MIDDLESBROUGH COUNCIL

AGENDA ITEM 10

OVERVIEW & SCRUTINY BOARD

SOCIAL CARE & ADULT SERVICES SCRUTINY PANEL

THE EXPERIENCE OF VULNERABLE OLDER PEOPLE IN CARE SETTINGS

3 JULY 2012

PURPOSE OF THE REPORT

1. To present the outcome of the Social Care & Adult Services Scrutiny Panel's investigation into the social care elements of 'the experience of vulnerable older people in care settings'. As a remit, the Panel decided to consider the following themes in particular detail.

1.1 The ways in which care providers cope with patients/residents with dementia;

1.2 How care providers ensured that people were treated with dignity and respect;

1.3 What provision is in place for feeding assistance for patients who required it;

1.4 How care providers ensured that staff are appropriately skilled to handle the variety of cases they were expected to deal with;

1.5 How the reduction in public resources for the foreseeable future would impact upon the care for vulnerable older people;

1.6 What the long-term issues would be for the care of vulnerable older people

1.7 In terms of the remit of the investigation it was suggested that the Health Scrutiny Panel concentrate on the issues of vulnerable older people in a hospital setting and that the Social Care Scrutiny Panel consider the issues for that group for people based in a residential care

setting. This report, therefore, complements the Health Scrutiny Panel's Final Report into Vulnerable Older People.

Introduction

2. Social Care for Older People, how it is provided and how it is funded seems certain to be a topic of significant national debate for the foreseeable future. It is a matter of fact that the United Kingdom has an ageing population and a greater proportion of that population will fall into the over 65 and over 85 categories. This is something that society should be proud of. It aptly demonstrates that people's standard of living, together with advances in medical science mean that people are living longer lives.

3. It does, however, raise questions for society to face. As people live longer, perhaps with conditions that historically they may not have survived, they require more care and that care comes at a cost.

4. It is widely accepted that a combination of tighter public spending and an ageing population bring about hugely significant pressures on the Health and Social Care system. Before considering the situation in Middlesbrough, the Panel felt it important to consider recent developments in thinking around the topic. According to the Dilnot Report[1], in 1901 there were just over 60,000 people aged 85 and over in the United Kingdom. Today, there are 1.5million- which represents a 25-fold increase.

5. Against this backdrop of hugely significant population change, there seems to be a growing consensus that the current system of social care, its structure and the methodology employed to establish its level of funding, is in significant need of reappraisal. As Dilnot says:

The current system is neither fit for purpose today, nor for coping with future pressures. [2]

6. The Dilnot Commission argues that the adult social care funding system is still operated against a framework conceived in 1948, which is not fit for purpose in the 21st century and is in urgent need of reform.

7. Dilnot outlines the dilemma facing people who find themselves requiring social care. Dilnot makes the point that having to cope with a care and support need, tends to come as both an emotional and financial shock. This is particularly so for people who have long experience of a NHS which is free at the point of delivery. The Dilnot report also makes the point that many people, when they are exposed to England's Social Care system find it inherently unfair. It points out that this is particularly the case when people have to sell their homes,

[1] Fairer Care Funding – The report of the Commission on Funding of Care & Support, July 2011. See Page 17.
[2] Ibid

or use the majority of assets they have built up, to pay for their care. Dilnot argues that the current system does not encourage or reward saving and is poorly understood. Further, people are not prepared, which can often lead to "poor outcomes and considerable distress"

8. The Dilnot report provides the following text to describe the current funding system

Today, the social care system in England provides care and support through a means-tested system, which is delivered at the local level by local authorities. Very broadly, under this system, people with assets over £23,250 receive no financial state support and need to fund their own care. The level and type of state support for people with assets below this threshold depends on their needs and income. There are currently different rules for domiciliary and residential care. In residential care, someone's housing assets (as long as there is no dependant still living in the home) are taken into account in the means test. The Government currently spends £14.5 billion per annum. on adult social care in England. Just over half of this is on services for older people[3].

9. The Dilnot report is keen to stress that genuine progress has been made in the way care is delivered and people now have much more choice and control, leading to greater independence and improved outcomes. It is, however, the way that social care is currently funded that Dilnot identifies major problems with.

10. Dilnot goes on to say that, in the view of the commission, a widely held consensus exists that fundamental reform is urgently needed. Indeed, the report argues that without such reform, the current system will

"Deliver ever poorer outcomes for individuals and families"[4]

11. One of the Dilnot report's major criticisms of the current system is that people can be exposed to very high care costs. By way of evidence the report highlights that around 1 in 10 people, at age 65, face future lifetime costs of more than £100,000. This can often require people to sell their homes and lose the majority of their assets.

12. One of the key reasons that the system requires people to utilise their assets to such an extent is, in the view of the Dilnot report, that the current social care system is "inadequately funded".

13. It reports that funding of social care for older people has not kept pace with that of the NHS. In the 15 years from 1994/95 to 2009/10, real

[3] Page 11
[4] Page 12

spending on adult social care increased by around 70% for older people. Over the same period, real spending in the NHS has risen by 110%. Dilnot makes the point that this needs to change, as when considered in its entirety, more pressures will be placed on the care and support system with the likely net result that care will be adversely affected.

14. A central tenet of the Dilnot report is that the current system of social care in England delivers inconsistent services. As evidence for the argument, the report highlights that there are currently 152 different adult social care systems in England – one for each local authority, which creates inequity of entitlement to service and a 'postcode lottery' of care. To contextualise the matter, Dilnot points out that

Each local authority carries out a financial assessment of what the person can afford to pay. For residential care there are national regulations on charging, but for domiciliary care local authorities can design their own charging policies within the overall national guidance, this leads to variation.

As we gathered our evidence, we concluded that the current approach to setting eligibility and assessing care – FACS – lack transparency, consistency and clarity. Although it takes into account a wide variety of factors, it does not seem objective. In particular, people are not able to work out for themselves whether or not they are likely to be eligible for local authority support and whether they have been dealt with fairly.[5]

15. Dilnot goes on to highlight that such a national system results in many people being unaware of how the system operates. The Committee points out that a scenario is created where many people believe they will receive free care in later life and are shocked when they discuss the 'scale of their financial liabilities' at the point that care is required. Dilnot states that

The state does not offer protection beyond the means-tested system and there are no financial products on the market to help people prepare in advance for future costs of care. The result is that many people do not plan for meeting future care needs[6].

Pressures on the system

16. As mentioned earlier, Dilnot states that the current system is neither fit for purpose today, nor for coping with future pressures. It is highlighted that in 1901, there were just over 60,000 people aged 85 and over in the United Kingdom. Today there are 1.5million, this represents a 25 fold increase.

[5] page 15
[6] page 16

17. It is highlighted that figures from the Office of Budgetary Responsibility show that UK public spending on long term care (on the current unreformed system) is expected to increase from 1.2% (2009/10) to 1.7% (2029/30) as a percentage of total gross domestic product (GDP). This is growth of 40%- faster than any other area of age related public spending – and is largely driven by demographic change.

A new Social Care Settlement?

18. Dilnot argues that the

overall objective for reform should be to enhance the wellbeing of individuals, families and carers, support people of all ages on achieving the outcomes they want from their lives and treat them with dignity and respect[7].

19. The report makes the point that to achieve the above aim, a reformed funding system should

19.1 Offer protection to everyone against the risk of high care costs and be clearer, helping people to plan and prepare, and encouraging saving;

19.2 Support everyone in making their personal contribution by opening up a viable space for financial products, supporting carers and providing targeted state support; and

19.3 Be better aligned with other elements of the care and support system to form a more streamlined and integrated system in which delivery is shaped around individuals, not services.

20. Dilnot makes the argument that capping the costs of care benefits everyone.

We think the best way to reform the adult social care funding system is for the state to step in and take responsibility for the area of greatest unpredictable risk. This approach means that individuals would need to take responsibility for their own costs up to a certain point, but after this, the state would pay. We see our proposals as a type of social insurance policy, with a significant excess that people will need to cover themselves.

A minority of people would reach the level at which the state steps in – these would be those with the highest care needs over the course of their lifetime. However, everyone would benefit from knowing that, if they ended up having to face these costs, they would be covered. We believe that by removing the fear and uncertainty inherent in the current

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system, people would be encouraged to make sensible preparations for the future. The approach would create a new space for financial products, which could support people in making their individual contributions. [8]

21. The Dilnot Commission Report goes on to outline how it envisages a 'new model of shared responsibility'. It argues that, under its proposed system, the following elements would be key points

21.1 The contribution individuals are expected to make in meeting the cost of care will be capped.

21.2 Those who cannot afford fully to make their contribution would continue to receive means tested support, which will be extended. Dilnot recommends that the upper threshold within the residential care means test should be raised from £23,250 to £100,000.

