system in which care is provided is confused and confusing. At an individual case level it is equally problematic.

“Securing the most appropriate care of the individual under the present system is precarious. If dignity and independence mean avoiding residential care unless it is absolutely necessary, the current system may be seen to push people into residential care and thereby compromise their dignity and independence at an earlier stage than might be necessary.... This complexity – a complexity which exists at all levels in the care system, militates against choice and dignity. The bias towards residential based care militates against independence. There must be a re-focusing on the needs of the individual”

(With Respect to Old Age – Royal Commission pg 41).

5.3 To address these issues and to achieve the realistic expectations of older people there does need to be a re-focusing on to the individual within a comprehensive re-alignment of care services for older people, in terms of the relationship between central and local government, the approach to social inclusion and the partnerships between health, housing, social services and life-long learning.

5.4 Without a radical whole-systems re-appraisal there will be limited scope to achieve best value, or best service, in meeting the accommodation needs of the frail elderly.

5.5 The way forward for the delivery of care which will meet people’s needs, as proposed by the Royal Commission (pg 83-84) is:

- More effective joint working and a greater sharing of responsibility between health, social services and housing authorities.
- Greater emphasis on the promotion of health and independence.
- Greater emphasis on rehabilitation.
- A more consistent framework for assessment and eligibility.
- More opportunities to enable people to stay at home.
- More support to carers.
- More real choice.
- Services should be continually sensitive.
- Greater emphasis on quality.
- System should be easier to access.
- A new relationship of trust between clients, carers and services must be created.

The Best Value review has sought evidence in relation to these objectives and examines the feasibility of meeting the expectations of older people within a model of partnership and user focussed services as identified by Government policy and evidence based best practice.

THE CURRENT SYSTEM – QUALITY AND BEST VALUE HISTORICAL PERSPECTIVE

1. INTRODUCTION

- 1.1 To understand the present structure of care provision, the process of assessment of needs, arranging care and how care is funded, it is necessary to describe the evolutionary process of these systems. The system is complex and confusing – for all parties.

“The current system is particularly characterised by complexity and unfairness in the way it operates. It has grown up piecemeal and apparently haphazardly over the years... Time and time again the letters and representations we have received from the public have expressed bewilderment with the system – how it works, what individuals should expect from it and how they can get anything worthwhile out of it”. (With Respect to Old Age – Royal Commission pg 33).

- 1.2 Strong words from the Royal Commission on long-term care. The system is criticised, it must be emphasised, is a national system within which local systems must work. This point is underlined for two reasons:

- a) The complex and confusing national system limits and constrains the scope for local action.
- b) It explains some of the reasons for the complexity and confusion at local level in implementing assessment, planning and financial regimes.

- 1.3 Nevertheless, there is scope to ensure that the existing flawed national system is implemented as openly and simply as possible. This Best Value Review examines the extent to which this is achieved within Devon.

2. HOW THE CURRENT SYSTEM HAS EVOLVED

“Confusion and uncertainty exist as an intrinsic part of the current system... In the post war period, long-term care was provided in residential (“Part III”) Local Authority Homes for which there was a waiting list and for which a means test was applied. Particularly ill or frail people might be looked after in the NHS. Two developments changed this:

- *The increasing use of social security benefits meant that a public fund, without cap and without a test of care need was available to fund people in residential and nursing homes in the private sector. Expenditure grew from £350m in 1985 to £2.5bn in 1993/94 and the ‘market’ was shaped in a particular way, driven by what could be paid for rather than what people needed.*

- *During the 1980's the NHS became aware of its costs for the first time and was subject to measured performance targets. Given the existence of the uncapped social security benefits residential and nursing home care provided one 'exit' from the NHS for many patients".*

[This has resulted in considerable costs shift from the NHS to the Social Security system and to Local Authorities. NHS long-stay beds reduced by 38% since 1983 (21,300 beds) while the number of private nursing home places increased by 900% (141,000 beds) with only 8% of the additional private nursing home places funded by health. The remaining 92% are funded either by individuals, Local Authorities or a combination of both].

(Source: Royal Commission pg 34)

"These changes introduced a new private sector infrastructure of residential and nursing home care... However, it;

- *discouraged domiciliary care;*
- *prevented the NHS and Local Authorities developing joint working and planned commissioning;*
- *but gave some people access to care they could not otherwise have afforded" (With Respect to Old Age – Royal Commission pg 38).*

3. COMMUNITY CARE

3.1 It is within this context of spiralling Social Security expenditure, an uncontrolled expansion in independent sector residential and nursing care further fuelled by an opportunistic reduction in NHS long-stay care provision that the White Paper, 'Caring for People' was published in 1989 to reverse the expansion of nursing care.

3.2 It led to the NHS and Community Care Act which was implemented in 1993. The implementation of the Act and how different stakeholders perceive it is greatly influenced by the historical context described above.

3.3 The Act introduced the process of Care Management, meaning a need based, rather than service led approach to assessment, care provision and service planning.

3.4 The Social Security budget was transferred to Local Authorities (less 10% in the anticipation that LA's would achieve efficiency savings) in a Special Transaction Grant. Implicit within this transfer of funding were the expectation that;

- the spiralling costs would be curtailed;
- the perverse incentive towards residential and nursing care would be reversed;
- there would be a planned market based on analysis of individual and population need.

4. SSA AND SPEND ON SERVICES FOR OLDER PEOPLE

4.1 The majority of Social Services Authorities spend at or above the Standard Spending Assessment (SSA) for Social Services. The average spend above SSA in 2001/02 is 10.2% nationally, 10.8% in the South West and 9.8% in Devon

4.2 However, the spend in relation to SSA for older people shows that the majority of Social Services Authorities spend below the SSA level for older people, at 29% below SSA for older people in Devon and 24% on average across the South West.

4.3 Devon has demonstrated, in its analysis of the Children's SSA that the Local Government funding formula is inadequate, and that core essential services are not being funded by Government. A report to the Executive Committee (March 2002: 55/02/13) 'Shortfall in Government Funding For Child Protection and Children in Care' highlighted that Devon's SSA for children was 28%, or £5m short of what was spent on children looked after and on the child protection register. In addition Devon spent a further £8m on children in need, which is not provided for in the SSA. This serious under funding of children's services, which is repeated throughout the County if not quite as severe as in Devon, has a direct impact on older peoples services. It is a factor which can not be ignored by this Review. If the under funding of children's services is not addressed then the constraints on older people services will continue.

4.4 The under funding of Local Authority Social Services, has been acknowledged by Government albeit without an as yet adequate response.

"I know there is real pressure on your budgets. I know that's true for children's care as well as elderly care. That is why we responded [with] growth in social care budgets of up to 3.7% in real terms next year compared to growth of 0.1%... prior to this Government coming to office".

(Alan Milburn: Speech to National Social Services Conference 19.10.01)

4.5 The demonstrably significant and long-term under funding of Social Services is one of the major factors which must be taken into account by the Best Value Review. The way in which the Review's recommendations will be implemented will be dependent on whether or not the problem of under funding of Social Services is addressed by the Government in its medium term Spending Review.

"From 1993 to 1996 general inflation has been 9% and the population of the very elderly has increased by 14%

The baseline standard spending assessment has increased by just 1% from 1993 to 1996. In 1997/98 the average spend is 9% above SSA...

However, it may become increasingly difficult for local authorities to sustain this level of spend as education becomes a priority.

The pattern that is emerging in Social Services departments is one of:

- *Continuing high use of nursing and residential home places;*
- *Lower priority given to alternative services in the community; and*
- *In some cases, limits on the number of placements.”*
(The Coming of Age, Audit Commission pg 45)

5. PROCESS OF CARE MANAGEMENT

5.1 A fundamental principle of the national Community Care policy is that services are arranged according to the assessed needs of the individual subject to resources.

5.2 Assessments must be timely, accurate, be multi-disciplinary and well co-ordinated and involve users and carers in both the assessment and care planning. Devon's comparative performance in relation to assessment and care planning for all adults shows;

- our performance in the top performance band for assessments per head of population (Appendix 6)
- is low in terms of the percentage of people receiving a written statement of how their needs will be met (See Appendix 7)
- is in the middle performance band for the number of assessments leading to provision of service (See Appendix 8)

5.3 Care packages must be reviewed in order to ensure that they continue to meet the needs of the individual, that the care provided is appropriate and still needed and that the services are of an appropriate quality.

5.4 There are difficulties in carrying out reviews, particularly for those service users considered to be in a stable situation and not overseen by the Personal Care Management system.

“In most authorities visited care managers complained that their heavy assessment workloads made it difficult for them to find time for reviews... Some fieldwork authorities have introduced central teams to review and nominate care packages”.

(The Coming of Age – Audit Commission). 5.5 Comparative data for Devon reveals a below average rate of reviews of ongoing cases. In 2001/02 only 38% of adults in receipt of a service had their care plan and review (PAF D40). The Best Value Review noted that Social Services action plan to improve on this performance and that progress on this is part of the Local Authority and Public Service Amendment proposal.

6. SUMMARY OF THE EXISTING SYSTEM

6.1 Local Authorities must operate a complex and confusing system which has evolved incrementally and without cohesion.

“Simply describing the current system vividly demonstrates a number of complexities and confusion. No doubt unintentionally, it appears at times to be designed around a service of different bureaucracies, rather than the needs of individual older people... Applying the commission value framework (See Appendix 2) makes that inadequately and more transparent.

Fairness

The current system clearly does not fulfil the reasonable expectations of old people... At a key point in people’s lives they find that they are expected to pay for themselves out of assets they have accumulated over a lifetime for care they had previously expected would be free...

Maximum choice, dignity and independence

Under the current system the amount of choice available depends on what is offered locally and the state of the Local Authority budget... If dignity and independence mean avoiding residential care unless it is absolutely necessary, the current system may be seen to push people into residential care and thereby compromise their dignity and independence at an earlier stage than might be necessary...

Security, sustainability and adaptability

The current funding system provides no incentive for anything other than the residential or nursing home care option in the private sector in many cases. It can in theory provide greater scope for new types of domiciliary care, but this would mean withdrawing sums from current patterns of provision into which Local Authorities are locked with contracts, their own provision and also from reliance on benefit to under-write the funding of care...

Quality and Best Value

*The current system is clearly biased towards residential care irrespective of the appropriateness and best value for the individual. For the Local Authority, this can easily represent the option with the least net cost”.
(With Respect to Old Age – Royal Commission pg 40-42)*

The conclusion of the Royal Commission has been quoted at length because it describes a poorly functioning national framework which Local Authorities are expected to make work as well as possible, despite its inherent contradictions and limitations.

6.2 It is important to stress these points because quality and best value will not be achieved simply by;

- replacing higher cost Local Authority care with lower cost independent sector care;
- improving the participation of service users and carers;
- improving inter-agency collaboration;
- improved strategic planning and market management.

6.3 All of these things are important and they must be achieved and be addressed within the action plan in order to achieve best value. However, Local Authorities are working within a system which has evolved and not been planned, in which

“There are a complex number of forces pulling in different directions”.
(Royal Commission *ibid* pg 42).

6.4 What can be achieved by Local Authorities is constrained by the inadequacies of the National system within which Local Authorities are operating.

7. CHALLENGING ISSUES FOR THE CURRENT SYSTEM

7.1 To provide a quality service which meets the expressed preferences of older people a number of issues must be addressed.

- The balance between preventative services and intensive care provision.
- Strategies to compress health morbidity within the elderly population.
- Development of advocacy services.
- Providing support to informal carers.
- Meeting the needs of ethnic minority elderly.
- Work force strategy covering recruitment, retention, remuneration and training.
- Quality standards and regulation for the physical provision of care and the processes and means by which care is delivered.
- Issues of differential cost and quality between the public and private sectors.

8. MEETING THE CHALLENGE

8.1.1 THE FINANCIAL FRAMEWORK

Inevitably, over the course of conducting a Best Value review changes occur which address in full or in part some of the issues and challenges identified by the review. Within this section there have been a number of references to the report of the Royal Commission and the long-term care of the elderly and the criticisms it made of the existing national framework.

8.1.2 The Government has responded to a number of issues raised by the Royal Commission and several changes have been introduced which will promote new opportunities to meet the accommodation needs of the frail elderly.

8.1.3 The principle changes are:

- The budget for Residential Care allowances and Preserved Rights have been transferred to Local Authorities to manage.
- The right to direct payments has been extended to the over 65's.
- Nursing care is free of charge and no longer means tested.

8.1.4 It is with a note of regret that at least two other important recommendations of the Royal Commission have not been addressed, namely that;

- The Government should conduct a scrutiny of the shift in resources between various sectors since the early 1980's, and should consider whether there should be a transfer of resources between the NHS and Social Service budgets given changes in relative responsibilities.
- That a more transparent grant and expenditure allocation system should be established.

- 8.1.5 One of the main criticisms of the present system is that it is finance driven, complex, contradictory and has an in-built cost drive towards independence sector residential and nursing care.

8.2 PARTNERSHIP/ JOINT WORKING

MODELS OF CARE

- 8.2.1 The Royal Commission concluded in respect to the provision of care that there was no single preferred model but that;

- a larger proportion of care than now should be provided in people's own homes;
- the quality of care must increase;
- there should be a greater variety of models of care and more flexibility in care provision;
- that if the delivery of care is provided coherently (and in full partnerships) the system could provide better value for money;
- a proper system of assessment will be needed which puts a premium on joint working and commissioning (Royal Commission pg 82)

“The Commission believe, with the Audit Commission for England and Wales, that better value for money can be obtained within the existing system but in recognising the different circumstances, needs and wishes of individuals does not advocate a single model. There should be a tapestry of accessible provision from which, within limitations, people may choose, confident that their needs can be met.” (Royal Commission ibid pg 82-83).

- 8.2.2 The ‘tapestry of accessible provision’ of accommodation for the frail elderly requires an active collaborative partnership between all levels of Local Government and the NHS. Partnership in planning must also be extended to care providers, users of care, future users of care and carers. (See Appendix 3)

HEALTH PARTNERSHIP

- 8.2.3 Just as changes in the financial framework have occurred during the process of conducting the Best Value review, so have there been developments in the framework of joint working. A ‘Single Assessment Process’ will be introduced in October 1992 which will bring together health, social care and accommodation needs assessments into a unified process.

- 8.2.4 The Single Assessment Process might facilitate the introduction of multi disciplinary assessment teams. The Royal Commission (ibid pg 87) identified positive outcomes both in terms of assessment and regulation of the institutional care market's size following the introduction of multi-disciplinary Aged Care Assessment Teams in Australia. These teams work to a national system of assessment and market regulation.

- 8.2.5 The introduction of the Single Assessment Process, the National Service Framework for Older People, the Health Act flexibilities of pooled budgets, lead commissioning and integrated teams provide a new framework of opportunity.