21.3 Everyone would be entitled to universal disability benefits (which will also support people in addressing lower care and support needs)

21.4 Those in residential care would be expected to make a contribution to their general living costs, just as they would be expected to meet the costs of living in their home.

22. The Dilnot Report argues that its capped costs scheme would work as follows

22.1 Everyone with a care and support need can ask to be assessed by their local authority

22.2 If they are assessed by the local authority as having some care needs above a defined, national set threshold, the local authority will work out how much it would cost to meet these needs. This would be based on the cost of a typical local authority package for that level of care, in that local area. If the individuals income and assets are low enough, means-tested support would be given.

23. For those not entitled to means-tested support, the local authority would use this assessed care package to determine at what point in time the individual would meet the cap. After this point, the individual would be eligible for free care from the state.

24. If someone's needs change, they can be reassessed and the time taken to reach eligibility for free support adjusted accordingly. The state funded care element will be based on a local authority care package, but people will be free to top up from their own resources, should they wish. If someone moved to a different local authority, they would take with them a record of their contributions to date.

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25. On the point of capping risk, the Dilnot Commission is clear in its view that protecting people from high care costs benefits everyone. The Commissions argues that

Everybody currently faces a high degree of uncertainty over the future costs of Social Care. At present, neither the state nor the private sector offers people the chance to protect themselves against these potentially very high costs. People are faced with a very significant risk that they can do little to avoid or mitigate.

Given this, our recommended approach is that individuals should take responsibility for their own care costs up to a certain point but, after this point, the state should pay. We see our proposals as a type of social insurance policy, with an excess that people will need to cover themselves. We are proposing that risks are pooled, so that the cost of an individual with very high care needs is shared across the population.[9]

26. The Dilnot Commission also made interesting comment on Deferred Payments. In the case of a deferred payment, local authorities agree to pay in advance for care if individuals cannot afford to do so without selling their home; then recoups the money when the house is sold.

27. The Commission reports that according to evidence submitted to it, the availability and use of deferred payment schemes is 'patchy'. Dilnot points out local authorities do not have to offer deferred payments, although they are encouraged to do so. Local authorities are also not currently able to charge interest on the loan and therefore running the scheme brings a cost.

28. The Dilnot Commission argues that as a minimum, the current deferred payment scheme should be extended so that it is a full and universal offer across the country. It argues

Anyone who would be unable to afford care charges without selling their home should be able to take out a deferred payment. In making this change, we believe it would be sensible for local authorities to be allowed to charge interest to recover their costs, to make the scheme cost neutral, and to remove the disincentive they currently face in promoting the scheme. The Government may decide that it wishes to extend the deferred payment offer further so more people could benefit from the scheme.[10]

[9] Page 30
[10] Page 41

A clear, national offer

29. The Dilnot commission is quite clear in arguing that a new and clearer national offer should be developed. It is pointed out that under the current system, each local authority can decise the level at which people are entitled to state support. Assessment processes are different and charging practices vary.

30. It goes on to highlight that the result of such variability is that people in very similar circumstances, with similar levels of need and financial resources, can be treated very differently and experience vastly different outcomes. Access to social care is often labelled a 'postcode lottery' and is seen as unfair. The level of variability adds complexity and leads many to be confused about how the system works.

31. In addition, Dilnot points out that local variability means that people are unable to take their assessments with them should they move and their local authority changes, meaning a new set of assessment processes. This does not carry any guarantee that they would receive the same level of care.

32. Dilnot also criticises the transitional arrangements between local authorities, which can mean that people are not even able to take their current assessment with them and use it until the new local authority completes their assessment. Dilnot is quite clear that this should change and that there should be a clearer, more objective eligibility framework and portable assessments.

33. As such, Dilnot argues that eligibility for social care should be set nationally, which would ensure that wherever people live in the country, they can expect to start receiving state support when their care and support needs reach the same point.

34. Despite advocating the establishment of national eligibility criteria for Social Care, Dilnot report is quite clear in its report that the delivery of social care is best commissioned and delivered at the local level. This is because local authorities are held accountable by their local populations for the services they deliver, and can take a strategic approach to the delivery of services.

35. Dilnot argues that local authorities are best placed to match service provision to the needs of their local population, to support individuals in purchasing the services they want, to ensure high quality provision, and to shape the overall market. Dilnot does argue, however, that local authorities should work with colleagues in the NHS and public health, with the best local authorities seeking to engage fully with the community in designing and planning services.

36. The Dilnot Commission's Report also strongly supports the concept of local authorities having a duty placed upon them, to stimulate and shape the market for services. It argues that if people are to have choice and control over their care, and design personalised packages, it is necessary for there to be a range of high quality services. The Commission is also keen to point out that this would also demand that the sector be adequately funded.

37. The Dilnot report concludes that:

The current funding system for adult social care is not working. It is widely perceived to be unfair, it is under-resourced and many people are not receiving the care and support they need. In addition, it is difficult to understand and, even if people want to try and prepare for the future, there is little action they can take. The system is highly variable across the country, and services often do not work well together.

We urgently need a new settlement – one that takes away people's fear and anxieties about the future, and helps them prepare for later life; one that better supports younger people with a care and support need to live active, independent lives; and one that recognises and encourages the valuable contribution made by carers.

We believe that our proposals are fairer than the current system. There is a clear national offer, which should be backed up by better information and advice. The system facilitates choice and puts people in control. By focusing resources on those with the greatest need, while enhancing the wellbeing of everyone, it offers value for money. It is sustainable and resilient in the longer term. It is a better deal – one fit or today and tomorrow.

Funding Social Care in the future is going to require more resources, both to address existing and future pressures and to implement the necessary reforms to improve the system. The extra resources will need to come from the state, from individuals and from carers, but we believe our proposals better balance the relationship between the three. By targeting public funding in the right place, we can assist individuals in making their financial contribution and support carers in their vital role.[11]

A Parliamentary Perspective

38. An important aspect of the national debate on the future strategy and funding arrangements for social care is the publication of the House of Commons Health Committee's report into Social Care.

39. The Health Committee's rationale for considering the issues facing the future of social care, was to make recommendations for consideration

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by the Government in advance of the publication of its White Paper on social care. The Health Committee points out that whilst social care's workload tends to be dominated by people aged 65 or over, social care is of equal importance to younger people with a disability, as well as people who have long term conditions.

40. The Health Committee commences its study by stating that

A high proportion of people require care and support at some point in their lives. Whilst families, neighbours, friends and informal unpaid carers are the main providers of this care, many people will also need to turn to the formal social care system[12]. Unlike the services provided by the NHS, which are largely provided free at the point of need, social care services are subject to a means test and many people will be expected to pay for some or all of their care and support. This comes as a shock to many. It also serves to sustain the artificial distinction between health and social care services, making joined up, integrated care more difficult to achieve.[13]

41. The Committee goes on to say that

The existing, fragmented systems are both difficult to use and expensive to provide, and funding for them (which comes from a multiplicity of sources, including local and national government spending programmes as well as private sources) is coming under increasing pressure from England's ageing population. The quality of services delivered and the outcomes achieved are highly variable[14].

42. The Health Committee makes a deliberate point of attempting to identify who the typical service user of social care is. It identifies them as individuals with long term and chronic conditions that require co-ordinated packages of care to allow them to lead fulfilling lives. The Committee points out that this group is around 29% of the population, yet 50% of all GP appointments and 70% of all inpatient bed days.

43. On the basis of evidence from the NHS Confederation, National Housing Federation and the Nuffield Council on Bioethics, the Committee presents a strong argument that many older people and those with disabilities and long term conditions need to access different health, social care, housing and other services, often simultaneously.

44. The Committee argues, however, that there is also clear evidence that such services are fragmented and those who need to rely on them often find that they are hard to access and that there are inadequate

[12] In 2010–11 there were 1.15 million people using the care and support system provided by councils in England, and 2.12 million contacts from potential new clients, The NHS Information Centre for Health and Social Care*, CommunityCare Statistics: Social Services Activity, England* 2010–11, provisional release, p 3

[13] Page 5

[14] Page 5

links between them, resulting in multiple assessments of older people. In the Health Committee's view

The result is that assessments are duplicated, opportunities to provide necessary help are not taken and the condition of individual patients deteriorates in many cases where this did not need to happen. Apart from a few notable exceptions, the provision of services to individuals takes place in unconnected silos – by the NHS, by local authorities and by the voluntary and independent sectors. The BMA told us that because of England's ageing population and increasing levels of long term conditions "there are dangers in creating fragmented services that separate their management from others within the system".[15]

45. In the Health Committee's view, the 'silo' mentality among service providers is reinforced by the fragmentation of commissioning budgets. It highlights that instead of looking at their services from the perspective of the service user, and challenging providers to deliver 'joined up' and efficient services, the development of separate commissioning budgets for health, social care, housing and other services has tended to entrench the fragmentation of services.

46. The Health Committee is quite clear that a direct link exists between the fragmentation of services and the fact that there are multiple funding streams and multiple commissioners.

47. The Health Committee points out that in its view, a key aspect of the fragmentation debate is the distinction that has been drawn between what is health care[16] and what is social care[17]. The Committee argues that whilst the distinction is often discussed, it is poorly understood and arises from a 'succession of political compromises stretching back to the 1920s.'[18]

48. On this point, the Health Committee highlights evidence submitted by the Kings Fund that that despite its importance, the integration of health and social care services has been a matter of debate for decades. The Kings Fund suggested that

    Integrated care has been a recurrent goal of public policy under successive governments for more than 40 years[19].

49. Indeed, the predecessor Health Committee reported the following in its 2009/10 report into Social Care.

[15] Page 7
[16] Those services commissioned and largely delivered by the NHS
[17] Mainly Commissioned by local authorities and individuals, and provided by many different sources.
[18] Page 10
[19] Page 10

50. There was growing concern in the 1960s about the lack of co-ordination of health and social services. This led to the appointment of the Seebohm Committee on Local Authority and Allied Personal Social Service, which reported in 1968. It commented that 'although for many years it has been part of national policy to enable as many old people as possible to stay in their own homes, the development of the domiciliary services which are necessary if this has to be achieved has been slow' partly due to the shortage of appropriately trained social workers. It recommended new, unified social services departments to assess local needs and resources and plan accordingly, taking account of and supporting the contributions of independent organisations, relatives and neighbours. The report stated: services for old people in their own homes will not be adequately developed unless greater attention is paid to supporting the families who in turn support them…. If old people are to remain in the community, support and assistance must often be directed to the whole family of which they are members.

51. The Health Committee cites an article on the issue of integration, highlighting that once the decision had been made to separate health (NHS) and local authority (social care) provision and commissioning in the 1970s, plans were developed to bring about more collaboration:

This exercise led to a number of statutory provisions, some of which remain in force today. The package included requirements for each authority to make its respective professional services freely available to the other and forbade them from directly employing staff from professions allocated to the other. In addition, on the grounds that collaboration was 'too important to be left to good administrative practice', it proposed that health and local authorities should work under a statutory duty to collaborate through a statutory Joint Consultative Committee (JCC).[20]

52. The Health Committee also points out that provisions in the National Health Service Act 1977 advise Area Health Authorities and local authorities on the performance of their duties, and 'on the planning and operation of services of common concern'. The Health Committee is very clear in pointing out that the Health & Wellbeing Boards will resurrect such a 'bridging' function.

53. The Health Committee highlights how integration of commissioning and service delivery of health and social care has never really being established as well as successive governments have intended. Nonetheless, if it is done well, it could save significant amounts of money and service capacity.

54. This Governments vision for health and social care highlights the clear benefits from integrated health and social care. The Government has stated its intention to:

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Identify and remove barriers to collaboration and to pooling or alignment of budgets across health and social care and bring together funding streams for employment support and consider the barriers to market entry for micro and small social enterprises, user led organisations and charities, and the proposed role for Monitor to play in market shaping'.[21]

55. The Health Committee is keen to ensure that sufficient attention is paid to the financial challenges facing health and social care. Particularly, how better integration can lead to better outcomes and noteworthy savings. Much attention has been paid to the challenge for the NHS to save around £20billion by 2015 and what that may mean for services. It quotes a recently published joint report by the Kings Fund & Nuffield Trust, saying that

Put simply, integrated care should become the main business for health and social care[22]***.***

56. There is strong evidence to indicate that the successful delivery of such exacting efficiency standards whilst protecting service quality, will require fundamental changes to the way health and social care services are delivered. However, the Health Committee highlights that according to the Audit Commission

"analysis of adult social services efficiencies in 2009-10, and those planned for 2010-11, shows that integration and working more closely with the NHS was one of the least common ways of achieving savings."[23]

57. The Committee is quite clear that the implications of not achieving sufficient levels of integration in both commissioning and provision are clear. For the individual they mean more disjointed care, more hospital admissions, later discharge and poorer outcomes. The Committee also notes that the consequences for health and social care economies as equally severe, given the pressures created by an ageing society and efficiency targets. David Nicholson, Chief Executive of the NHS has said that

"if an acute hospital thinks they can carry on as they are and, in a sense, salami-slice their service through efficiencies, it will not work for them. They will have more and more difficulty. They increasingly need to look at how they integrate with health and social care and to think about what sort of organisation they are going to be"[24]

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[22] Page 13
[23] Page 13
[24] Page 14

58. On the point of ensuring efficiencies and congruence of service commissioning and provision, the Health Committee makes a bold suggestion.

The recent Future Forum report on integration states that services must be integrated "around the individual". However, the current system has multiple commissioners and multiple funding streams. The policy has been to tolerate separate services and seek to build bridges between them. Given the failure of that approach, a single commissioner should now be established to create integrated services. [25]

59. As such, the Committee argues that when commissioning responsibilities are divided between different bodies, the effect is to undermine the ability of the system to deliver truly integrated services. It asserts that each commissioner is inevitably subject to different pressures and priorities, with the result that it becomes impossible to focus on the key objective, which must be to integrate services around the individual.

60. Having made that point, the Committee warns against a disruptive and costly structural reorganisation to deliver a more joined up unified approach to commissioning. Rather, it argues that a policy objective of more unified commissioning process is a more important consideration than structures. As the Association of Directors of Adult Social Services submitted to the Committee:

…any integration must be bottom up rather than purely just England-wide prescribed structural reform. The dynamic of localised commissioning provides the vehicle for real integration which is referenced against a localised JSNA and articulated as a local Health & Wellbeing Strategy, subject to local democratic scrutiny and endorsement[26]

61. The Committee highlights the high levels of support from local government, and the Future Forum, for the creation of Health & Wellbeing Boards and the role that they could play. Indeed, the Future Forum argued for them to be given more powers than they were initially envisaged as having.

62. The Committee argues that Health & Wellbeing Boards should have a fundamental role in bringing together commissioning processes for the benefit of more streamlined services. It argues that:

We note, however, that the Government has not encouraged the development of the HWB as the holder of a single integrated budget. The Committee believes this could be a lost opportunity. In those areas where good working relationships have been established between NHS

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[26] Page 15

and social service partners, HWBs would seem to represent an obvious starting point for a radically strengthened commitment to integrated health and social care commissioning[27].

63. It is emphasised again, however, that this should be done within existing structural plans.

The Committee does not, however, support the imposition of a single statutory framework for the achievement of the objective of service integration. It proposes, instead, that the Government should place a duty on the existing commissioning structures (including the proposed new NHS structures) to create a single commissioning process, with a single accounting officer, for older people" health, care and housing services in their area[28].

64. The Committee goes on to say that

A single commissioner will have multiple lines of financial accountability, including to the NHS Commissioning Board, local authorities and service users. Central Government, NHS bodies and local authorities will need to establish robust procedures to ensure effective financial accountability.

The holder of a single commissioning budget will also need to demonstrate proper local democratic accountability for its decisions. The Committee sees the development of the Health & Wellbeing Board, as an agency of the local authority, as a means of achieving this objective.[29]

65. The Committee is keen to emphasise that without such integration of commissioning decision making and funding, it is always difficult to ensure that services (and their funding) appropriately react to the needs of the patient. The Committee cites the findings of *the Partnerships for Older People*, which states

Moving monies around the health and social care system was a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation. For instance, monies could be moved from residential care budgets to home care budgets within a local authority, but a claim for monies by a local authority from either primary or secondary health care budgets did not prove possible[30]

66. The Health Select Committee also explores in some detail the funding issues facing the Social Care system and particularly the concept that the amount of expenditure on older people's services, has not kept up

[27] Page 16
[28] Page 16
[29] Page 17
[30] reference

with demand. Indeed, the Health Committee quotes the Dilnot assessment that over the last four years demand has outstripped expenditure by around 9%. The Health Committee is quite clear that:

Many witnesses to our inquiry have restated that a crisis in funding exists within social care. The Local Government Association has stated that "…the current system is underfunded and has been for many years. The demand is growing and, therefore, that gap is growing. That is a case the Local Government Association, and indeed others, have been making for a long time[31].