8.2.6 The NHS plan signals a shift in direction for the NHS, with an emphasis on community and primary health care services, away from the narrow institutionally focused hospital sector. The requirement for each PCT to appoint a Director of Public Health as an executive Board member will ensure that issues of health promotion, compression of health morbidity and health inequality are made important priorities for the 'primary care led NHS'.

"Their [Department of Health] latest estimate demonstrates if morbidity rates can be reduced by a fairly modest 1% per annum, then publicly provided formal care costs can be reduced by 30% or £6.3bn, per annum by 2030. This reduction is dependent upon delaying the onset of disability, i.e. compressing morbidity".
(Continuing Care Conference - Fit for the Future).

8.2.7 Strategies to compress health morbidity have the potential to bring about considerable benefits both for the independence of older people and a more effective use of resources.

"Increasing emphasis has been placed on encompassing community based teaching within medical education... The aim of this approach is to produce community orientated doctors who are willing and able to serve their communities and deal effectively with health problems at primary, secondary and tertiary levels through the delivery of a health orientated rather than a disease orientated physical education". (Continuing Care Conference – Fit for the Future pg 25).

8.2.8 The establishment of the new Peninsular Medical Schedule, with its emphasis on primary and community health medical education, has the potential to make a valuable contribution to the supply and development of medical personnel with the skills to contribute to multi agency teams to promote the care of the frail elderly within the community.

8.2.9 The Royal Commission (ibid pg 83-84) summarised the key developments required in the way care is promoted;

- More effective joint working and greater sharing of responsibility between Health, Social Services and Housing;
- Greater emphasis on prevention and the promotion of health, and independence.
- Greater emphasis on rehabilitation.
- More consistent framework for assessment and eligibility.
- More opportunities to enable people to stay at home.
- More support to carers.
- More real choice.
- Culturally sensitive services.
- Greater emphasis on equality.
- System easier to access.
- A new relationship of trust between clients, carers and services must be created.

"The main recommendations represent an opportunity for a new contract between Government and people and between all generations of society, so that not only will the nations resources be spent on the care of older

people in a more effective way, they will be spent with an aim of promoting increased social cohesion and inclusiveness... The nation will have demonstrated that it values its older citizens, and will have given them in large measure the best thing any society can offer – freedom from fear, and a new security in old age. (Royal Commission ibid pg 109).

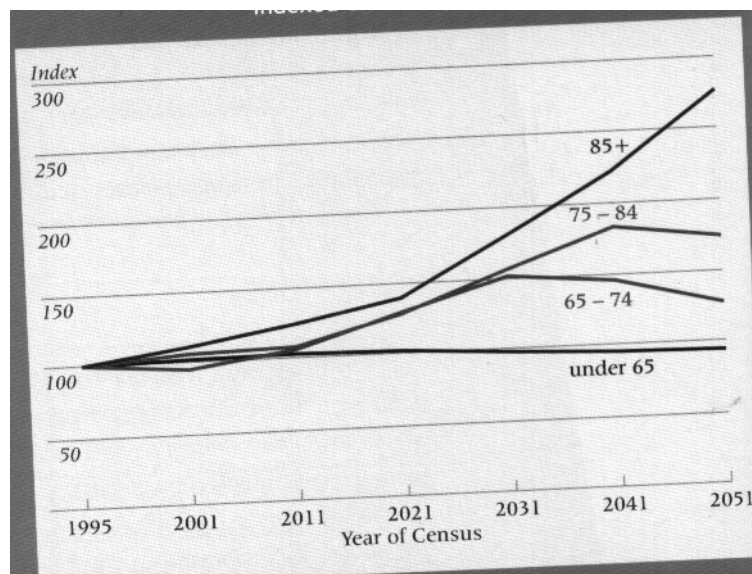
DEMOGRAPHIC TRENDS

1. INFLUENCE ON DEMAND AND AVAILABILITY OF INFORMAL CARE

1.1 The UK population has been growing since the beginning of the century with a long-term upward trend in the number of people aged 65 and over:

- The number of older people has increased by 400% since the turn of the century.
- The pattern will continue until about 2030 when the population stops growing.
- Almost half of the elderly population is at least 75.
- The number and population of over 85's will continue to rise and be three times more numerous by 2050.

Figure 1.1 – UK Population projections Indexed on 1995 (100) (Source: 'With Respect to Old Age' – Royal Commission.)



Note: The graph shows data as indices to allow consideration of both the individual and relative rates of growth of the different age bands. Each data series are set to a value of 100 in the start year (1995) and changes in later years are measured compared to the start year. An index value for subsequent years are the rates of change over the given time period.

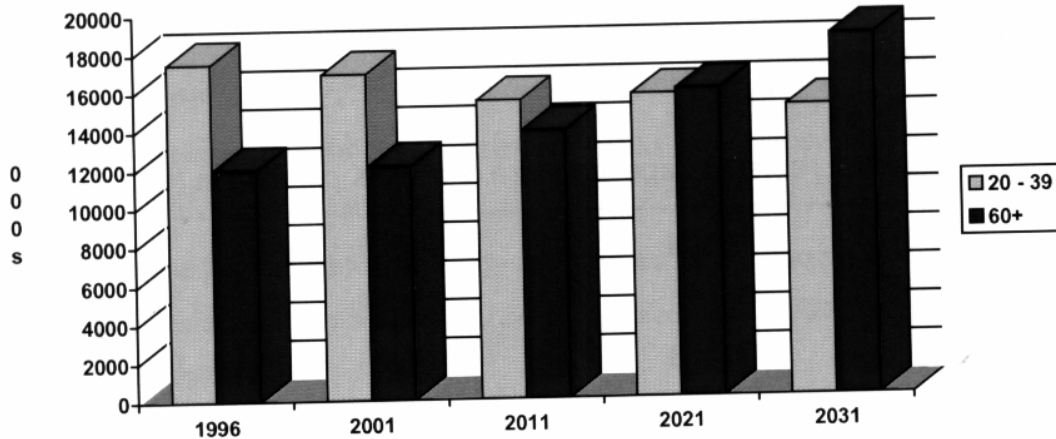
1.2 In contrast to the rise in the number of the elderly, especially the “very elderly”, i.e. those aged 85 and over, the number and proportion of younger people – from whom the care work force and informal carers is drawn – is projected to fall:

- The population is ageing and fertility is falling.
- The number of children under 16 is expected to fall by 9% between 1996 and 2021.
- The population of working age is expected to remain virtually static (meaning more competition for employees given the labour-intensive

nature of personal care and the projected increase in the very elderly from whom most demand for care arises.

- The proportion of working to retired people will change substantially after the first quarter of the next century.

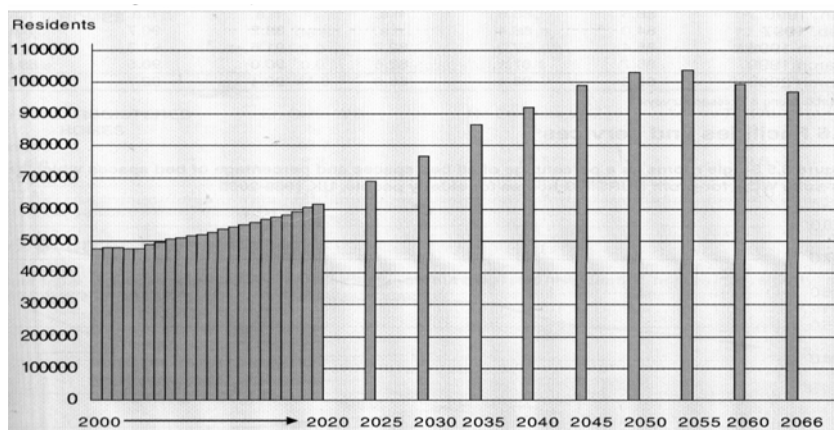
Figure 1.2 – The changing age balance of the UK population –(Source: ‘Future Imperfect?’ M. Henwood)



2. DEMAND FOR CARE SERVICES

2.1 The natural growth in the number and proportion of older people in the community when translated into demand for residential and nursing home places, indicates that demand will more than double between now and 2059 with the beginning of the increase beginning in about 2004/5. Until then there is a slight lull in the upward demand for care.

Figure 2.1 – Projected* numbers of elderly, chronically ill and physically disabled people living in residential settings, UK 1999-2066, all sectors**



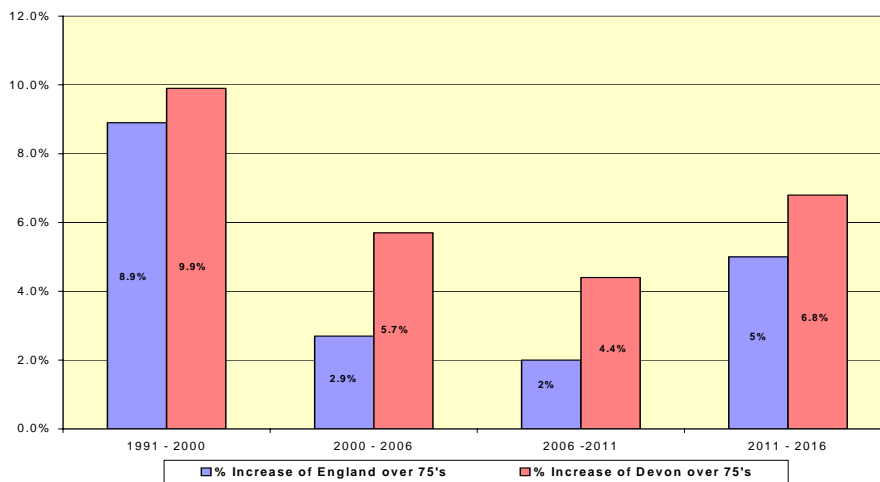
* Calculated by applying age-specific risks of living in a residential setting to official population projections.

** Aggregate of all sectors – private, voluntary and public

“The calculations assume that age specific rates of provision will remain constant at the same level as in 2000. Implicitly, this amounts to assuming that funding will be made available, whether from public or private services, to meet increased demand and that non-residential alternatives will not make further deep inroads into the demand for care in residential settings. This latter assumption stems from the wide spread recognition that non-residential alternatives cease to be affordable beyond a certain level of dependency.”
(Healthcare Market 2000-01 – Laing & Buisson, 2000, Pg 191).

The challenge for Devon is of anything a greater one.

Figure 2.2 Rate of Increase Over 75 Population 1991-2016 – England and Devon



Appendix 9 shows the projected increase in the numbers of people in the County, and by each District upto 2011.

2.2 If levels of demand remain the same as today, the increase in referrals, as a consequence of demographic change, is shown in Appendix 10. By 2006 there will be an increase in demand of 7.3%. Ranging from a fall in demand of 1.8% in Exeter to an increase of 12.2% in Mid Devon.

By 2011 demand will increase by 15.4%, ranging from 9% in Exeter to a high of 23% in Mid Devon.

2.3 Translated into budget terms, assuming the same mix of service provision, and based on prices in 2002 this would mean an overall increase in budget demand to £5.7m in 2006 and £12.2m by 2011 from demographic pressures alone.

2.4 Alternatively, there would need to be a reduction in level of service equivalent to 7% by 2006 and 15% by 2011 if the level of resource

provision does not match increased demand from the ageing of the population.

2.5 If there is an increase in referral rates, which might occur for a number of reasons such as the number of informal carers in the population declining, increased expectations on the part of service users; higher quality standards or a continuing shift in the focus of care from the NHS to the community then this would have an impact on demand (see Appendix 11). It would translate into an additional budget demand of 16% by 2006 and 23% by 2011 based on today's prices and pattern of services.

3. PROJECTION OF FUTURE COST

3.1 It is a very inexact science to take population projections and then try to predict future costs based on this. Three factors have a major impact on care costs:

- Availability of informal carers;
- Increasing personal wealth and the ability to purchase care on one's behalf;
- Improving health/reductions in health morbidity.

3.2 The Department of Health in evidence presented to the House of Commons Health Committee in October 1995 summarised the demographic; care and cost implications of long-term care. (See Table 3.1)

Table 3.1 – Sensitivity of DH Estimates of Social Services, Hospitals and Community Health Expenditure on Long-term Care

	2010	2030
Base estimate billions @ 1995-96 prices	17.4	21.4
Increased wealth 1% per annum	-3.5%	-7.5%
Increase in real costs 1% per annum	15.5%	41.5%
Morbidity rates fall 1% per annum	-14.4%	-29.4%

“The table highlights the importance and cost effectiveness of actions to reduce age-specific morbidity. If morbidity rates can be reduced by a fairly modest 1% per annum, then publicly provided formal care costs can be reduced by 2030 on the DH estimates, by 30% or £6.3bn per annum”. (Continuing Care Conference ‘Fit For the Future’ 1998. Pg 5)

3.3 The promotion of good health in older age, the maintenance of preventive services and promotion of reablement strategies should be one of the key planks in our future strategy. The finding of a recently completed research project, ‘Buying Time’, commissioned by Social Services Authorities in the South West, provides evidence of the effectiveness of both community and

residential based reablement services. It demonstrates successful outcomes in promoting early discharge from hospital, and in enabling people to continue to live independently. The project and its findings are described on pages 61-63 of this report

4. AVAILABILITY OF INFORMAL CARERS

4.1 There are about 5.7 million people providing informal care, representing about 14% of the adult population. Most of this care will be provided to older people.

4.2 Most care is of a small number of hours a week, 4 hours or less, but about 800,000 people provide 50 hours or more informal care per week.

Table 4.1 – Characteristics of people providing informal care, GB 1995 – With Respect to Old Age, Royal Commission

	All carers %
Carers:	
Men	40
Women	60
Aged:	
16-24	32
45-64	48
65+	20
Dependant's relationship to care:	
Spouse	19
Parent/ parent in-law	43
Child (any age)	9
Other relative or friend	28
Total	100

Source: ONS 1998 based on General Household Survey 1995.

4.3 More women than men provide informal care with the peak age of care giving being between the ages of 45 and 64. Any reduction in the future availability of informal care would have a significant impact on the cost of care from statutory services and on the capacity to maintain frail and vulnerable people within the community. The Royal Commission has concluded that on balance it is unlikely that there will be a reduction in the availability of informal care.

“There is genuine concern about the effect on the supply of unpaid care because of changes in family structure brought about by focus in birth rates, higher divorce rates, re-marriage, greater family mobility and less living together across generations.... There is a measure of uncertainty which surround any projections about the availability of informal care... (However) we conclude that after

allowing for the factors described in this paragraph there will be no real change in the future availability of informal care.”
(Royal Commission 1999 ibid pg 17-18).

4.4 Informal care is the main source of care in the community. The statutory care services complement informal care. As people’s dependency increases so does the reliance on informal as well as formal care services.

Table 4.2 – Dependency and receipt of informal care: England 1994 – With Respect to Old Age, Royal Commission

Level of Dependency	% with informal support (for domestic tasks)
No dependency	46
Inability to perform one or more domestic tasks	85
Difficulty performing one personal care task	76
Difficulty performing two or more personal care tasks	83

Source: PSSRU analysis of the General Household Survey England 1994/1995 data.

5. SUPPORTING INFORMAL CARE

5.1 Effective support for the frail elderly is dependent upon a partnership between statutory care services, voluntary organisations and informal carers. These networks need investment and support from the statutory services to be maintained and to be effective. The financial pressures on Social Services is undermining the capacity to continue to invest in and support voluntary sector and informal care providers.

“It is an inescapable conclusion that the care sector is under resourced.... We urge the Government to recognise the significant under-investment in care and support services and commit to making good the substantial shortfalls that have occurred year after year.” (M Henwood – Future Imperfect Exec Summary).

“Care staff provide a highly valued and essential service for millions of people. The individual commitment and dedication of many staff cannot be faulted. Nonetheless, there is potential for a major deterioration in standards of care. Expenditure constraints have forced local authorities systematically to drive down costs. Although trying to obtain ‘Best Value’ is a useful concept, it can result in a damaging preoccupation with price at the expense of quality. We are concerned that the tool of ‘Best Value’ risks being discredited by the disproportionate emphasis which, in practice, is being laid on driving down costs, at the price of quality.”
(M Henwood ibid Exec Summary).

5.2 Best Value is about quality as well as cost, and this review has been as much focussed on quality as well as cost. There is no-doubting, however, that the chronic funding pressures on Social Services are undermining quality, scope and effectiveness of services. This is a real limitation and constraint on the Best Value review. Unless the services funding problem is addressed, a problem which is emerging as a national crisis, the future direction and development of services for the frail elderly will continue to be cost driven.

5.3 There is scope to improve the way in which informal carers are supported, irrespective of resources. Service users and carers need to be more formally integrated into a planing system, both at individual case level and strategic planning.

“On the grounds of equity and justice we believe carers need more support. They need to be more actively involved in the process of needs assessment (and service monitoring and review), and where possible services to support them must be considered”. (Royal Commission ibid pg 89).

5.4 The King’s Fund Inquiry (ibid Exec Summary) recommends that users and carers “have a vital role to play in training staff to better understand users’ needs and the principles that should inform care and support”. Information to carers about what help is available and how to access it is important. Devon provides information through a variety of ways including the Care Management Help Desk, a Departmental Information Strategy through membership of a joint Local Authority/Health service informative inclusive Community Care Information and Advice Federation (CCIAF). Devon is also a pilot acting for Care Direct.

5.5 While there are very positive aspects to the promotion of information by Devon, it is acknowledged that there is some inconsistency in practice and that this needs to be addressed. The Best Value review concludes that the public would be better served if there was a co-ordinated information and sign posting service in relation to community health, housing, social care and benefit services.

5.6 The Royal Commission recommended that:

“A national carer support package should be considered by Government” (ibid Recommendations 8.8 pg 91).

5.7 This was based on the success of the Australian Federal Government initiative which:

“provides a range of basic advice targeted at supporting carers (e.g. health and safety, legal and financial) with an explanation of how and where to obtain more information”. (ibid pg 91).

- 5.8 The Australian initiative is part of a co-ordinated programme which has achieved a regulation of the care markets size and mix through a single assessment process implemented by a Multi Agency Assessment Team.
- 5.9 The Single Assessment process, Care Direct Pilot, and NHS Direct, could provide a framework for incorporating some of the systems and findings of the Australian Federal initiative.
- 5.10 The Government's modernisation agenda for public services emphasises that services should be planned through partnerships which are inclusive of statutory agencies, service users, carers, voluntary organisation and independent sector care providers. Thus Devon's inter-agency planning system needs to be more open and inclusive of service users and carers.
- 5.11 The Royal Commission (ibid pg 41; pg 89) concluded that the national finance and benefit system does not provide much support to informal caring, either in terms of benefits, taxation or pensions. It is noted that the recent Pensions Green Paper proposes that pensions be available to help those who give up work to undertake a caring role. The Best Value Review recognises the positive benefits which a change in pension rights of carers will make in the national infrastructure in support of informal care.

RESIDENTIAL AND NURSING CARE INDEPENDENT SECTOR PROVISION

1.INTRODUCTION

- 1.1 The independent sector provides the majority of all residential and nursing care beds. Over the past 10-15 years the independent sector is estimated to have invested between £10bn-£12bn into the long-term care sector, much of this funded by the public sector (Royal Commission; With Respect to Old Age, paragraph 7.6).
- 1.2 At April 2000 there were an estimated 538,300 places in residential setting for long stay care of elderly and physically disabled people. In 1997 just over 70% of all residents were funded in some way by the public sector.
- 1.3 There is, therefore, a significant relationship between the independent sector and Social Services Departments which, since 1993, have had responsibility for purchasing residential and nursing care.
- 1.4 The relationship between the majority of social services authorities and the independent sector is characterised by tension, a lack of trust, and little mutual understanding.

*“For many years local authorities have abused their monopoly purchasing position by paying inadequate fee levels to independent care home providers. The direct result of this is the present situation which is causing closure of homes”.
(Independent Healthcare Association – April 2001).*

- 1.5 Some independent care providers recognise that it is not so simple but nevertheless place responsibility for inadequate fee levels and subsequent home closures at the door of Social Services.

“Social Services were handed a poisoned chalice in 1993; they had to cash limit the out-of-control social security budget... Social Services in many areas of the country have singularly failed to work effectively with the large residential and nursing home market. They have suppressed fees and restricted placements to the point where many homes have become unviable”. (Lancashire Care Association – Evidence to Sector Committed 2002).

2. CARE COSTS

- 2.1 A major source of friction has been the accusation by the independent sector that Social Services have misused their commissioning powers to drive down the costs in the independent sector while paying higher rates for in-house provision.

2.2 There is a difference in rates between fees paid to the independent sector and the charge for Local Authority Services (Table 2.1).

Table 2.1-Comparison of LA Standard Charges and Independent Sector Fee Levels - Devon

	1999/2000	2000/2001	2001/2002
Local Authority Homes	323.19	353.50	364.50
Ind Sector Care Homes	262.43	264.04	267.96
Ind Sector Nursing Homes	330.96	341.32	356.65

This difference raises two important issues which need to be examined, and which are considered in more detail within the Best Value review.

2.3 The first is why the independent sector fee levels have been so tightly contained. Put simply, is it due to an antipathy to the independent sector, a lack of understanding of the pressures they face or alternatively a consequence of under funding of Social Services?

2.4 The second key question is whether independent sector fee levels are a true reflection of market costs. Self-funded residents in the independent sector often pay a higher fee than that negotiated by the Local Authority for publicly supported residents. There is emerging evidence that self funded residents are increasingly subsidising the care of publicly supported residents.

2.5 Support for the argument that fee levels in the private sector are inadequate is provided by the National Review Group commissioned by the Scottish Executive to examine the costs of providing nursing and residential care in Scotland. The National Review Group concluded that the real care home costs, including return on capital, ranged between £332 and £360 per week for residential homes and £390 for care with nursing (National Review Group: pg 10, Scottish Executive Health Department).

3. EXPANSION OF RESIDENTIAL CARE

3.1 In the early 1980's there was a rapid expansion in private sector residential and nursing care funded by open-ended income support. The expansion of the Social Security budget increased exponentially. It was out of financial control.

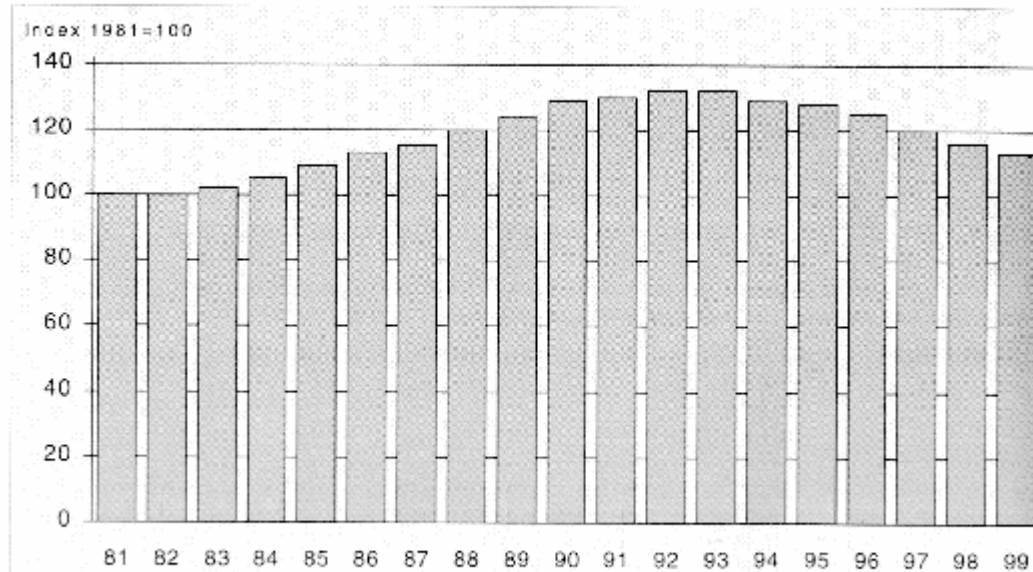
3.2 Figure 3.1 standardises the trend in numbers of people cared for in residential care between 1981 and 2000. It shows that between 1981 and 1992 the numbers in residential care;

“grew faster than would be predicted from demographic growth alone. By 1992 there were an estimated 32% more elderly, chronically ill and physically handicapped people in long-term care

establishments then there would have been if age specific rates had remained unchanged from a base year of 1981. From 1993 age-adjusted care home demand stabilised; and by 2000, seven years after implementation of the reforms, the excess over the 1981 baseline had fallen to 11 percentage point". (Laing and Buisson: Healthcare Market Review – 2000-01)

Figure 3.1

Age standardised index* of demand, UK 1981-2000 - elderly, chronically ill and physically disabled residents in private, voluntary, and local authority nursing and residential homes and NHS continuing care facilities - Index, March 1981 = 100



* Ratio of observed to expected residents, the latter being the number that would have been observed in a given year if 2000 age specific rates of occupation of nursing and residential homes (grossed up for elderly people receiving continuing care in the NHS) are applied to the population in that year.

Source: Care of Elderly People Market Survey 2000, Laing & Buisson

3.3 Independent sector residential and nursing beds increased by 242 percent between 1983 and 1996 with independent sector residential provision increasing by 124 percent. During the same period the number of local authority beds fell by 43 percent. (Ref: The Coming Of Age, pg10, Audit Commission 1997).

3.4 In contrast;

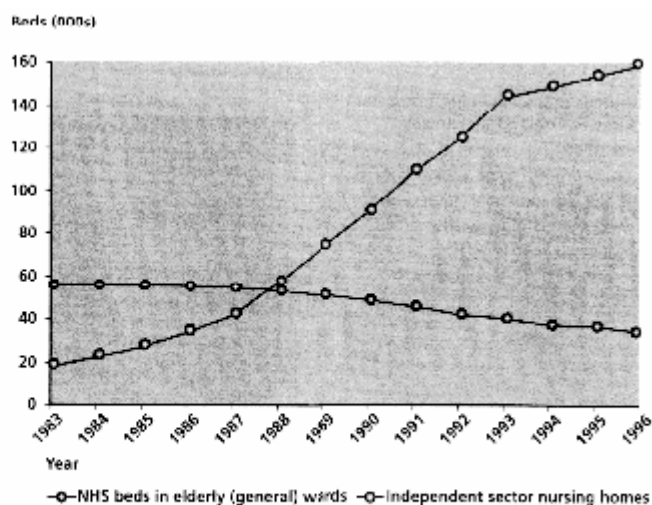
“Between 1977/78 and 1984/85, provision of homecare hours per head aged 75 plus provided by local authorities fell by 15 percent, with a further 10 percent fall between 1986/87 and 1992/93. Thus throughout the 1980’s, residential and nursing home care expanded while homecare reduced per head of population aged 75 plus”. (The Coming of Age, pg11, Audit Commission 1997).

3.5 At the same time the NHS reduced the number of long stay beds (by 21,300 or 38% since 1983) – see figure 3.2.

Figure 3.2

Changes in continuing healthcare provision in England

There was a 38 per cent reduction in beds designated for older people and an almost ninefold increase in nursing home beds.



Source: 1983-1994: House of Commons Health Committee (Ref. 10); 1995/96: DH, *Nursing Homes and Private Clinics Bulletin* (1996 and 1997 issues) and *Bed Availability for England (financial years 1994/95 and 1995/96)*

3.6 These policy changes have had a significant impact on the pattern of services for the care of older people. This happened in an unplanned way. The market changes were not based on an analysis of need or service user preferences. The consequences of these ad-hoc changes on the pattern of service provision and the financial consequences thereof are considerable.

“We recommend that the Government should conduct a scrutiny of the shift in resources supporting long-term care since the early 1980’s, and should consider whether there should be a transfer of resources between the NHS and Social Services budgets given changes in relative responsibilities”. (With Respect to Old Age p34 Royal Commission).

3.7 It is within the context of uncontrolled expansion in the supply of residential and nursing care, a reduction in domiciliary care and a retrenchment by the NHS from long-stay care provision that the changes in the residential and nursing care market needs to be considered.

It is a complex inter-relationship, summarised by the Royal Commission (ibid pg78)

“Since 1993, with the introduction of capped budgets the independent sector tells us that profitability has been dramatically eroded. Analysis shows that there are too many providers, often in the wrong places. Local Authorities have used their purchasing power to drive down fees to a level where providers say it is increasingly difficult for them to achieve an adequate return on investment”.

4. MARKET TRENDS

National

- 4.1 Over the past twenty years the market has swung from rapid, uncontrolled expansion to one of reduction in volume and some uncertainty due to low fee levels.
- 4.2 For the fifth year in succession in 1999/2000 the increase in average fee levels was below the rise in hourly earnings for women, which has been used as a proxy for staffing cost increases in the core industry. This is a fair indicator that fee levels have not kept pace with independent sector care costs.
- 4.3 While bed capacity is beginning to reduce existing market capacity is still 11% above the age adjusted rate for residential provision in 1980, as can be seen from Figure 3.1 above.
- 4.4 National occupancy figures and total capacity show a total reduction of approximately 30,000 over places between 1996 and 2000. However, a possible indication of an emerging problem in market supply is that 23,000 of the lost beds are in nursing care (see table 4.1).