67. The Association of Directors of Adult Social Services advised the Health Committee that

…the gap has never been disputed. The gap exists… what we try and do is avert the collapse of social care by constantly trying to re-examine what we do in the absence of the reform and resources that we have clearly asked for, for some time.[32]

68. On the same point, the Kings Fund says

The squeeze on local authority budgets over the next four years will see a widening gap between needs and resources. As we indicated in our evidence to the Committee's previous inquiry into public expenditure, despite the additional £2billion announced in the Spending Review and the best intentions of local authorities to protect social care, a funding gap of at least £1.2billion could open up by 2014 unless all council can achieve unprecedented efficiency savings. Since then, the ADASS budget survey shows that there will be almost £1billion less in adult social services budgets this year, of which councils aim to recover £681 million from efficiency savings. This is a very ambitious target when taking account of efficiencies already achieved in recent years.[33]

69. The notion of a funding gap is not accepted by the Government, with the Minster of State for care Services telling the Committee that

The point I am making is that there is no gap. There is no gap in the current spending review period on the basis of the money that we are putting in plus efficiency gains through local authorities redesigning services […] we don't accept the position that there is a gap. We have closed that gap in the spending review.[34]

70. The Local Government Association, upon hearing this statement, responded by saying

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[33] Page 21
[34] Page 21

It is deeply worrying that despite the best efforts of Councils, leading charities and the government's own experts, the message that we are facing a financial crisis still doesn't seem to be getting through[35]

71. In response, the Department of Health advised the Committee that an additional £2billion a year (compared to pre 2010 levels) will be available for social care by 2014-15. It argues that this, when taken with the 3.5% a year efficiency savings that local authorities are being asked to make, means that there is no funding gap for social care.

72. Against this, the Local Government Association has told that Health Committee that in 2011-12 "the (social care) service's budget has already been reduced by nearly £1billion".

73. Age UK pointed out to the Committee that that

Councils have reduced their spending on older people's social care by £671m in real terms in the year between 2010-11 and 2011-12. This is a decrease of over 8% […] Even after adding the £330million transferred from PCTs to the amount spent by local authorities, the overall effect is still a real decrease in spending on older people's social care of £341million, or around 4.5%.[36]

74. Inextricably connected to the debate around the amount of money available, is the debate about the quality of service on offer. The Health Committee quotes several sources of evidence that would seem to suggest that the quality of social care is highly variable. Age UK advised the Health Committee that

The whole area of quality, both in care homes and domiciliary care, is key. There are huge issues around the funding of care being in crisis, but there is a deeper and hidden crisis around the quality of care[37].

75. The Health Committee argues strongly that

The weight of evidence that we have received suggests that social care funding pressures are causing reductions in service levels which are leading to a diminished quality of life for elderly people, and increased demand for NHS services. Although the transfer of £2billion from health to social care is welcome, it is not sufficient to maintain adequate levels of service quality and efficiency[38].

76. The Health Committee argues that it is time to make a new offer to the country's older people. The Department of Health has told the Health Committee:

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[35] Page 22
[36] Age UK, Care in Crisis 2012, 30 January 2012, page 1.
[37] Page 23
[38] Page 24

The state of current adult social care legislation has been roundly criticised as opaque, complex and anachronistic. Over 60 years, a patchwork of legislation has grown and evolved, with more added from time to time to mould the framework to different policy objectives, but without any substantial reform. There are now around 30 different pieces of legislation which relate to adult social care, with the base statute still the 1948 National Assistance Act[39].

77. The Health Committee argues that such a difficult legal landscape not only makes it very difficult for professionals to navigate the system, but it makes it practically impossible for service users and carers to manage. The Local Government Association has said that

78. With a range of assessments, means and needs tests, charges, eligibility and interactions with other systems (such as health and benefits) the adult social care system is incredibly confusing for the individual. And as legislation has developed piecemeal over time it is also often confusing for practitioners, with different aspects of adult social care codified in primary legislation, statutory instruments or set out in guidance. This level of complexity in the current system is unsustainable for the future.

Evidence from Department of Social Care – 2 February 2012

79. The Panel was keen to consider the views of the Department of Social Care on a few key questions that the Panel had identified as key to this piece of work. Those questions were

79.1 How do care providers cope with patients/residents with Dementia?

79.2 How do care providers ensure that people are treated with dignity and respect?

79.3 What provision is in place for feeding assistance for residents who require it?

79.4 How do care providers ensure that staff are appropriately skilled to deal with the cases they are expected to deal with?

79.5 How will tightening public resources, for the foreseeable future, impact on care for vulnerable older people?

79.6 What are the long term issues facing the care of vulnerable older people?

80. The Panel opened the discussion by raising the topic of Dementia and specifically, care homes dealing with patients with Dementia. The Department of Social Care advised the Panel that the way in which

[39] Page 35

care providers coped with patients/residents with Dementia varied according to the provider. Some providers provided specialist units offering alternative therapies, with staff specifically trained to deal with patients/residents with Dementia.

81. The Panel was advised that some providers, on the other hand, do not have specialist staff to work with patients with Dementia. As a consequence, care workers without the necessary training are expected to care for those patients who present challenges to both residents and the staff. The Panel noted with concern that care home providers can simply extend their registration to cover those with Dementia. As such, the net result can be that people with severe Dementia can be cared for in non-specialist environments, by generalist staff. Further, the CQC no longer has a requirement that patients with Dementia are accommodated in specialist sections of homes. The Panel was also advised that a Care Home Provider Forum was due to be established to enable providers to share best practice and raise awareness of the issues surrounding caring for patients with Dementia.

82. Members were interested to learn that the Four Seasons group had introduced the PEARL (Positively – Enriching – And Enhancing – Residents – Lives) system, with accredited homes specialising in Dementia care where a specific project manager supports Dementia care home managers to improve practice[40].

83. It was highlighted that the Care Home Liaison Team funded by Tees, Esk & Wear Valleys NHS Trust also provided support to care homes in terms of offering advice, training and support from fully qualified, skilled nurses to assist staff in dealing with patients with Dementia. It was confirmed that the nurses worked with patients and staff, on a one-to-one basis, and also delivered a number of training sessions to the care homes to increase staff awareness about difficulties experienced by those diagnosed with Dementia. It was confirmed that the Care Home Liaison Team also raised any issues of concern with regard to gaps in training and care plans with the Department of Social Care.

84. On the point of training, the Panel heard that as a commissioner of services, the Department of Social Care will stipulate that certain training requirements are part of its contract with providers and those requirements are monitored by review officers. As part of the annual review, training in the care homes was monitored and training records were also checked for accuracy. Staff at the homes, were required to complete a staff survey form and the results of the latest staff surveys had indicated that when asked if staff were provided with the appropriate training to carry out their job, 90% of staff had responded positively. Similarly when staff had been asked if they received appropriate training in respect of risk assessments and care planning the figures had been 90% and 92% respectively.

[40] http://www.fshc.co.uk/our-services/care-types/PEARL-Dementia-care

85. The Panel heard that of the 29 care homes located in the Middlesbrough area, 16 had dedicated Dementia units. Members were advised that care home providers were only required to register the building itself in order for the care home to be eligible to be registered to care for Dementia patients.

86. The Panel raised a question around whether all the care homes were equipped to deal with the changing needs of an ageing population and specifically whether care homes were sufficiently prepared for present needs, as opposed to historical ones. Specifically, it was highlighted that many elderly people lived independently for longer in their own homes, so when they are eventually admitted to a care home they had more intensive care needs. The Panel was advised that the Quality Tool used by the Department of Social Care, recognised the need for providers to be re-educated about the facilities and training required to meet the increasing care needs of the ageing population.

87. Reference was made to the NHS' Continuing Healthcare funding (CHC) obtained through NHS Tees. The Panel was advised that CHC was free care outside of hospital, that was arranged and funded by the local NHS. It was only available for people who required ongoing healthcare and met the eligibility criteria. If a resident in a care home was eligible for continuing healthcare, they would be entitled to the cost of their care home fees, including the cost of accommodation, personal care and healthcare costs.

88. It was stated that that there were some difficulties in obtaining the funding as to be eligible for CHC, the person had to be assessed as having a "primary health need" and have a complex medical condition and substantial and ongoing care needs. The Panel heard that the Department of Social Care, was trying to obtain assistance to help residents with the appeal process in respect of refusals of funding with the help of advocates.

89. The Panel heard that when residents were admitted to a care home, they were assessed to ascertain what their requirements were in terms of health, dietary requirements and personal care and a care plan was drawn up by the care home. It was confirmed that residents should be monitored on a daily basis and any concerns such as fluctuations in weight, feeding problems, mental health problems or physical ailments were recorded on the care plan. In response to a query from a Member regarding where the responsibility lay for making referrals to dieticians, doctors and other health professionals, the Panel was advised that the responsibility for such referrals was ultimately the role of the Care Home Manager, but was usually delegated to senior staff at the home for practical reasons.

90. The Panel was advised that if the Department of Social Care had any concerns regarding the operation of a care home, it was within their remit to suspend local authority funded placements, if it fell below the

required standards. The Department could be alerted to concerns from Council professionals such as Social Workers, staff or residents at the home, the PCT, District Nurse or a member of the Care Home Liaison Team.

91. It was confirmed that the Department of Social Care could carry out an unannounced inspection visit, to investigate any concerns about a particular care home. It was reported that when a care home was the subject of a suspension order, the Department of Social Care could try and prevent other residents from being admitted to the home by advising potential residents of the suspension. Still, if self-funders or service users funded through the local authority chose to ignore the advice of the Department of Social Care, then they could still be admitted to the home. It was highlighted, however, that it was the responsibility of the care home provider to write to existing residents of the home, or their relatives, to advise that the care home was under suspension and the reasons for that suspension.

92. The Panel noted that it was not always the fault of the care provider, if a home was placed under suspension. Care homes could be placed under suspension because of an outbreak of a virulent or contagious disease, such as Norovirus.

93. The Panel was keen to establish about how self-funders' interests would be protected, in the case of a care home being suspended. The Panel heard that the Department of Social Care did not have any authority to inspect any correspondence sent by the care provider to self-funders although they could speak to the residents themselves regarding any concerns about a home. If the Department of Social Care had any serious concerns regarding the wellbeing of a resident, it could arrange for a Social Worker to carry out a review of the resident, with a view to removing them from the care home. It was confirmed that Middlesbrough has sufficient care home spare capacity to deal with such events. Indeed, the Panel was advised that the Council has a broker team who operated a vacancy list in respect of Middlesbrough care homes.

94. The Panel heard that in the previous 12 months, 4 care homes in Middlesbrough had received suspension orders, although 3 of those suspension orders had since been lifted. When a care home was subject to a suspension order, the Department of Social Care issued a report with recommendations to assist the care home to 'get back on track'.[41] A copy of the report would be sent to the CQC, the manager of the care home and the care home provider. In addition, other local authorities in the north east were advised when a suspension of placements was made. It was confirmed that when a care home had a suspension of placements imposed, the Department of Social Care

[41] It should be noted that report outlining recommendations for action takes place after every assessment of a home, irrespective of whether placements have been suspended.

visited the home as often as was required. This could even be on a weekly basis to ensure that any recommendations contained in the report were being implemented.

95. The Panel was advised that as part of *Fair Price for Care*, every year the older persons care homes in Middlesbrough are awarded a Quality Star Rating based on 5 stars being excellent and 1 star being poor. The Quality Star Rating assessment score was made up of the following elements:

95.1 The Contract Review (up to 20 points awarded);
95.2 The standard of the accommodation and grounds (up to 30 points awarded);
95.3 The quality of the service based on the views of the staff (up to 10 points awarded);
95.4 The quality of the care service based on the views of resident's relatives and representatives (up to 20 points awarded);
95.5 The quality of the care service based on the views of residents of the home (up to 20 points awarded).

96. The total score for each element was then added up to determine the overall rating of the home. The star rating of a home determined the price that the Council was willing to pay per week for care. Members were advised that the *Fair Price for Care* was negotiated with the care providers. The price was determined by calculating the overall expenditure incurred in running a care home with a slight profit element built into the price.

97. Members were advised that the current Grades of the care homes located in Middlesbrough and the price rate that the Council was willing to pay in respect of places in those care homes was as follows:

Grade	**Price**	**No of homes in Band**
Grade 1	£417 per week	0
Grade 2	£427 per week	7
Grade 3	£437 per week	16
Grade 4	£447 per week	6
Grade 5	£457 per week	0

98. The Panel was advised that all the price rates in respect of places in care homes had been frozen for the first time the previous year because of the economic downturn. It was noted, however, that there was concern expressed about the impact on the quality of care, should

a further price freeze be imposed for the following year. It was reported that the problems posed by this would be particularly acute for care providers with premises located across a number of local authorities. The Panel expressed concern that if efficiencies were made within care home in terms of domestic staff or activities co-ordinators, then the dedicated care staff may have to carry out additional domestic tasks, which could detract from the quality of their care duties. This was acknowledged by the Department of Social Care as a concern that would require close attention.

99. The Panel made an enquiry as to whether potential residents were provided with a checklist of what to look for when choosing a care home or good questions to ask before choosing a care home. The Panel was advised that the Department of Social Care produces a Care Homes Brochure for Older People. The brochure includes a list of care homes in the Middlesbrough area and details of the different services that each home provided in terms of residential care, nursing care, elderly Dementia care, elderly Dementia nursing or respite care. A checklist was also provided which included questions to ask regarding first impressions of the home, quality of accommodation, quality of life within the home and suggested questions to ask about the proposed fees and contract terms in relation to the care home.

100. The Panel also suggested that the checklist include additional questions on details of any periods of suspension for any particular home and questions in relation to staff turnover, qualifications and training of staff and the types of support that staff and managers received from the organisation and the care provider.

101. Reference was made to the Citizens Portal set up by the Department of Social Care and Members were advised that details of any care home suspensions could be included on the portal, along with any subsequent downgrading of care homes. It was suggested that the facility for residents and resident's relatives and representatives to submit reviews on the care homes in Middlesbrough be included as part of the portal.

102. Following an enquiry, the Panel was advised that concerns regarding care homes could be raised via the CQC or direct to the Department of Social Care. Usually if concerns were raised with the CQC, the CQC referred the matter to the local authority to investigate with an expectation that the local authority would report back to the CQC.

103. The Panel was advised that liaison between the CQC and the Council could sometimes be difficult. It was said that when the CQC was undertaking an investigation, the Council did not receive details of the investigation until the CQC had issued the final report on the CQC website. The timescales adhered to by the CQC when carrying out an investigation and the process involved before issuing a report, were also much longer than the timescales set by the Council.

104. Members were advised that the Council did however hold quarterly information sharing meetings with the CQC and on the whole the working relationship between the two organisations was very good.

105. A number of other points were raised with the Panel, which the Panel was keen to have recorded in this Final Report. The model of Care Home provision in this country as a market, which is required to turn a profit is not without its challenges. It can create a downward pressure on the wages of those working in care homes, who understandably seek to earn more and will therefore leave if an opportunity presents itself. This, in turn, can create an environment of high staff turnover which does not particularly benefit anyone, and damages the quality of care. Related to the point of Care Homes operating in a commercial market place, it was reported to the Panel that fewer people are being referred to Care Homes than have been historically, as more people are cared for at home. This creates a pressure on Care Homes' business model that, if taken to its logical conclusion, will damage the sector's ability to survive.

Evidence from Dementia Advisory Service

106. The Panel was keen to gather the views of the organisation providing the Dementia Advisory Service, given the impact of Dementia on an ageing population. As such, representatives from Sanctuary Carr-Gomm attended the meeting, to provide Members with an overview of the work of the Middlesbrough Dementia Support Service.

107. The Panel heard that the Middlesbrough Dementia Support Service had been in operation since August 2010 and in that time had received 310 referrals. Of these cases, 157 had been referred by carers and 153 had received a formal diagnosis, usually by the memory clinic. It was reported that patients were given a choice with regard to who they wished to receive the outcome of their diagnosis, either the patient themselves or their carer. In terms of the breakdown of referrals by gender, the service had received 131 male referrals and 179 female referrals. The Panel was advised that the reason for the vast majority of referrals was for general advice, information, emotional support, advice and information.

108. The Panel heard that the aim of the Dementia Support Service was to offer a support service tailored to the individual needs of the service user. Assistance could include emotional support and advice, referrals to specialist agencies, advocacy and assistance to access training, help to access employment opportunities and support to access welfare benefits.

109. It was reported that when the Dementia Support Service received a referral, a risk assessment was carried out with the service user and an individual support plan and a carer support plan was completed. The

service user was consulted and given a choice in relation to where they wished to be assessed e.g. in their own home or at an alternative venue. Once the support plan(s) had been completed they were passed to a Social Worker to be signed off.

110. The Panel heard that an Individual Support Plan contained a record of the service user's goals and aspirations, details of any progress made and a record of what the service user planned to do next. The form contained a Measuring Change Toolkit which contained 14 sections to assist the service user in deciding what areas they would like to work on such as health, wellbeing, education, basic skills, personal behaviour, benefits and money matters and social activity.

111. In addition, the Carer's Support Plan contained details of how providing care had impacted on the carer's life including the impact on health, relationships, work, social life and daily routine. The Assessor considered what actions needed to be taken to meet the carer's needs and identified risks that could arise as a result of the requirements of their caring role. A risk assessment was then carried out for all the different elements of risk identified and a Carer Support Plan was completed.

112. The Panel was told about the "About me and my care" booklet which had been designed by Sanctuary Carr Gomm to assist in the care of the service user. The booklet contained general information in relation to the service user with regard to personal details such as name, address, date of birth, marital status, next of kin and details of family members and friends.