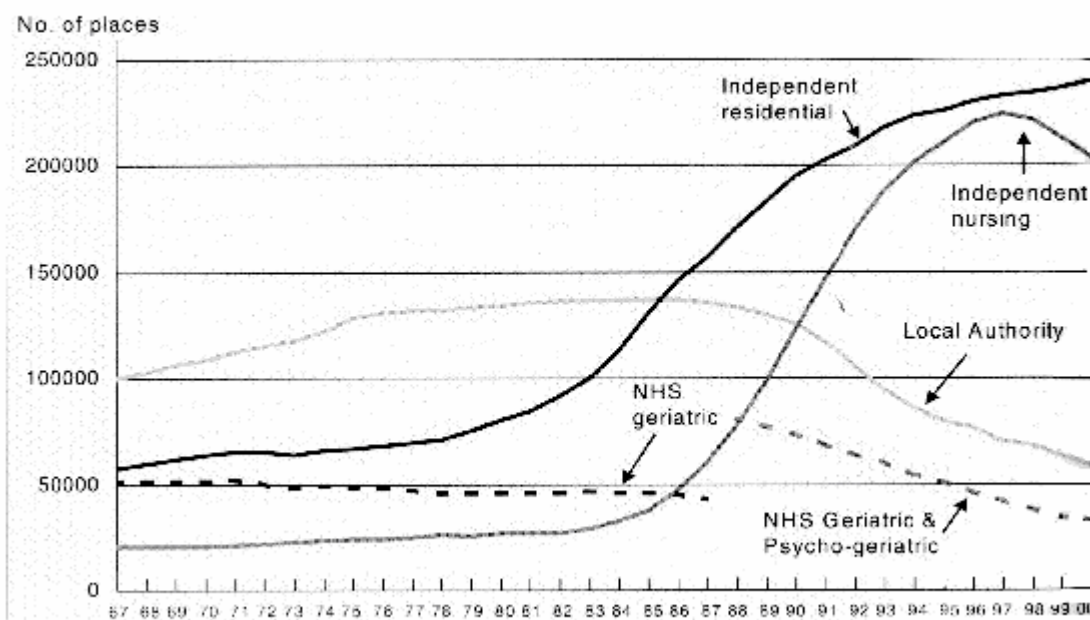
Table 4.1 - Volume of demand and total capacity for elderly and physically handicapped people in residential settings 1996-2000

	Private Nursing 000's	Private res 000's	Vol nursing 000's	Vol res 000's	NHS 000's	Local Authoritie 000's	Total Occup 000's	Total Capacity 000's
1996	175	153	17	53	42	68	507	575
2000	164	164	16	51	30	52	477	538
Change 000's	-11	+11	-1	-2	-12	-16	-30	-37

- 4.5 The points to note from these national figures are a reduction in 23,000 (-10%) nursing care beds (all sectors), a reduction in 16,000 (-24%) Local Authority residential care beds and an increase of 9,000 (-4%) independent and voluntary sector care beds.
- 4.6 The increase in the number of care beds disguises the extent of the reduction in nursing care provision. The trends are shown in Figure 4.1.

Figure 4.1

Nursing and residential care places for elderly, chronically ill and physically disabled people by sector, UK, April 1967-2000



Source: Care of Elderly People Market Survey 2000, Laing & Buisson

Devon

- 4.7 There are approximately 4,000 elderly residents supported by the Local Authority in independent sector care provision. In addition the Local Authority provides 701 residential places in 25 Local Authority residential care homes. Traditionally Devon had a high reliance on residential care and provided less support to people living in the community.

“Care for older people focuses more on residential care and less on homecare than is found in other similar authorities” (Joint Review of Devon County Council Commission, 1999).

This trend is now being reversed and is described in more detail on pages 53-55 of this report.

- 4.8 Within Devon, as nationally, the number of nursing care beds is falling. Figures provided by the Registration and Inspection Units of the North and East Devon Health Authority and South and West Devon Health Authority show there was a reduction of 418 nursing beds, or 17% of the total between March 1996 and March 2000. In South and West between January 1997 and March 2002 there was a reduction of 293 nursing care beds, or 25% of the supply. Over the period 1992-96 the number of nursing care beds rose, but since then there has been a steady decline. While the total supply of independent sector nursing care provision in 2001

is still in excess of what was available in 1992 this must be put into the context of a major reduction in the supply of long-stay NHS bed provision for the frail elderly and a change in NHS practice to reduced length of hospital stay. These changes within the NHS have resulted in shifting the demand pressures into community based services. The challenges facing Devon, and every other Local Authority, in respect of nursing care is how to ensure supply of essential nursing care in the context of a cocktail of adverse trading conditions.

4.9 The supply of general nursing care beds varies across the localities and this could be a factor in bed pressure in neighbouring areas. Table 4.2 shows the ratio of general nursing and EMI nursing provision in the former North and East Devon Health Authority area. There is very high pressure on nursing beds in Exeter. Contributory factors could be the low ratio of general nursing provision in Mid Devon and the low ratio of EMI nursing provision in East Devon.

Table 4.2 - No. of General, Elderly and Mental Health Nursing beds per 1,000 over 75

	General Nursing	Elderly/mental Health
East Devon	30	1.5
Exeter	30	7
Mid Devon	12	8
North Devon	51	3

4.9 The low supply of general nursing care in Mid Devon may be a factor in the pressure on nursing beds in Exeter. The low rate of elderly mental health beds in both East and Mid Devon leads to problems in meeting needs.

4.10 In contrast to the national trend of an increase in the supply of independent sector residential care beds; the amount of provision in Devon has been falling. (See Tables 4.3 and 4.4).

Table 4.3 - Residential Care – Changes in Bed Provision 1999-2001 Devon County Council

Care Homes Older People	March 1999	March 2000	March 2001	Change 1999-2001
Large Homes	346	336	308	-38
Small Homes	80	95	85	+5
Total	426	431	393	-33

**Table 4.4 - Residential Care – Change in no. of Bed Places 1999-2001
Devon County Council**

Care Homes Older People	March 1999	March 2000	March 2001	Change 1999-2001
Large Homes	6614	6312	5633	-981
Small Homes	210	278	246	+36
Total	6824	6590	5879	-945

5. MARKET RE-ALIGNMENT

5.1 There is an over supply of standard residential care nationally and locally; (Royal Commission para 7.4; Joint Review of Social Services, Devon County Council). However, the present pattern of reduction is in effect a shake-out driven largely by operating and financial pressures:

- staff recruitment and retention are more difficult in a buoyant economic market
- national minimum wage and European working time directives have added over 10% to wage costs
- shortage of skilled staff, in particular nurses
- NHS above inflation pay increase for Nurses
- Cost of implementing Care Standards Act
- Changing attitude of financial institutions to care sector borrowing
- Period of below cost fee increases for Local Authority supported residents

5.2 The re-alignment is not happening in a planned way. Consequently some of the services in short supply, e.g. nursing care and care for the elderly mental infirm, are under greater threat due to their higher service costs.

6. OPPORTUNITIES

6.1 Despite the present gloomy position it is suggested by the leading care sector market analyst that the market is now in a process of readjustment, which could in due course lead to a recovery of financial health” (Laing and Buisson: Health Care Market Review 2000-01). This is because:

- elimination of excess capacity
- cost pressures from implementing the National Minimum wage and Working Time Directive have worked their way through the system
- reduction in demand will begin to slow
- demographic led demand will remain steady until about 2005 after which it is projected that double the amount of residential care will be required by the middle of the century.

7. STRATEGIC PLANNING AND COMMISSIONING

- 7.1 It was stated at the beginning of this paper that, in general, the relationship between Social Services Departments and the independent sector is characterised by tension, a lack of trust and little mutual understanding (Ref Future Imperfect pg 84-85. King's Fund)
- 7.2 An important factor in bringing stability to the independent sector will be the ability of Local Authorities to pay fee levels which reflect the real cost of placement and provide a fair return on capital.
- 7.3 The independent sector is a major and essential supplier of services in support of the elderly. Strategic planning and commissioning arrangements between the statutory commissioners of services, i.e. for Social Services, NHS and Housing are not well developed.
- 7.4 Fully inclusive strategic planning arrangements need to be established at County and locality levels. Such planning arrangements must be inclusive of all stakeholders, including service users; carers, voluntary organisation and independent sector care providers. (See Appendix 3)
- 7.5 The purpose of strategic planning bodies is to plan and commission a wide range of services to meet the varying care needs of older people. Within that continuum of provision residential and nursing care will be required.
- 7.6 Joint commissioning of arrangements should promote "a constructive on-going partnership between Local Authorities and the independent sector". (Royal Commission ibid pg 78).
- 7.7 Partnership in commissioning will facilitate more active market management (ref Royal Commission, ibid para 823(b)) in which key features will be:
- balance between provision of residential and home based forms of care
 - planned reduction from sectors with over capacity and re-investment in under capacity and new opportunities
 - joint initiatives to tackle common challenges of;
 - recruitment and retention
 - training
 - quality standards
 - status of care workers
 - balance between preventive and intensive services.

THE MARKET IN DEVON **SUPPLY OF SUPPORTED HOUSING, RESIDENTIAL AND** **NURSING CARE**

1. INTRODUCTION

- 1.1 The Demographic challenge for Devon, due to having one of the highest ratio's in the country of over 85's in the population, has been identified in the previous section.
- 1.2 With the context of the overall pressure on Devon there are varying local pressures. In many parts of the County rural factors of population scarcity, higher than average costs to deliver services and the absence of scarcity of services (e.g. transport, leisure, day services or specialist support services) are factors which have to be taken into account in assessing the adequacy of existing provision and planning patterns of service provision for the future. Additionally, the shortage of affordable housing in parts of the County are driving out people on low incomes. This makes it more difficult to recruit staff to care work which is not well paid.
- 1.3 The starting point for the evaluation of the appropriateness of the mix and supply of existing accommodation arrangements for the frail elderly has to be the views expressed by the majority of older people which is their wish to remain independent and to live in their own homes.
- 1.4 The majority of older people are supported in the community. Following the implementation of the NHS and Community Care Act and the requirement to be assessed before going into care, the last decade has seen many changes. The rate of admission to care has slowed down, the level of dependency of new residents has risen, and the level of dependency of people within the community has increased. This has resulted in more complex support systems being developed within the community.
- 1.5 The Royal Commission (ibid pg 9) estimated the number of people receiving (formal) long-term care services by type of service.

Table 1.1 – Number of people in the UK receiving long-term care services by type of service and funding

Domiciliary care	Number of recipients		
Home care	610,000		
Community Nursing	530,000		
Day care	260,000		
Private Hire	670,000		
Meals	240,000		
Institutional care			
Residential care	Publicly financed	205,000	Total 288,750
	Privately financed	83,750	
Nursing home care	Publicly financed	115,000	Total 157,500
	Privately financed	42,500	
Hospital	34,000		34,000
All institutional residents			482,250

Source: PSSRU estimates

1.6 In evidence presented to the House of Commons Health Committee, October 1995, it was estimated that;

- 23% of those aged 85 and over were in residential or nursing home care, compared with 5% of those aged 75 to 84 and 1% of those aged 65 to 74;
- an increasing proportion of people in the community were receiving more intensive care services, those who had more than 5 hours per week rose from 14% in 1992 to 20% in 1994;
- between 1987 and 1994 there was an increase of 61% in short stay care in residential care homes;
- the number of people aged over 85 will rise from 0.96m in 1997 to 1.63m in 2030 (75-84 from 2.68m to 3.96m and 65-74 from 4.15m to 6.27m).

2. BUDGET SERVICES FOR OLDER PEOPLE

2.1 Devon's SSA for older people and services in 2001-02 was £76m. The net revenue budget allocation was £54m which is 29% below the SSA. While this is a matter of some controversy it is a position in which Devon and most other authorities find themselves in due to chronic under funding of other Social Services functions.

2.2 The gross revenue spend in 2001/02, when taking account of income from sources such as charging, amounted to £79m, (Source: For Access to Care Request to SMG 27.02.02)

2.3 A higher proportion of the budget (£52m or 66%) is spent on Residential and Nursing Care than on supporting people within the community (£27.1m or 34%). Most services are purchased from external providers – 56.8m or 72% - as against £22.3m or 28% for in-house services.

Table 2.1 – Gross Budget Spend on Residential and Non Residential Services

	Community Based Services					
	Dom Care £m	Equipme nt £m	Meals £m	Day Care £m	Total £m	%
Externally Purchased	12.3	0.7	1.4	2.5	16.9	62
In-house Resources	7.6	NIL	0.5	2.1	10.2	38
Total	19.9	0.7	1.9	4.6	27.1	100
	Institutional Services				Total	%
	Residential Nursing Substitutes			£m	£m	%
	£m	£m	£m			
Externally Purchased	29.4	10.5	39.9	77	56.8	72
In-house Resources	12.1	NIL	12.1	23	22.3	28
Total	41.5	10.5	52.0	100	79.1	100

3. SUPPORTED AND SHELTERED HOUSING

3.1 Housing provision is of crucial importance in the support of the frail elderly within the community.

“The other principal source of support to sustain independent living in the community (i.e. in addition to NHS and Social Services) is the local housing authority and other housing providers. Although not typically associated with care in the community, housing services are in fact, a core component in making the approach work. Suitable housing provides a stable base for independent living and affords access to other services such as health and social care, education and training. The housing service is also an important

source of practical assistance for many people, often being the first point of contact with the local authority, as well as being highly accessible, particularly for those who are tenants". (Audit Commission 1998, Home Along pg 6).

3.2 There is a total of 7791 supported and sheltered housing units in Devon. The spread and type of unit is shown in Table 3.1.

Table 3.1 – Sheltered and Supported Accommodation by District – January 2002

	Designated Housing*	Sheltered Housing**	Very Sheltered***	TOTAL
East Devon	427	1403	0	1830
Exeter	215	854	0	1069
Mid Devon	88	690	11	789
South Hams	55	690	28	773
Teignbridge	96	1370	0	1466
North Devon	233	694	61	988
Torridge	23	480	19	531
West Devon	23	322	0	345
TOTAL	1160	6512	119	7791

***Designated Housing:** (category 1 or 1.5) – housing specifically designated for older people with an alarm system and access to support services.

****Sheltered Housing:** (category 2) for older people – housing for older people with warden support on site (or peripatetic). May have communal areas, facilities and alarm system.

*****Very Sheltered Housing:** (category 2.5) – housing for frail elderly people with enhanced communal facilities, special design features, warden support and the capacity to offer extra care services.

Table 3.2 – Ratio of Population over 65 and 75 to Sheltered and Supported Accommodation by District – January 2002.

	Units of Accommodation	Population Aged 65+ (2000)	Ratio pop 65+ to units	Population Aged 75+ (2000)	Ratio pop 75+ to units
East Devon	1830	34173	18.7	17945	9.8
Exeter	1069	17739	16.6	8790	8.2
Mid Devon	789	12847	16.3	6116	7.8
South Hams	773	17376	22.5	8624	11.1
Teignbridge	1466	26354	17.8	13313	9.1
North Devon	988	17898	18.1	8839	8.9
Torridge	531	11760	22.1	5594	10.5
West Devon	345	9703	28.1	4732	13.7
TOTAL	7791	147850	19	73953	9.5

- 3.3 Responsibility for housing is with District Councils/ City Council and is not a County Council function. This emphasises the importance of integrated strategic planning, involving all key partners, to ensure that a comprehensive and co-ordinated range of services is developed in support of the frail elderly.
- 3.4 The Supporting People programme is a welcome and timely initiative with potential to be the focus and provide the drive for the co-ordination of housing and support services across Devon.
- 3.5 It is beyond the remit of the Best Value Review to carry out a fundamental review of supported and sheltered accommodation. The Review did, however, examine the scope and capacity of supported accommodation to provide safety and independence for frail elderly people. We concluded that there was considerable scope to develop a “whole system” approach, incorporating health, housing, social services and community resources, with supported housing being a crucial component. In reaching our conclusions we were informed by work under taken by Housing colleagues which was brought together in a conference held in Devon on 28.06.00. The Best Value review also received specific evidence from a housing and social care consultancy in respect of developing an integrated care and accommodation strategy in support of older people. The review team also received evidence from, and made visits to relevant schemes in Devon and elsewhere.

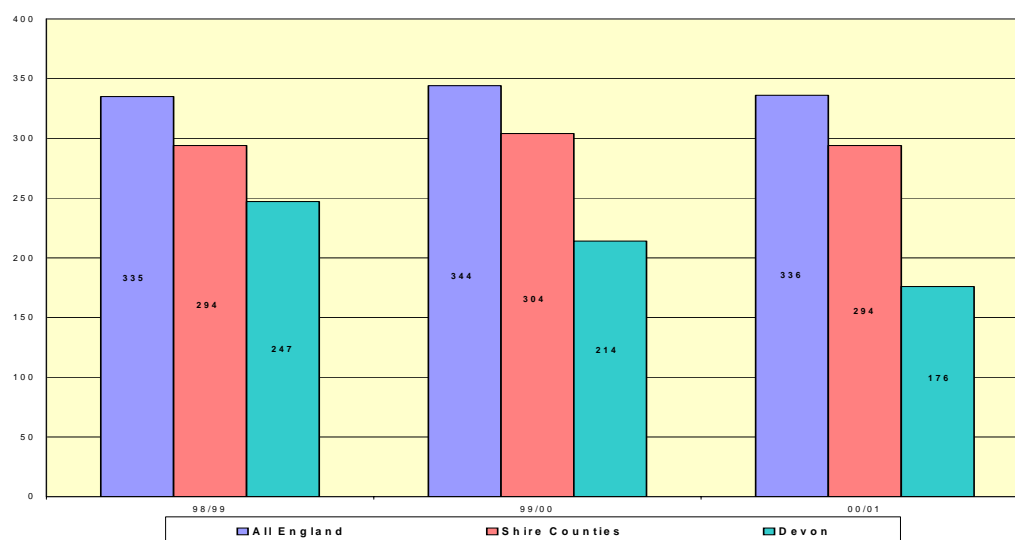
4. RESIDENTIAL AND NURSING CARE PROVISION

Total Supply

4.1 It is very difficult to establish the exact number of nursing and residential care beds in Devon at any one time for a number of reasons. There is a dynamism in the market with homes closing, opening or changing their capacity. The process of dual registration means that some bed capacity can be counted twice, i.e. as both a residential care bed and a nursing care bed. Some homes have a national capacity, e.g. dual-occupancy rooms which in practice are always single occupied.

4.2 A high proportion of the residents in these beds will be self funding. The Local Authority provides financial support to 2562 residents, or 176 per 10,000 of the population over the age of 65 years. This is a considerably lower proportion of supported care than for England and the Shire Counties.

Figure 4.2 – Supported Residents Aged 65+in Residential/Nursing Care per 10,000 over 65 – England and Devon



4.3 The Local Authority supplies 721 beds across 25 establishments in three main categories.

Long stay	520 beds
Short stay/ respite	91 beds
Reablement	110 beds

Average occupancy is 95%, but with short-stay/respite and reablement having a lower occupancy rate due to the nature of the function. The national trend in supply of residential and nursing care has been noted elsewhere in this report.

4.4 The key national trends being:

- the steady reduction in the supply of Local Authority provision;
- a reduction in the rate of growth in residential and nursing care over the past decade;
- the total number of residential care beds in the independent and voluntary sector continues to expand, albeit more slowly;
- the number of nursing beds began to decline nationally and locally in the late 90's and is continuing.

4.5 The market in Devon has similarities to the national picture, but there are some key differences.

The major difference between the market trends in Devon and the rest of the country is that the number of standard residential care beds in Devon is reducing – a reduction from 6,824 beds in March 1999 to 5879 in March

2001. This represents a reduction of 945 beds or 14%. The number of Local Authority provided beds has remained fairly stable over the past decade, albeit there has been some change in function with Local Authority care, with an increasing emphasis in providing short-term/respite care reablement and meeting the needs of the confused elderly (EMI provision).

4.6 In comparison, between 1996 and 2000 the national supply of residential care in the private and voluntary sector increased by 9,000 (+4%) and reduced in the public sector by 16,000 (-24%).

5. STRATEGIC SHIFT FROM RESIDENTIAL TO COMMUNITY CARE

5.1 The shift from a reliance on residential and community based care has been part of a planned strategy by the Social Services Directorate.

5.2 The Joint Review of Social Services in Devon (1999) identified the high reliance of residential care in Devon. There has been a planned shift to providing more care within the community as can be demonstrated in the following figures.

Figure 5.1 – Supported Residents (65+) – 31/03/99 to 31/03/01

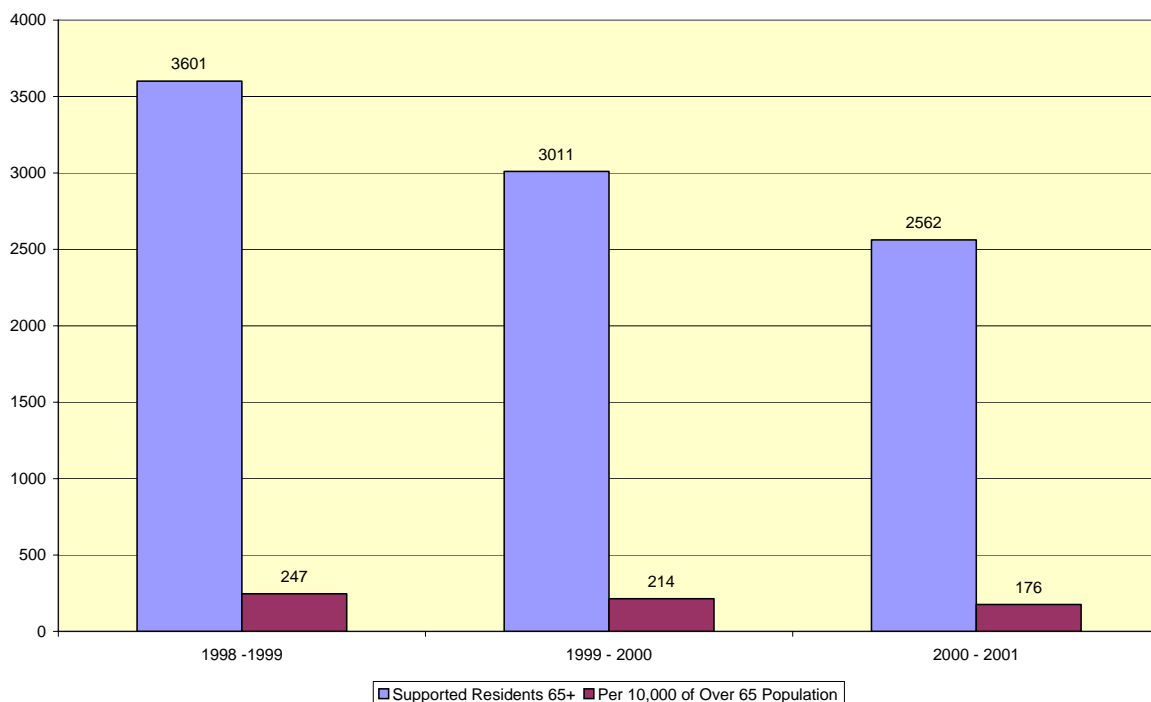


Figure 5.2 – Admissions Aged 65+ to Long-term Residential/Nursing Care per 10,000 over 98-01 (England, Shires and Devon)

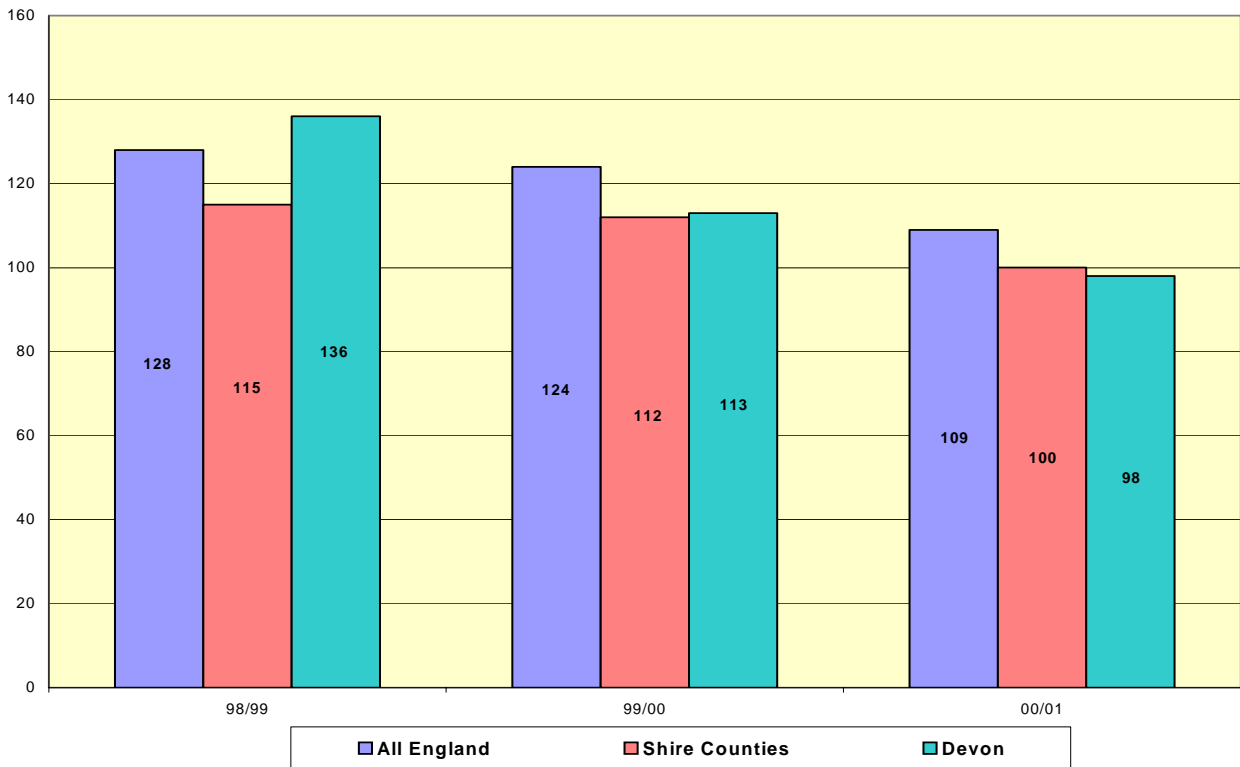
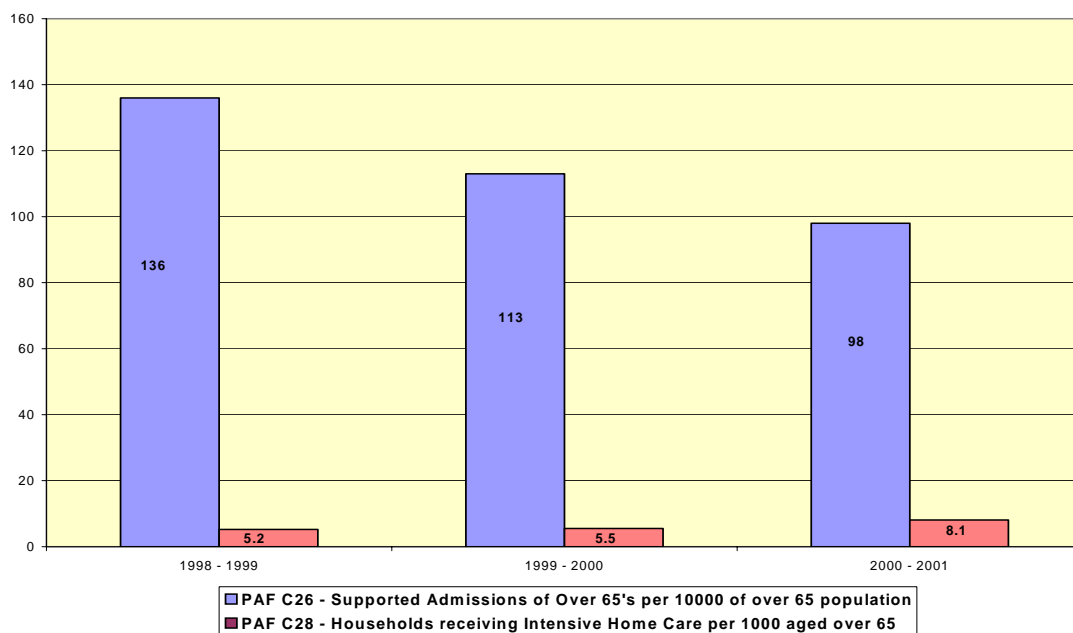


Figure 5.3 – Rate of Supported Admissions and Intensive Home Care 1998-2001 - Devon



5.3 These graphs show;

- the reduction in the total number of supported residents (5.1)
- the reduction in the rate of admissions from a rate above the national average to one below the national average (5.2)
- An increase in home care and a decrease in residential care (5.3)

6. FEE LEVELS – INDEPENDENT SECTOR

6.1 The fee levels to purchase care in Devon are comparative with those paid by neighbouring authorities. Information obtained from neighbouring authorities about fee levels in 2001/02 and proposed increases in 2002/03 are set out below. It should be noted that it is very difficult to establish direct comparison as most authorities operate banding systems that relate payment to levels of needs, as determined by eligibility criteria. (The very high percentage increase in fees by some authorities relates to a prioritisation of specialist care, i.e. for the elderly mentally infirm, rather than across the board increase.