113. The "About me and my care" booklet also contained sections on medical conditions, allergies and details of any prescription drugs taken by the service user. Details of any communication difficulties, physical needs including details of optician, doctor, whether the person had hearing or mobility difficulties, service user's dental history or details of any prosthetics were also included as part of the booklet.

114. The booklet also contained details of self care needs, routines including bedtime routine, any unusual behaviour and how to deal with it, physical and mental ability, information about socialising, emergency contacts, details of religious needs, whether an advance directive form had been completed and details of the service user's likes and dislikes.

115. The Panel enquired about the staffing for the service. The Panel was advised that there was currently 2 full time employees working for the service, however funding had been obtained to employ a person to carry out Life Story work for 12 months. Members were advised that the Dementia Support Group also worked with the Older Persons' Mental Health Forum and the Young Onset Dementia Team.

116. In terms of the range of activities available for people with Dementia, Members were advised that service users enjoyed a wide range of activities including pub lunch clubs, daytrips, organised Christmas lunches and carer support information was available within the Lifestore in the Cleveland Centre. Service users with Dementia were also made aware of Carelink and Telecare and carers were able to discuss strategies with regard to managing behaviour, such as placing signage in the home to assist service users with Dementia and assistance with Life Story work.

117. The Panel was interested to hear that one of the main problems associated with Dementia was with people refusing to accept support and declining social care assessments, which could then place even more of a burden on those close to a service user. It was reported carers could access support from the Dementia Support Group and receive assistance with claiming carer's direct payments. Carers are entitled to assistance with their own responsibilities, such as cleaning their own home, if they were unable to do this work because of their caring responsibilities. The Dementia Support Group assisted carers in maximising income by providing advice and assistance in accessing benefits.

118. It was highlighted that the Dementia Support Group had in place a local agreement with the DWP[42] which specified that service users with Dementia, or their carers, would receive a home visit from the DWP within 10 days to carry out a full assessment of their benefits. Members were advised that the Dementia Support Service Staff had received a wide range of training from Sanctuary Carr-Gomm and other external agencies. The Dementia Support Service staff sometimes received assistance from student social workers to help with their caseloads. The service had also received funding from the Department of Health to help develop a website.

119. The Panel was advised that the contract for the provision of the Dementia Support Services was due to end in August 2013 and it was presently unclear as to what would happen to the service when that contract expired. The Panel heard that Clients had raised concerns with Sanctuary Carr-Gomm about the fact that many Dementia patients had built up relationships with the current contractors and were concerned about losing good relationships. The Panel also heard that the Dementia Support Service operated 9 GP drop in services per week. In response to a query regarding work carried out in care homes, Members were advised that there was some liaison with care homes. It was highlighted that one care home had written to the Dementia Support Service to acknowledge the value to the home of the "All about me" booklet.

[42] Department for Work & Pensions

120. The Panel heard that the Dementia Advisory service aimed to raise awareness of Dementia and develop awareness training and education. It was reported that client feedback indicated that many service users were concerned about the future welfare reforms and whether the reforms would result in the service user no longer being eligible for services.

121. The Panel enquired how the service measured its success rate. It was reported that the service received regular reviews from the Department of Social Care. In addition, the Dementia Support Service also carried out exit questionnaires and stakeholder questionnaires, which had resulted in very positive feedback about the service.

122. The Chair of Health Scrutiny Panel advised that the Director of Nursing from the James Cook University Hospital was due to attend a meeting of the Health Scrutiny Panel and an invitation was extended to the Dementia Support Manager to attend that meeting.

123. The Panel heard that in terms of the issues facing people affected by Dementia, the person diagnosed with Dementia may refuse help which can place undue stress on the person's carer. It was highlighted that service users with Dementia and their families had also expressed concern regarding the number of different people involved in their care, as this caused the service user added confusion. The Panel was advised that the best model of care for a Dementia sufferer should involve the least number of people being involved, with one key contact liasing and working with other agencies. Members were advised that the key reasons that service users accessed the Dementia Support Service for assistance were emotional support, advice and information.

Evidence from Department of Social Care – 12 April 2012

124. The Panel was keen to speak with senior representatives of the Department of Social Care regarding the future pressures facing the planning and provision of Social Care in Middlesbrough.

125. Initially, the Panel was keen to understand some of the headline budgetary figures facing the Department of Social Care. The Panel had heard previously that the Council had secured a freeze of care home tariffs for its 2012/13 budget. It was confirmed that the estimated saving that this produced was around £400k per annum. The Panel heard that such a saving was crucial to the Social Care budgetary position for 2012/13, which included Commissioning savings of around £1.1 million in total.

126. It was confirmed that the Commissioning element of the Department of Social Care was expected to make savings of around £600,000 for the 2013/14 budgetary year.

127. It was noted with interest by the Panel that residential care represents a hugely significantly element of Council spending, accounting for around 50% of the Department of Social Care's budget and 10% of the Authority's overall budget. As such, debate around price freezes and price changes has significance for the entire Local Authority.

128. The Panel was keen to pursue the question of the impact of that price freeze on care provision and specifically to gather the views of the Department on that point.

129. The Panel heard that a series of workshops were held with providers to enable some of the impact to be considered beforehand. The Panel was advised that the Department did not receive any significant opposition from providers, as it was the first time that the Department had not given an increase to fees. The Panel heard that this is not the case with neighbouring local authorities.

130. It was confirmed that no care homes had ceased to trade as result of the price freeze and, in addition, there has been no identifiable reduction in the quality of care delivered. The Panel was advised that the annual assessment of care quality, an exercise undertaken by the Department of Social Care, has seen little change. Indeed, it was confirmed that from a Contract & Commissioning point of view, the service had not seen any impact of the price freeze, in terms of a reduction in care delivered.

131. That is not to say, however, that providers of care homes across the country have not experienced financial pressures. The Panel was reminded of the cases of *Southern Cross* and the alleged financial pressures faced by *Four Seasons*. It is worth noting however, that such pressures owe more to the particular business model employed by those companies, as opposed to pressures being created by local authority price freezes. Nonetheless, the Panel felt it important to note that significant financial pressures can potentially build in the care system, even in large operators.

132. The Panel was, however, advised that concerns do exist within the Department of Social Care regarding staffing levels in some cases, but this has been an issue since minimum staffing levels were abolished from National Minimum Standards for care provision. It was confirmed to the Panel that the now defunct Commission for Social Care Inspection (CSCI) used to have minimum staff to resident ratios, although this is not now part of the Care Quality Commission's Quality Standards. The Panel was advised that the Department of Social Care has a concern form that professionals can detail any issues that they have with a contracted service. It was reported that in the period October 2011 to the end of February 2012 the amount of concerns received did show an increase of just under 1 per month. The Panel heard that there is nothing to suggest that this is linked to a price freeze.

133. The Panel was advised that Adult Protection Alerts have increased, but there is no indication that this is as a result of lower standards brought about by a price freeze. It was reported that the likely reason for this increase, in the view of the Department of Social Care, is because Alert Training sessions were given to all the providers in the months of October and November 2011.

134. The Panel was interested to explore the possibility of a further price freeze for Care Home providers and specifically, what sort of impact any price freeze may have.

135. The Panel was advised that a further price freeze (to take effect 2013/14 financial year) is extremely unlikely. The Panel heard that a price increase had already been budgeted for 2013/14. In addition, the panel learned of a significant recent court judgement, concerning Sefton Council, where a successful legal challenge to a 2nd year freeze was successfully launched[43].

136. The Panel heard that in the Sefton Council case, they were found to have acted unlawfully when freezing rates paid to providers and failing to have regard to the 'real cost of care' it purchased. Upon analysis of the case[44] it is clear that the actual 'price freeze' of the fees was not the issue and indeed the claimants did not challenge this.

137. It was reported that the grounds on which Sefton Council was successfully challenged, were that Sefton Council had failed to properly assess the true cost of care. The Court found that Sefton had not taken into consideration a full break down of the costs involved in providing services and that they had failed to properly consult with the care home proprietors.

138. The Panel was advised, therefore, that if a decision was made to freeze rates for a further year in 2013/14, there would be a likelihood of legal challenge. Further, it was reported that providers accepted a price freeze for 2012/13, largely with good grace and in recognition of the significant budgetary constraints that the local authority was facing. It would be highly unlikely that such a spirit would be extended to a further year, as providers are also facing a tough economic climate of rising costs and squeezed margins.

139. The Panel heard that in Middlesbrough, a 'Fair Price for Care' was introduced for residential care homes in 2008, in full consultation with the Care Home Providers. It was reported that a number of the independent providers provided the Department of Social Care with their accounts, on which a financial model could be based. The 'Fair Price for Care' included all operating costs, including the repayment of

[43] http://www.bbc.co.uk/news/uk-england-merseyside-15665980
[44] The Sefton Care Association & Ors, R v. Sefton Council [2011]

capital investment, profit and occupancy rates. This Fair Price for Care is linked to a grading system consisting of 5 levels, all of which attract a different fee. It was put to the Panel that by not inflating costs year on year, Middlesbrough arguably no longer had a “proper” assessment of the true cost of care.