Table 6.1 – Fee Levels Residential and Nursing (South West) 2001/02 – 2002/03

Residential Care Fees	2001/02	2002/03	% increase
South West (Low)	225	232	2
South West (High)	303	323	29.4
Devon (4 bands)	229-285	239-299	5
Nursing Care Fees	2001/02	2002/03	% increase
South West (Low)	334	355	2
South West (High)	394	419	23.5
Devon (2 bands)	360-390	378-410	5

6.2 It is concluded that Devon's fee levels are as good as other authorities in the South West. However, the Best Value review recognises that fees are at a level which will not sustain essential parts of the market in the medium term, that quality of provision is being undermined as a result of the low level of fees, and the market is contracting in an unmanaged way. These are all factors which are of concern.

6.3 There are two main consequences of the economically driven exits from the care market. The first is redressing over capacity, and as such the balancing of the market is welcome. The second is less positive, and is due to the economic fragility of the independent care market in large part due to Local Authorities having held down annual fee increases for much of the past decade. It is a potential threat to the balance of services in that financially driven exits from the market is not necessarily linked to over-supply. Instead, the higher cost pressures are greater on those

providers of meeting higher levels of need, i.e. nursing and EMI care, which is in under supply.

6.4 The financial pressure on independent care providers has been analysed in national reports, ref National Review Group; Scottish Executive Department; and at local level 'Understanding the Cost of Residential Care'; Residential Care Homes Trust 2001.

DIFFERENTIAL IN FEES

6.5 Table 6.2 shows the difference in fees between Local Authority homes and the independent sector.

Table 6.2 – Comparison of LA Standard Charges and Independent Sector Fee Levels – Devon

	1999/2000	2000/2001	2001/2002
Local Authority Homes	323.99	353.50	364.50
Independent Sector Care Homes	262.43	264.04	267.96
Independent Sector Nursing Homes	330.96	341.32	356.65

6.4 The Best Value review does not, however, concur with a simplistic view that shifting supply from the Local Authority to the independent sector will save almost £100 per bed per week. Firstly, current fee levels in the independent sector are not at a level which will sustain supply and quality in key parts of the market. Secondly, the level at which the Local Authority is purchasing care means that self funded residents are increasingly paying higher levels of fee in order to cross-subsidise publicly supported residents. We conclude that fee levels will need to increase if quality and supply is to be maintained. This can only be achieved, given the financial constraints on Local Authorities, if;

- (a) the chronic under funding of Social Services by central Government is properly addressed;
- (b) the supply of residential and nursing care is better balanced against demand, which in turn is supported by;
- (c) efficient, effective and economic preventative measures to maximise the numbers of people who can be supported within the community.
- (d) There will need to be a continuing reduction in the over supply of standard residential care provision in parts of the County.

6.5 A detailed survey has been carried out to assess the fit between the Local Authorities' residential care and the Care Standards Act 2000. Key findings of the survey are that:

- Many homes are in a poor state of repair due to insufficient funding for structural and non-structural maintenance.
- The majority of homes meet the standards for sitting, recreational and dining space.
- All homes meet the ratio of WC's to residents.
- Bedrooms sizes - 32% (224) are above recommended size of 12sqm
 - 14% (100) meet 10sqm standard for existing homes
 - 48% (335) do not meet spatial/standard of 10sqm but are above 9.3sqm minimum requirement
 - 7% (46) do not meet the minimum requirement of 9.3sqm. The majority are in 3 residential homes.

6.6 Whatever the function for Local Authority care service provision, there will need to be a significant capital investment to make it fit for purpose. The report makes a number of recommendations for the development of Local Authority residential provision which will be decided upon by the County Council following this Best Value review.

7. THE ROLE FOR LOCAL AUTHORITY PROVISION – OPTIONS

7.1 It is not appropriate for the Local Authority to use its limited resources on the supply of standard residential care when there is already an over supply of such care in the market. It can be provided more cheaply by the independent sector, and given the introduction of the Care Standards Act there will need to be a significant capital investment to bring the homes to a standard of structural quality which will be required in future.

7.2 However, while in terms of market supply it may not be necessary for the Local Authority to continue supplying standard residential care. It might be argued that the Local Authority should remain on the supply side of the market as a regulator and benchmark for standard residential care. However, if there is a system of joint strategic planning in which all main parties have a stake it is believed that this will provide a basis of trust such that the regulatory rate of direct Local Authority provision in standard residential care will not be required.

7.3 If Best Value raises questions about the role of the Local Authority in relation to standard residential care it may be more appropriate for the Local Authority to concentrate its resources in more specialist service provision and on those areas of under supply, e.g.

- respite care
- Intermediate care (reablement)
- elderly mentally infirm

These options will be examined in turn.

7.4 The analysis in the Best Value report is based on a number of levels:

- Older people have a preference to retain their independence and to live in their own home.
- The market is not in balance and is going through a period of adaptation which is partly finance driven (residential care) and partly preference and quality driven (sheltered housing).
- There is over supply in some sections of the market, and under supply in others.
- The internal readjustment of the market provides an opportunity to reshape services, if it is planned and managed. If unmanaged, there is considerable risk that the range and quality of services will not be available.
- There are considerable challenges in the demographic trends.
- Key services are under-resourced. There is scope to improve efficiency and effectiveness, but not to disinvest from services for older people.
- Recruitment, retention and training of a quality workforce will be a key factor in being able to provide effective, high quality services.

8. FORMING A STRATEGY

a) Preventive Services

8.1 Fletcher et al (1998) (Fletcher P; Hardy B; Waddington E) ('Preventative Strategies and Services for Older People'. Nuffield Institute for Health) identify that preventative strategies and services cluster into two categories;

- 1) Strategies to promote or delay the needs for more costly intensive services. The focus is mainly on those approaching the Fourth Age of their lives, i.e. 75+.
- 2) Strategies to promote the quality of life of older people and their engagement within the community. The focus is on people in the Third Age of their lives, i.e. 65+.

8.2 Preventive services for people in the Third Age is a 'whole system' challenge to which Social Services has a contribution to make, primarily by funding voluntary organisations, carers groups and older people led initiatives. Prevention at this level is under increasing threat because of the financial pressures on Devon and other Local Authorities.

8.3 The preventative role for personal care services, whether directly promoted or purchased by Social Services, is most appropriately focussed on those individuals who are beginning to lose their independence through frailty and ill health.

"Preventative strategies and approaches with the health and social care sectors can play a critical role in enabling older people to

continue to maintain an independent or semi independent lifestyle. Alternative approaches can have the opposite effect of disabling the older person and leading unnecessarily to models of service which are about 'doing to' or 'caring for' vulnerable people..." (Continuing Care Conference: Fit for the Future, 1998 pg 1).

b) Respite and Intermediate Care

- 8.4 Respite and intermediate care are different services. Over the past decade there has been a shift within the Local Authority to develop these services. Respite care is an important service in support of carers looking after the physically frail or mentally infirm. Devon provides 91 respite and short-stay beds. They are of higher cost than long-term residential care because of turnover and periods of fluctuating demand. It is recommended that this service continue to be directly provided by the Local Authority and purchased from the independent sector, and that respite care services be as closely interfaced as possible with the range of community support services such as day care, domiciliary care and community health services.
- 8.5 Intermediate care, or reablement services, have been developed in Devon over the past decade, indeed Devon played a leading role in establishing and demonstrating the effectiveness of those services.
- 8.6 Devon provides 116 reablement intermediate care beds. Development has been incremental rather than strategically co-ordinated. The units range in size from 20 beds at Bodley House to 2 beds at Rushbrook. With the increase in knowledge about reablement/intermediate care interventions and outcomes it is recommended that existing units be reviewed to establish the most effective and efficient size and regime for reablement care. There is an uneven spread of intermediate care provision across the County. (See Table 8.1).

Table 8.1 – Intermediate Care Provision – Local Authority

District	Number of beds (Feb 2002)
<u>Teignbridge;</u> <ul style="list-style-type: none"> • Mapleton • Tracey Vale • Daw Vale Sub Total	8 6 6 20
<u>South Hams;</u> <ul style="list-style-type: none"> • Harford View • Rushbrook Sub Total	8 2 10
<u>West Devon;</u> <ul style="list-style-type: none"> • Harewood • Wardhayes Sub Total	6 5 11
<u>East Devon;</u> <ul style="list-style-type: none"> • Green Close • Exebank Sub Total	19 16 35
<u>Exeter;</u> <ul style="list-style-type: none"> • Alphin House • Bodley House Sub Total	3 20 23
<u>North Devon;</u> <ul style="list-style-type: none"> • Oakwell • Fairlea Sub Total	6 3 9
<u>Mid Devon;</u> <ul style="list-style-type: none"> • Charlton Lodge • St Lawrence Sub Total	4 4 8
Total	116

8.7 In the period April 2000 to October 2001 a total of 1061 service users were admitted to the 13 units and 1045 were discharged. The average age of the service user was 83 years and the average length of stay was 32 days. Tables 8.2 and 8.3 show the place from which people were admitted, and to whence they were discharged.

Table 8.2 – Admissions to Intermediate Care Units – April/ October 2001

Admitted From	Number	%
Hospital	785	74
Nursing Homes	45	4
Devon County Council Residential Care	16	1.5
Independent Sector Residential Care	31	3
Own Home	146	14
Other/ Not known	38	3.5
TOTAL	1061	100

Table 8.3 – Discharges from Intermediate Care April/October 2001

Discharged To	Number	Percent
Hospital	94	9
Nursing Home	17	2
Devon County Council Residential Care	41	4
Independent Sector Residential Care	63	6
Own Home	757	72
Other/ Not Known	73	7
TOTAL	1045	100

8.8 These tables show that Intermediate Care/Reablement services are being targeted at the interface between health and social care.

- 74% of admissions to the units are directly from hospital.
- It is safe to assume a proportion of the admissions from the community would have had to be admitted to hospital had the units not been available.
- 91% of the discharges from the unit were to community, non-hospital settings.

9. STUDY OF INTERMEDIATE CARE/REABLEMENT OUTCOMES

9.1 The Social Services Authorities in the South West, in partnership with the Centre for Evidence Based Social Services commissioned and researched a study of the comparative impact of residential and home based Intermediate Care/Reablement delivered mainly through domiciliary care and community health services.

9.2 The study is in two parts:

- (i) Buying Time – a study (212 participants) using random controlled technique to establish actual and comparative outcomes between residential and community based Intermediate Care/Reablement services.

The populations studied received services from either a large residential unit or a community reablement team. There was a random control group established to match each group of service recipients.

- (ii) The User Voice – A qualitative study (18 participants) to establish the participants perspective of the experience of residential reablement, with a comparison with a hospital based service.

9.3 Both studies were undertaken in Devon and the main findings (the research is now in the final stages of being written up) are:

- Residential and home based Intermediate Care services are equally effective.
- The residential based service can reduce the length of hospital stay by upto 7 days more than the home based service.
- The costs fall differentially on health and social services. The residential route is more costly for Social Services but has lower costs and greater savings for health. The home based Intermediate Care/Reablement service incurs increased hospital and community health care costs than the residential route.
- Both options are cheaper than keeping someone in hospital.

9.4 It is possible to make a rough calculation of the savings to the NHS in terms of cost of hospital beds delivered by the residential reablement alone, based on the following assumptions;

- 785 discharges from hospital to residential Intermediate Care/Reablement services April-October is equivalent to 1346 discharges in a full year.
- The average length of stay in the residential reablement unit is 33 days. Assume 2 weeks (approx. 50%) of that time has been direct saving to the NHS by permitting earlier, safe discharge from NHS provision.
- The cost of acute and community hospital beds is £1960 per week (£280 per night) respectively.

(Source: North and East Devon Health Authority – July 2001)

9.5 The savings to the NHS hospital sector in Devon from the residential Intermediate Care/Reablement units alone is in excess of £5.3m p.a. in acute sector bed costs or over £3.4m in community hospital bed costs.

(Acute Sector Hospitals: 1346 people X 2 weeks X £1960 per week)

(Community Hospitals: 1346 people X 2 weeks X £1260 per week).

9.6 These figures show the significant savings in NHS hospitals through Intermediate Care/Reablement services. They do not take account of savings to the NHS from those people discharged directly to their own homes and in receipt of home based reablement services.

9.7 The Best Value review concludes that this is an important function for continuing Local Authority provision which should be maintained and developed. The key areas to focus on for development are;

- establishing the most effective size of Intermediate Care/reablement unit;
- ensuring appropriate cover across the County;
- agree consistent joint funding arrangements with the NHS;
- integrate residential Intermediate Care/Reablement services into a planned continuum of preventative community support services.

Dementia Care

9.8 The Best Value group considered the demands in relation to dementia care. It is not easy to establish either local, regional or national baseline figures as there is no standard system of classification. As part of the review process a dementia care study day was held, and the Review group was informed in its work by ongoing contributions from Dementia Voice and a paper from the Exeter EMI Group of Independent Care providers which is included in the evidence documents of the Review.

9.9 It is known from demand pressures that EMI residential and nursing care placements are in short supply. Figures obtained for EMI nursing provision across North and East Devon health Authority show a wide variation in supply across the PCT localities, with a low of 1.5 per 1000 over the age of 75 in East Devon and a high of 8 per 1000 over 75 years old in Mid Devon.

9.10 Because of the weaknesses in joint strategic planning for older people the health and social care communities across Devon, Plymouth and Torbay are establishing a Joint Development Network which will be facilitated by the King's Fund through the Institute for Applied Health and Social Policy of King's College, London. The purpose of the network is to establish a joint framework for strategic development and management and to identify options for practice development and delivery of services for older people with mental health problems.

9.11 It is estimated that by the age of 80 one in five people may be affected by dementia. The risk of developing dementia increases with age, the percentage doubling among each five year age group over the age of 65 years (source: Continuing Care Conference – Fit for the Future). Thus dementia care will be an increasing challenge for Devon given our ageing population profile.

9.12 The three main cause of dementia are Alzheimer's disease, accounting for 50-60% of cases; dementia with Lewy bodies, accounting for 15-25% of cases and vascular dementia (or multi-infarct) dementia accounting for 15-25% of cases.

9.13 The evidence presented to the Best Value group in relation to dementia care was consistent with other evidence, namely that people preferred to remain within their own homes. In order to achieve this safely and with adequate quality of life a range of supportive packages for dementia sufferers and their carers was necessary. Evidence of preventive strategies in Berkshire (quoted in 'Fit for the Future' – ibid pg 30) show that it is cost effective to invest in low level preventive help rather than more intensive and expensive services.

9.14 There does, however, need to be a range of focussed services designed around the needs of dementia sufferers and their carers. Services for dementia care need to be;

- strategically planned;
- be integrated between health, housing, social services and community networks;
- provide a planned continuum from care within the persons own home and in the community through respite care services to residential and nursing care;
- The supply pressures in relation to dementia care need more focussed attention, particularly in relation to skills, quality of service and cost.
- The joint development network will provide a focal point for joint strategic planning.
- The advice and expertise of organisations such as Dementia Voice can make valuable contributions to the development of our strategies and services.
- The Local Authority should remain as a direct provider of residential services for people with dementia because there is;
 - a) under supply within the market;
 - b) the differential in cost between independent sector and local authority provision is not so great as to justify ceasing supply;
 - c) the Local Authority should develop its services as a focal point for respite care and community support, with some provision for long-stay care, albeit physically separated from community resources if they are on the same site.

MATCHING SERVICES TO NEED - ONE SIZE DOES NOT FIT ALL

1. INTRODUCTION

- 1.1 There is a consistent message from older people, namely that the majority want to continue to have a safe and quality life in their own homes for as long as they can.
- 1.2 The analysis of existing service provision has identified that services for older people are delivered through complex local and national systems. That there is a lack of confidence and trust on the existing systems. Services are not well matched to needs and are not well co-ordinated between the main statutory services of health, social services and housing.
- 1.3 The challenge of moving forward and applying Best Value principles should not be underestimated. Firstly, we operate local systems within a national context which has been strongly criticised as complex, muddled and contradictory (cf “With Little Respect to Old Age”, Royal Commission 1999; “Home Alone”, Royal Commission, 1998; “The Coming of Age”, Audit Commission 1997). Secondly, the organisational context in Devon is particularly complex, with the County Council having responsibility for Social Services; seven District and One City Council having responsibility for housing and six PCTs having responsibility for primary and community health care services.
- 1.4 Nor is there a single model or blueprint which will meet the complexity of personal needs across the wide diversity of Devon’s communities.

“The [Royal] Commission believe, with the Audit Commission for England and Wales, that better value for money can be obtained within the existing system, but in recognising the different circumstances, needs and wishes of individuals we do not advocate a single model. There should be a tapestry of accessible provision from which, within limitations, people may choose, confident that their needs can be met”. (Royal Commission, ibid pp 82-83)

- 1.5 In analysing different kinds of need and how the services to meet them will be funded the framework outlined by the Royal Commission is helpful (ibid pp 67-69). It classifies categories of care and funding options within:

- Housing costs
- Living costs
- Personal care costs

- 1.6 The Royal Commission recommends that housing and living costs should be the responsibility of the individual, subject to a means test of ability to pay. Living costs are defined as:

- Cleaning and housework
- Meals
- Laundry
- Shopping
- Specialist transport (eg dial a ride)
- Sitting services

2. PERSONAL CARE

2.1 The Royal Commission recommended that personal care ie care which “*directly involves touching a person’s body, incorporated issues of intimacy, personal dignity and confidentiality*” (ibid p 67) should be exempted from means testing, but only following a careful assessment of how best it can be provided and by whom.

2.2 Irrespective of whether “personal care” is exempted from means testing, this framework for analysis is helpful because it underlines the necessity for:

- Co-ordination between different bodies (health, housing and social services) is meeting the accommodation and care needs of the frail elderly;
- Points to the different public and personal funding streams necessary to fund both the strategy and individual care arrangements.

2.3 In respect of “personal care”, the Royal Commission points strongly towards an integrated approach between health and social services in meeting needs, and such a joint approach is now more easily attainable by making use of Health Act flexibilities. It is recommended that this be examined in detail by Social Services and PCT’s. This should be related to current initiatives and the review of Continuing Care criteria in relation to “Fair Access to Care Services”.

By “personal care” the [Royal] Commission means the care needs which give rise to the major additional costs of frailty and disability associated with old age. We deliberately do not use the term “health care” or “social care” ...

Personal care is care that directly involves touching a person’s body ... and is distinct from treatment/therapy ... and from indirect care such as home help or the provision of meals. This type of care is the main source of contention in the debate about the distinction between health care and social care. It falls within the internationally recognised definition of nursing, but it may be delivered by many people who are not nurses, in particular by care assistants employed by social services departments or agencies”. (Royal Commission ibid pg67).

3. HOUSING

3.1 The supply of appropriate housing is a crucial element in older people being able to remain in their own homes.

Housing Services Provided	Beneficiaries
Community alarms	More than 1.1 million older people
Aids and Adaptations	125,000 Disabled Facilities Grants made since 1991, plus an unknown but significant number of council house adaptations.
Home Improvement Agencies	Nearly 200 agencies nationally provide assistance with repairs and grants.
Vulnerable Single Homeless	45,000 people with mental health problems. 40,000 physically disabled and 45,000 older people have been accepted as homeless since 1990.
Specialised Housing	450,000 units of sheltered housing with on-site wardens for older people. 82,000 units of supported housing for people with mental health problems, physical disabilities, learning disabilities, and other needs.
Mainstream Housing with Support	Housing agencies provide extra support to enable vulnerable people to maintain their tenancy, eg helping older people with gardening, or regular visits from housing officers. Provision of support is not consistently defined or recorded.

“The Audit Commission found that housing authorities are struggling to cope with demands being made, particularly in the light of demographic pressures from the older people needing support to remain in their own homes”.

(M Henwood, “Future Imperfect” King’s Fund 2001, pg23).

3.2 The problems as identified by the Audit Commission are due to weaknesses in agencies collaborating in the joint commissioning of services.

“A lack of integrated planning and decision-making, operating reactively and a tendency to give a low priority to the housing aspects of community care are three common weaknesses:

- *Separate and unilateral decision-making ...*
- *Reactive approaches ...*
- *Failure to prioritise the housing role in community care ...*

The second major challenge is community care itself, which has placed in council tenancies many more people who, at times, need intensive support. The result is that a significant welfare role has crept up on housing authorities, even those that have transferred their stock through LSVT.

To deliver services effectively within this context requires:

- *An adequate supply of housing ...*
- *The capacity to repair or adapt properties*
- *Flexibility in the provision of personal support ...*
- *Good joint working arrangements with health and social services' staff and also the voluntary sector"*

(Home Alone, Audit Commission 1998 pp18-19)

3.3 Improved strategic planning between health, social services and housing is essential if the accommodation and care needs of the frail elderly are to be met. The joint process of strategic planning should be inclusive of other key parties such as older people and carers' representatives, voluntary sector organisations, Registered Social Services Landlords and Independent Sector care providers.

3.4 The process of jointly planning services will be simplified and enhanced by the Supporting People initiative which has reformed the Housing Benefit system.

"The aim is to achieve a more flexible person-centred funding system, though at the price of bringing in a cash limited control of expenditure, needs assessment for support services and prioritising between client groups".

(Fletcher "Social Inclusion for Vulnerable People " Pavilion 2000)

3.5 The transfer by Central Government to Local Government of an open access budget which it is unable to manage, in this case Housing Benefit, is reminiscent of what happened with the Community Care budget at the beginning of the 90s. Without question Local Government is capable of managing and prioritising these resources, however, the amount of transfer of what will be a cash limited budget will, we hope, be closely monitored by Local Government organisations so that there is not a hidden shift in the taxation burden from central government to local government which has occurred over the past decades in respect of social services funding.

- 3.6 The opportunities to use funding streams transferred from Central Government to Local Government, ie Supporting People, Preserved Rights Transfer and Residential Care Allowance should be used to develop services in line with identified need, rather than a continuation of historic funding patterns.
- 3.7 This should be achieved by developing a medium term financial strategy, in partnership with NHS and Housing Authorities, to support the strategic development programme for the support of older people (cf Joint Investment Plans for Older People: Social Services Strategic Programme).

4. THE WAY FORWARD

- 4.1 The Best Value Review into the accommodation needs of the frail elderly recommends that the aim of health, housing and social services authorities should be to support people in their own homes for as long as practical, taking account of the quality of life of the individual and the cost of providing care and accommodation.
- 4.2 There needs to be a suitable range of care and accommodation provision to give people a realistic choice developed through a joint structure of strategic planning.
- 4.3 Strategic planning should be co-ordinated through a Partnership Board for Older People and People with Disability. Membership of the Partnership Board should be inclusive of all main stakeholders.

The Partnership Board would set the high level strategic aims and objectives with responsibility for local planning and implementation progressed through Joint Investment Planning Groups.

The Partnership Board for Older People and People with a Disability should be represented on the Devon Strategic Partnership.

- 4.4 Strategic Planning for accommodation services could be co-ordinated through the Supporting People Management Group. Its relationship to the proposed Partnership Board would need to be established.
- 4.5 The existing system of providing support, care and accommodation to the frail elderly is complex and confusing. It should;
- Be simplified in respect of those aspects of the system within the remit of local agencies.
 - Examine the scope for a single information and signposting service in relation to housing, benefits care and community health services
 - Examine the scope for a single point of personal contact in respect of housing, social care and community health services.

- Establish the Single Assessment Process to incorporate the dimensions of health, housing and social care.
- Examine the scope for a single computerised care record based on the single assessment process.
- Examine the scope for multi-agency assessment teams to undertake the single assessment process.

4.6 Preventive strategies are being undermined and reduced as a result of funding pressures on statutory services, in particular Social Services.

- In consultation with service users, carers and voluntary organisations to identify the priorities for a preventive strategy which prevent or delay the need for more costly and intensive services.
- To establish joint strategies to reduce health morbidity in old age.

4.7 Develop day services as focal points for community care services incorporating day services, access to community health and therapy services and to domiciliary care services.

4.8 Supporting frail elderly people in maintaining independence requires a greater emphasis on the role of housing in Community Care strategies:

4.9 Provision of equipment and adaptations:

- Establish an effective joint equipment service
- Timely provision of equipment and adaptations
- Simplified process for implementation of Disabled Facilities Grants, incorporating monitored time limits at each stage of the process which is linked to the “Better Care, Higher Standards Charter”.

4.10 Development of extra-care housing schemes in which the frail elderly can continue to live and be supported as an alternative to residential care.

- Extra-care housing schemes can be established in either accommodation of 20+ units, incorporating community facilities, or alternatively developed as clusters of free-standing units of accommodation located in the vicinity of a community resource centre through which personal and daily living care can be accessed.
- It would be appropriate to locate the co-ordination of the extra-care housing strategy within the Supporting People Steering Group.
- An approach should be made to suitable Registered Social Landlords and Housing Associations to explore the potential to enter into a partnership for the strategic development of extra-care housing in Devon.

4.11 The provision of institutional care through residential and nursing care needs to be more closely matched to need. There needs to be more active market management based upon a joint strategic programme:

- To sustain and, in some cases, stimulate development of services in short supply in some parts of the County, eg nursing care and care for the confused elderly
- To address problems of quality and instability related to tightly constrained fee levels
- To expand reablement services to promote independence and self care among the frail
- To develop community based support services for the confused elderly as a complement to an expansion of residential services

4.12 Funding new developments more closely matched to the needs of the community will be, in part, achieved through:

- Greater efficiency of more strategic planning between health, social services and housing
- The opportunity of transferred funding streams, ie Supporting People, Preserved Rights and Residential Care Allowance
- Disinvestment from over supply and/or high cost service provision

4.13 Oversupply is being managed by means of eligibility criteria rigorously applied through the care management process. This applies in particular to standard residential care. This should be maintained.

4.14 A significant proportion of Local Authority residential provision is in the delivery of standard residential care. The conclusion of the Best Value review is that this is not the most effective use of resources. It is recommended that the Local Authority residential services be developed to provide:

- Reablement services
- Care for the confused elderly, in particular promoting and supporting the safe care within the community through outreach, day care and respite services
- Community Resource Centres incorporating day care services and providing a single point of leisure and lifelong learning
- Access to a range of community support services including community health and therapy, access to respite care and domiciliary services
- Capital assets be used to promote additional extra care housing

4.15 The Local Authority would need to continue to supply standard residential care in those localities where there was an absence or shortage of independent sector residential care.

4.16 The recommendations outline a medium to long term programme of strategic change which will only be achieved by establishing:

- A robust, integrated system of strategic planning and joint commissioning;
- Working to a programme of specific, measurable, properly resourced and timely objectives using project management methodology;
- Ensuring the programme is informed by a medium to long term financial strategy.

ACTION PLAN

AIM: The aim of health, housing and social services authorities should be to support people in their own homes for as long as practical, taking account of the quality of life of the individual and the costs of providing care and accommodation.

Objective	Implementation Programme	Partners/Links	Outcome	Lead Responsibility	Timescale
Strategic Planning 1. Consideration of the recommendations of the Best Value Review	1.1 Endorsement by (i) Executive Committee DCC (ii) Devon County Council (iii) Housing Authorities (District and City Council) (iv) Primary Care Trust	Health; Housing and Social Care Authorities	Endorsement of Best Value Review recommendations	Portfolio Holders Director of Social Services	Executive Committee May 7 th County Council May 23 rd Housing Authorities end July PCTs end July
2. To plan services for older people strategically and in partnership	2.1 Establish County wide strategic Partnership Board. 2.2 Membership of Partnership Board to reflect all main parties. 2.3 Develop JIPs as the local focus of joint strategic planning, which is linked to the Partnership Board. 2.4 Membership of JIPs to include representation of all main parties. 2.5 Partnership Board to be represented on Devon Strategic Partnership	Local Government (County, District and City Councils); PCTs; Voluntary; Organisations; Service User Representatives; Carer Representatives	Co-ordination of strategic planning through Partnership fora operating at County and Locality levels	DCC PCTs	Autumn 2002

Objective	Implementation Programme	Partners/Links	Outcome	Lead Responsibility	Timescale
Preventive Services 3. To use resources as effectively and efficiently as possible in supporting the frail elderly	3.1 To make full use of the Health Act flexibilities to improve practice and outcomes between health and social care.	Social Service Dept PCTs NHS Trusts	More effective use of resources. Attainment of targets within NSF and Strategic Programme.	Director of Social Services PCT CXs	Ongoing
	3.2 Through the Supporting People Programme to integrate care services and housing provision	Supporting People Programme Partners	Supporting a higher proportion of people in their own homes	Supporting People Joint Commissioning Group	Ongoing
4. To develop effective preventive partnerships and strategies	4.1 Preventive strategies, resources and outcomes to be made specific within the Strategic Programme 4.2 Social Services contracting strategy and process to be explicit and transparent 4.3 To prioritise reduction of health morbidity in older people through the implementation of National Service Framework Programmes and preventive strategies 4.4 To develop links with the new Peninsular Medical School in the training and education of medical staff in community and preventive programmes.	'Whole system' partnership SSD and service contractors Health; social services and community groups Health; Social Services; Peninsular Medical School	Reduction in health morbidity in older people Increased expertise in health promotion	Partnership Board SSD Health Improvement Programme Board Partnership Board	