140. The Panel was particularly interested in a possible implication of price freezes on top-up fees. It was argued that the freezing of fees for a further year could see the introduction of ‘top-ups’ in homes who do not yet have them and bring about an increase in those that do. It was confirmed that a “top up” is an additional charge from the provider direct to the resident or family member. It was reported to the Panel that this is already an issue in one particular home in Middlesbrough, who apparently insist on imposing significant top-ups to service users, to cover costs that they claim the Council should be meeting.

141. It was confirmed that there is no anticipated issues associated with not implementing a further price freeze. Budgets for 2012/13 have been constructed on the basis that an increase of up to 3% will be applied.

142. Moving away from the price of care, the Panel was keen to hear the view of the Department of Social Care on its view, as managers of the local market, on the overall quality & capacity of the care home sector in Middlesbrough.

143. In terms of capacity, the Panel heard that Middlesbrough currently has 29 older persons care homes in Middlesbrough, which equates to a total of 1,360 beds across all older persons services. At the time of reporting, there were 207 vacancies (15% voids), 131 of these are residential and 76 are nursing beds.

144. The Panel heard that, in the view of the Department of Social Care, there was a historical over capacity of residential beds in Middlesbrough and that this largely remained the case. To illustrate the point, the Panel heard that some homes can have up to 40% vacancies, which can threaten the viability of a facility. The Panel was advised that in the view of the Department of Social Care, having the preferred provider status can play a part in protecting the high quality facilities from the full extent of market forces. The Panel heard that the Department of Social Care has embarked on a piece of work to understand in more detail the likely future need in Middlesbrough and the bed configuration that would be required across the market.

145. The Panel heard that an important element of this discussion in discussing and meeting future need was the ability to make accurate predictions about what will be needed, as opposed to making assumptions on future need, based on historical data and experience. There are two points that are crucial to bear in mind when this debate is discussed. Firstly, people are living longer and are surviving medical complaints that may have killed them in past decades. These same

people, as a result of national policy, have been (correctly in the Panel's view) cared for in their own homes for as long as is reasonably possible. As such, when they do enter the Care Home system, their needs will be more severe and complex than the traditional care home admission of previous decades.

146. Secondly, there is a national and local policy drive to reduce the number of older people being admitted to acute hospitals and to reduce their length of stay once they are there. Again, these are older people with more complex needs (and at an older age) than their counterparts of previous decades. If acute hospitals are not the place for them to be in the medium and longer term (which the Panel strongly believes is the correct approach) the local configuration of care services needs to have sufficient, and the right sort, of capacity. The Panel heard, and agrees with the view, that there is likely to be nowhere in the country that is currently configured in the way it needs to be to deal with the next 10 to 20 years' demands. A period of significant research and service redesign will be required around the country.

147. In terms of the quality of care homes in Middlesbrough, the Panel heard that since 2008/09, the Council have a carried out an annual quality review of older persons care homes. This has meant that the standards of care delivered can monitored on an annual basis.

148. In 2010/2011 there were 28 homes with the grades (grade 1 being the highest) as detailed below:-

Grade 1: 2 homes
Grade 2: 5 homes
Grade 3: 16 homes
Grade 4: 5 homes
Grade 5: 0 homes

149. In 2011/2012 the same 28 homes had the following grades:-

Grade 1: 0 homes
Grade 2: 6 homes
Grade 3: 15 homes
Grade 4: 7 homes
Grade 5: 0 homes

150. In summary 3 homes went down a grade, 17 homes maintained their grade and 8 homes increased a grade. This illustrates that the majority of services are either maintaining their standards or increasing them.

151. The Panel was keen to gather the view's of the Department of Social Care on the extent to which the care home sector in Middlesbrough needs to develop, to respond to demographic changes of an aging population with more complex needs.

152. It was reported to the Panel that from July 2010 to February 2012, the Department of Social Care has seen a reduction in the number of residential beds available and an increase in the number of nursing beds available. Likewise, there has been an increase in the amount of Dementia beds in the market. The Panel heard that this highlights the continuing change in the needs of people accessing residential care. Generally, people are staying in their own homes for longer than they used to and now when people go into a care home, they have more needs and higher dependency levels than those who historically used the homes.

153. The Panel was further advised that the Department of Social Care has seen an increase in the number of Dementia units available, as a result of the demand. The Panel learned, however, that in order to respond appropriately to this need, the Department of Social Care felt it would need to work with Care Homes to develop more specialist Dementia services, in terms of the physical environment and appropriate expertise, interventions and activities.

154. The Panel was interested in the views of the Department of Social Care as to whether homes without specialist Dementia care should be allowed to accept and accommodate people with Dementia.

155. The Panel was advised by the Department of Social Care, that the CQC regulates this matter. The Panel heard that, as far as the CQC's standards are concerned, if a home has a statement of purpose that it can deliver services to people with Dementia, then they can do so.

156. Whilst accepting that this is the reality, the Panel found it hard to grasp that a regulator can demonstrate such a *laissez-faire* approach to such an important point. Whilst understanding that the Care Quality Commission was established to operate a less 'burdensome' regime, it does seem to be the case that the CQC has stepped away from being an inspection led organisation, to one that is mostly concerned with establishing minimum standards. The Panel also considers that on such an important point, the perception is that the regulator is somewhat 'hands off', simply requesting providers to state that they can deal with residents who have Dementia. Whilst it may be an issue to do with the CQC's remit, it seems strange that the regulator does not do more to assure itself of a facility's capability to accommodate people with Dementia.

157. The Panel considers that there is a feeling within Social Care circles that the CQC has developed an understanding that if an organisation, such as a local authority, contracts with a provider, that local authority has an important role in assessing and monitoring quality. Despite the feeling that the CQC has stepped away from inspection responsibilities, the Panel was reassured that the Department of Social Care continues to play an active inspection routine. At the Panel meeting, reference

was made to a unannounced visit that the Department had made to a provider over the Easter weekend, which has resulted in a suspension of local authority placements until flaws had been corrected.

158. To confirm, the Panel heard that the CQC does not specify the training and qualifications that staff have to have, but they would expect the home to be able to demonstrate that they have the appropriate skills to carry out the service that they are registered for. The Panel heard that the CQC would expect staff to have basic Dementia awareness training, but this is not a specific minimum standard. Again, the Panel cannot accept that this is sufficient for dealing with such a complex group of people.

159. The Panel was advised that as a major commissioner and purchaser of care, the Local Authority would expect that staff be suitably trained. The Department of Social standard contract states the following, relating to workforce;

159.1 The Service Provider shall at all times during the term of this Agreement provide sufficient persons with suitable experience, skills, abilities and qualifications to deliver the Service to the standards specified in this Agreement and to the satisfaction of the Council.

159.2 The Service Provider shall, at all times during the term of this Agreement ensure that staff are trained to meet the needs and requirements of the Residents in the Home and not to merely to mandatory Health and Safety requirements.

159.3 The Service Provider shall at all times ensure that its workers are given sufficient training to ensure they have knowledge of and are competent in the latest legal requirements and technical developments needed in the performance the Service.

160. The Panel noted, with some concern, that in the experience of the Department of Social Care, very few homes have staff trained in specialist Dementia. Further, the Panel heard that it is common to see care workers who are trained to a standard residential care level, having to deal with residents with severe Dementia.

161. The Panel heard that there is also an issue around mixed units. The Panel was surprised to learn that it is no longer a requirement of CQC to have separate units for people with Dementia and those who do not. In the view of the Department of Social Care, there are arguments both for and against this. Nonetheless, it was reported to the Panel that there has been 4 Adult Protection referrals since November 2011 in one home. It was reported that this has involved residents with Dementia entering into the rooms of residents without Dementia, resulting in them being physically assaulted.

162. It was reported to the Panel that whilst some care homes in Middlesbrough have dedicated Dementia units, none of them have been adapted in terms of colours and Dementia specialist environmental features. Further, only seven of the twenty homes that provide Dementia care have begun to introduce Dementia therapies in terms of reminiscing, photos on walls, the use of dolls and animals. The Panel heard that Dementia, its incidence and how those with Dementia are cared for, will become a bigger and bigger issue for Social Care in Middlesbrough. The Panel was advised that the Department of Social Care has formulated a view as to the sort of service mix that would be required in the town over the next few years to deal with the demands that will be present. There is, however, a lot of work yet to be done to ascertain how services need to develop both in terms of configuration and capacity, to deal with the demands that Dementia will pose for nursing and care homes in the next ten to twenty years. To confirm, the Panel heard that the Department of Social Care is clearly of the view that there is certainly a need for more specialist Dementia services both now and as the population ages. The substantial question, however, of how and when this capacity is brought 'online' remains unanswered.