Objective	Implementation Programme	Partners/Links	Outcome	Lead Responsibility	Timescale
	<p>4.5 To jointly develop Community Resource Centres in accessible locations which:</p> <p>(a) directly provide a range of community health and social care services to support the frail elderly within the community</p> <p>(b) provide a single point of access to community health and social care services</p>	<p>Service user representatives; Carer Organisation Representatives; Voluntary Sector; Health and Social Services</p>	<p>Network of accessible jointly provided services to support frail elderly people within the community</p>	<p>Social Services and PCTs</p>	
<p>Public Access to Information</p> <p>5. To provide single points of access to information for health, housing, social care and welfare benefits</p>	<p>5.1 To revise the existing range of information services and to establish single points of contact through which the public can access information about support services and welfare benefits</p>	<p>Local Government services NHS Direct Benefits Agency Housing Providers</p>	<p>Easy public access to accurate and consistent information</p>	<p>Partnership Board</p>	
<p>Assessment and Care Planning</p> <p>6. To establish an integrated process of assessment, care planning and review</p>	<p>6.1 Implementation of Single Assessment Process</p> <p>Examine feasibility of establishing multi-agency assessment teams</p>	<p>Health; Housing; Social Services; Service Users; Carers; Service providers</p>	<p>Single Joint Assessment Process</p> <p>Joint agency teams established; more efficient practice</p>	<p>Health & Social Services (SMG/PCTs) Health & Social Services (SMG/PCTs)</p>	<p>Oct 2002</p> <p>Dec 2002</p>

Objective	Implementation Programme	Partners/Links	Outcome	Lead Responsibility	Timescale
	<p>6.2 Implement programme to improve existing practice (Performance Assessment Framework implementation programme).</p> <p>6.3 Examine feasibility of integrated computerised care management record for health and social care</p> <p>(a) commission feasibility study (b) consider findings (c) develop EPR/EHR programme</p>	<p>Social Services; Service Users; Carers; Service Providers</p> <p>Health; Social Services; Links to Care Management programme; Electronic Patient Record; Electronic Health Record</p>	<p>Improved effectiveness and efficiency and assessment and care planning specified PAF targets attained</p> <p>Integrated computerised client/patient records</p>	<p>Social Services (DMGs)</p> <p>Health (Strategic Health Authority); Social Services</p> <p>Health and S/S Health and S/S Health (SHA through LIS)</p>	<p>Sept 2002</p> <p>Jan 2002 Apr 2002</p>
<p>Support at Home</p> <p>7. To develop a consistent range of services to support people at home</p>	<p>7.1 Help at Home Services</p> <p>7.2 Provision of equipment and adaptations through Joint Equipment service.</p> <p>7.3 Maintain County wide network of practical help schemes, eg Care & Repair.</p> <p>7.4 Develop strategy for provision of extra care housing for the very frail elderly</p>	<p>Health; S/S; Housing; Link to Better Care Higher Standards Charter; Social Services; PCTs; Districts; Voluntary Orgs; Health; Housing; Providers (statutory and independent); Social Services; link to Supporting People Programme</p>	<p>Timely and practical support to promote independence</p> <p>Network of practical housing support for the frail elderly. Strategically planned network of extra-care housing provision</p>	<p>Health and Social Services (SMG/PCTs)</p> <p>Partnership Board</p> <p>Supporting People Strategic Commissioning Group</p>	<p>Dec 2002</p> <p>Dec 2002</p> <p>Commence Autumn 02</p>

Objective	Implementation Programme	Partners/Links	Outcome	Lead Responsibility	Timescale
Managing The Market: Residential and Nursing Care 8. To commission a range of quality residential and nursing care provision based on current and projected demand	8.1 To establish current and future capacity requirements across the continuum of health and social care provision (Intermediate Care; Residential Care; Nursing Care)	Health; Social Services. Link to Capacity Planning initiative	Managed market supply based on current and projected need.	Social Services and Health (SMG/PCTs)	
	8.2 To establish capacity requirements at locality level	Health and Social Services; Joint Investment Planning programmes	Market supply matched to local need.	Locality JIPs linked to Partnership Board	Ongoing
	8.3 To clarify required level of independent sector fee levels consistent with a quality service	Health; Social Services; Independent Providers	Sustainable market supply	Social Services	Autumn 2002
	8.4 To jointly develop a financial strategy to achieve fair fee levels within the resources available to the local authority	Independent sector care providers; Resources Directorates	Sustainable market supply	Social Services	Autumn 2002

Objective	Implementation Programme	Partners/Links	Outcome	Lead Responsibility	Timescale
Managing The Market: 9. The Role of Local Authority Provision	9.1 To develop a medium term programme to focus LA provision on supply of - Community Resource centres - Reablement and Respite care	Health; Housing; Social Services; Service users; Carers; Workforce;	Strengthening of preventive strategies and services for people with special needs.	Social Services (SMG)	(a) Identify development options for existing establishments by Autumn 01
	- Residential and community care for the confused elderly - Location for extra care housing schemes	Trade Unions; Voluntary Sector; Links to Care Standards Act			(b) Implementation programme phased over 3-4 years
Workforce 10. To ensure a well trained and motivated workforce	10.1 Ongoing development of workforce strategy in a context of NHS Workforce Confederation initiative which addresses; (i) recruitment (ii) retention (iii) training and skills (iv) remuneration (v) job satisfaction and status	Health; Social Services; Independent Sector; Service Users and Carers; Link to Workforce Confederation	Maintenance of a quality and motivated work force	Health; Social Services; Resources Directorate	Ongoing
Medium Term Financial Strategy 11. To develop a medium term financial strategy which supports the	11.1 Model future demand and resource requirements 11.2 Identification of funding streams to promote strategic programme 11.3 Identification and	Health; Social Services; Housing; Link to Health Act; Supporting People Initiative	Medium term financial strategy linked to strategic development programme	Finance leads in Health; DCC and Districts	Autumn 2002

Objective	Implementation Programme	Partners/Links	Outcome	Lead Responsibility	Timescale
implementation of the strategic programme	<p>progression of joint commissioning and investment opportunities to support the strategic programme</p> <p>11.4 develop financial model to support the phased strategic development programme</p>				

Appendix 1

Views of service users from consultation meetings with the Inquiry

- Lack of understanding and compassion on the part of care workers.
- Lack of understanding of empowerment or enabling independence; care workers concerned instead with 'looking after'.
- In both subtle and overt ways, service users are often bullied by care and support staff.
- Lack of staff time and lack of appropriate skills.
- Services do not provide what people really want.
- Problems of continuity of care, particularly with high staff turnover.
- Institutionalised discrimination against older people in services, with lower cost ceilings for services than for younger people.
- Charging policies are a major deterrent for people who really need services.
- Direct Payments can offer a way forward, but are not appropriate for everyone.
- It is very difficult to make complaints. There is a fear of the consequences of 'whistle blowing', and an unwillingness to get staff into trouble.
- Lack of attention to needs of black and minority ethnic groups.
- Fears over future of social care and the risks of it being taken over by the NHS, which is seen as 10-15 years behind in its attitudes to disability.
- Particular problems at transition from children's to adult services, and from younger adults to elderly.
- How do you ensure a quality service when the prime motive of providers is that of profit?
- Workers cannot empower service users unless they themselves are empowered.
- Important aspects of support are not seen as core parts of the job and do not get done (particularly in interacting with people and encouraging communication and engagement).
- Care staff have become too professionalised to get involved in individual interaction.

Source: Views of service users from consultation meetings undertaken by the Inquiry.

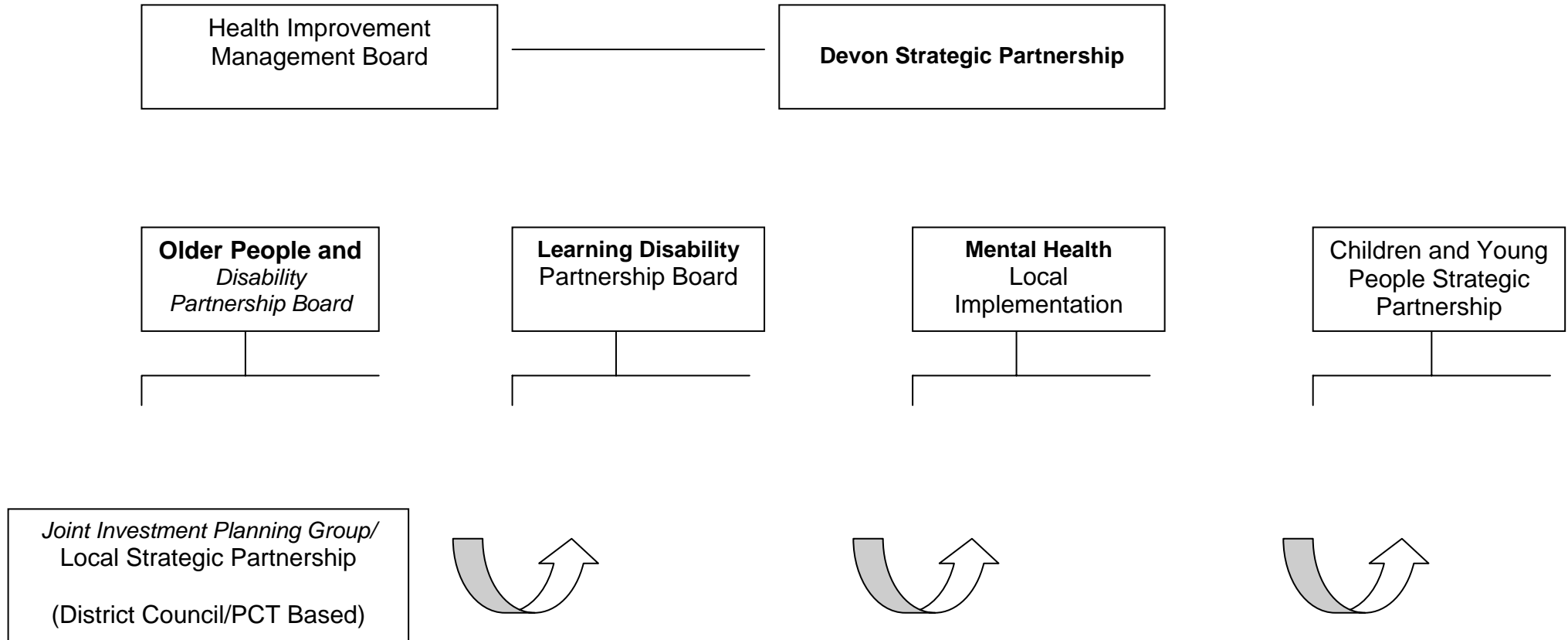
Appendix 2

Royal Commission Long Term Care **Values which informed The Work of the Commission**

- Older people are a valuable part of society and should be valued as such.
- Old age will come to increasing numbers of the population and this should be seen as a natural part of life and not as a burden.
- Old age represents an opportunity – for intellectual fulfilment and for the achievement of ambitions put on hold during working lives. Those who are involved in Government, or who provide and develop products and services should work to make available to old people the tools to enjoy education, leisure and their day to day lives.
- To compartmentalise old age and to describe old people as a problem is intolerable – morally and practically.
- A more positive and inclusion climate should be created and nurtured, so ensuring that development of more opportunities which can be taken up by older people.
- The whole approach to long-term care should be created and nurtured, so ensuring the development of more opportunities which can be taken up by older people.
- The whole approach to long-term care should be to view the management of older peoples' needs as a set of positive actions over time which help people to lead the kind of fulfilling lives they want to lead – and to be able to continue to contribute to society in a positive way – both economically and intellectually – and not as a management of decline.
- The funding system for long-term care should provide the widest possible opportunity for older people to lead the lives they want, whether it be in their own homes or in other settings.
- In improving the recognition of the importance of old age, the funding system must also strengthen the links between generations and spread the financial responsibility.

Appendix 3

STRATEGIC MANAGEMENT OF HEALTH AND SOCIAL CARE PARTNERSHIPS



Appendix 4

User involvement in service evaluation and inspection: the Hampshire Consumer Audit Project

The Hampshire Consumer Audit Project* was established with funding under the Department of Health Community Care Development Programme and run by Southampton Centre for Independent Living. The project recruited and trained 'consumer auditors'. Volunteers needed to be current users of community care services, or carers, and to want to help service users in 'having a say'. The approach was distinguished by an understanding and promotion of the social model of disability, and had the following objectives:

- To develop consumer definitions of outcomes and criteria for their measurement.
- To develop a training and support programme for consumers to undertake independent audits on service outcomes.
- To demonstrate how a focus on the value to consumers can influence commissioning and providing processes.
- To demonstrate a task-focused model of partnership between consumers, health and social services, and the independent sector.

Consumer auditors emphasised a number of strengths of the approach, in particular:

- The independence of the audit, and opportunity for service users to speak to people who understood the issues as 'kindred spirits'.
- Good training and on-going support provided to auditors by the scheme co-ordinators.

* Henwood M. *The Community Care Development Programme: building partnerships for success. An evaluation report to the Department of health.* London: Department of Health: London, 1998.

Appendix 5

User involvement in service evaluation and inspection; user-focused monitoring (UFM) of Mental Health Services (Sainsbury Centre for Mental Health)

- All interviewers were themselves services users. Some of the interviewers were in the top tier of the CPA, 'yet with the right training all completed their interviews and all gained in confidence as a result of doing so'.
- UFM produced 'a different and more open response from their interviewees than professional researchers might have done'.
- All of the evaluations were commissioned by services agencies which were progressive in their approach and committed to user involvement and empowerment.
- Follow-up review indicates that UFM can make a difference, with many changes resulting from the findings.
- Interviewers gain self-esteem from the process; for some, this has led to full-time employment, while others have become more involved in user-focused research.
- UFM is moving into service development by enabling service users to participate in user-led evaluations in their own areas. 'The aim is to concentrate on solutions rather than problems and to ensure that the concerns raised... are effectively addressed as services evolve'.

Key recommendations arising from UFM include:

- Users should be involved in training all psychiatric and social care professionals.
- Purchasers and providers should facilitate but not control user involvement and empowerment at all levels.
- User involvement in planning and delivering individual care should be for purposes of empowerment not compliance.
- The measurement of the extent of user involvement should be the extent to which users themselves feel involved.
- The complaints of users should be taken seriously. They must not be pathologised or dismissed as symptoms of mental illness.
- There should be at the centre of the monitoring and evaluation of mental health services.

Source: Rose D. *users' voices: the perspectives of mental health service users on community and hospital care*. London: The Sainsbury Centre for Mental Health, 2001.

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Audit Commission	Home Alone - the role of housing in community care	1998	
Audit Commission	The coming of age - improving care services for older people	1997	
Continuing Care Conference	Fit for the Future: The Prevention of Dependency in Later Life	1998	
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Rural Development Commission Help the Aged	Growing Old in the Countryside Resource Allocation Systems and Rural Areas	June 1996	
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University of Leicester/The Nuffield Community Care Studies Unit	Charging for Care in Later Life A summary of the effects of reforming the means test	2000	Ruth Hancock

Best Value Review
Accommodation Needs
of the Frail Elderly

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