163. In terms of numbers, the Panel heard that in Middlesbrough, there are 20 homes providing Dementia care, in a total of 23 units as follows:-

- 4 Care Homes have mixed units, which have residents with Dementia and those without.
- 13 Care Homes have dedicated Dementia residential units.
- 6 Care Homes have dedicated Dementia nursing units.

164. The Panel was keen to establish whether the Department of Social Care has a view on the current national debate around the funding of Social Care and the proposals outlined by the DiInot Commission. In addition, the Panel was interested to hear the Department's perspective on what would be the best national policy for Middlesbrough.

165. The Panel was advised that no further views have been formed by the Department of Social Care, since there are relatively few self-funders in Middlesbrough in any case.

166. It was confirmed that the proposals would reduce the number of people who self-funded and the amount paid by those who still would. It is anticipated however, that government funding to meet any income shortfall would be forthcoming.

167. It was confirmed to the Panel that the major differences proposed by the Dilnot Commission are:-

- Nil contributions from those who need care before they are 40 years old.

- A cap of £35,000 on the total contribution made by an individual.
- A raising of the capital amount an individual can have before they have to self-fund from £23,250 to £100,000.

168. The Panel was advised that typically, the difference in contribution between a self-funding resident and other residents is approximately £320 per week (for Older Persons Care). This equates to £16,640 per annum. Analysis has shown that the average length of a residential stay is approximately 8 months, so the total additional contribution for someone self-funding place by Social Care is approximately £25,000, some £10,000 below the maximum level of contribution the new legislation would propose.

The Panel's questionnaire

169. As part of the Panel's investigation into the topic of 'the experience of vulnerable older people in care settings', the Panel felt it crucial to seek the views of the care homes based in Middlesbrough, about some of the big issues facing social care over the next few years. A questionnaire was circulated to all 28 of the care homes based in Middlesbrough and a total of 8 questionnaires were returned. The questionnaire contained a number of key questions in relation to:

Finance and budgets - *including the care homes view on price freezes and the impact on the care home of a price freeze.*

170. Comments received included concerns regarding:-

- Difficulties filling places due to insufficient funding to cover care costs and the possible closure of homes as a result of the price freeze or possible relocation of residents;
- The impact on quality of service; staffing levels and profitability of business;
- Request for the Council to allow top ups and concerns regarding the impact of 3rd party top us on residents or their relatives;
- Price freeze could result in a reduction in services e.g. economies in heating, staff wages and provision of activities for residents;
- Suggestion that the benefits of bulk purchasing for care homes be considered

171. In terms of the comments regarding the difficulty in filling care home places, it would be legitimate to ask if this was due to the impact of the price freeze, or rather the current over provision of certain categories of beds available. It was acknowledged, however, that the demand for beds would likely increase over the next few years, due to the anticipated demographic changes of an ageing population with complex needs.

172. With regard to the request for the Council to introduce "top ups", the introduction of "top ups" could have an impact on the Social Care

Department's budget in terms of an increase in personal budgets at a time when the Department were already making significant reductions in finances as a result of current budgetary pressures.

173. During the investigation the Panel was advised that a Care Home Provider Forum was due to be established, to enable providers to share best practice and raise awareness, particularly in relation to the issues surrounding caring for patients with dementia. As part of the Forum, care home providers could also investigate the benefits of bulk purchasing for care homes with possible assistance from the Council's Commissioning and Procurement Teams.

Staffing and qualifications – *what are the minimum qualifications for a care assistant to be employed as a care assistant within their care home; the qualifications of existing staff; who assesses the care home staffs NVQs and who pays for staff training within the care home;*

174. All care home managers indicated that the minimum qualification required was NVQ2 or at least working towards NVQ2. The majority of managers were qualified to NVQ4 or above. All of the NVQ qualifications were assessed by Independent Assessors/External Assessors. All of the training received by staff was paid for by the care home provider.

Care home suspensions – *whether details of care home placement suspensions should be included in the Department of Social Care's Brochure of Care Homes and who the care home would notify if their care home was placed under a placement suspension and how and when they would be notified;*

175. Of the eight questionnaires returned, four of the care home managers indicated that details of care placement suspensions *should not be* included in the brochure; three indicated that they *should* be included and 1 indicated that it should be dependant on the reason and duration of the suspension. Six care home managers indicated that they would notify the Council and the CQC and two indicated that they would only inform the CQC.

176. What may be of particular concern, is the fact that none of the care home managers mentioned that they would advise their residents of any suspension of places. It could be argued that this highlights the requirement for further awareness of care home managers regarding of the procedures to be followed, in the event that a care home has a placement suspension imposed.

Activities within the care home – *whether the care home employed a dedicated Activities Co-ordinator, what kinds of activities were available for residents within and outside the care home and who paid for the activities;*

177. Six of the care homes had dedicated Activities Co-ordinators and the remaining two used existing care staff to co-ordinate activities. Residents were encouraged to influence the type of activities on offer and most activities were paid for through fund raising activities, by the care provider or the residents themselves if the activity was outside the care home.

Facilities within the care home – *how often the care home reviewed the facilities offered within the care home and whether any adaptations had been made to the premises to meet the needs of residents;*

178. Most care home managers indicated that they carried out ongoing reviews of facilities on a daily/monthly/annual basis. All care home managers stated that their care home had been purpose built or adapted to meet the needs of residents.

Criteria for admission to the care home – *whether the care home had a framework based on client need which specified the client groups a home would accept, whether clients would be refused a place if they did not meet the criteria*

179. All of the care home managers indicated that their care home had a framework, which specified the client groups that the care home would accept. 50% of care home managers advised that residents would be refused admission if they did not meet the criteria specified in the framework and the remaining 50% advised that they would carry out risk assessments and undertake staff training to meet the needs of the resident.

180. What could become an issue for residents, care home managers and the Council was if a resident's physical or mental condition deteriorated after they had been admitted to the home. This would be of particular relevance to those developing dementia in a care home, that was not specifically registered to cater for, or did not have properly trained staff to deal with, patients with dementia. Given the amount of competition from care homes for care home beds, providers could be reluctant to relocate a resident and lose the finance associated with that care home place.

Support from Middlesbrough Council – *what support the care home received form the Council and which areas they would like to receive more support from the Council;*

181. On the whole there was a mixture of positive and constructive comments ranging from comments regarding the excellent support from staff; support with training and advice; social worker input and reviews for funded residents.

182. A few suggestions were received regarding the provision of assistance with training induction, the provision of free training and development

for staff and the sharing of information, in relation to updates regarding changes in legislation and sector news such as demand and supply. Another suggestion received was for each care home to have a named care manager allocated to each care home for ease of contact and financial support.

183. The negative feedback included comments such as inhibits care and imposition of pay freeze.

184. If the Care Home Provider Forum was established then the training and the sharing of information could be included as part of the remit of the Forum. The Social Care Department would need to consider whether the suggestion regarding each care home having a named care manager was feasible.

Liaison with outside agencies – *whether the care home liased with other agencies such as specialist charities for advice regarding residents;*

185. The care home managers named the NCA, CQC, RCN, NMC, NAPA, Advocacy, Citizens Advice, Red Cross, Parkinson's group, CPN and Woodside as agencies that they would contact for advice.

Food and diet – *whether the care home had access to a dietician and what support was provided for residents with special feeding needs and who provided the support.*

186. The number of care homes that had indicated that their home had access to a dietician was very encouraging. Most care home managers had advised that the support for residents with specialist feeding needs was carried out mainly by care home staff with advice from GPs, dieticians and key workers. Senior staff/dieticians/health care staff and the care home chef assisted with monitoring whether dietary requirements were being met.

Other comments

187. One care home manager indicated that she did not agree with the Preferred Providers being listed in the Department of Social Care's Care Homes Brochure. It was said that it implied that those homes were better, when some had not been rated by the CQC or Environmental Health, or were relatively new homes so did not have a history of proven care. (Care homes were awarded preferred provider status because they had increased service standards included in their contracts).

188. It could be suggested that the Department Social Care includes in the Care Homes brochure, alongside the list of homes with Preferred Provider status, the details of the criteria that a care home is required to meet in order to achieve Preferred Provider status.

Department of Social Care Questionnaire

189. As part of the investigation the Panel also obtained an analysis of the results of a care home resident's survey carried out in 2011 as part of the Department of Social Care's Older Persons' Residential Care Homes Quality Review. The questionnaire asked residents a number of key questions in relation to the quality of care they received in the care home, the activities available, the cleanliness of the home, the quality of staff and managers and the quality and availability of food in the care home.

190. The questionnaire asked residents how they rated the information they received during the first year of their stay at the home. 72% of residents had rated the information received as good to excellent; 7% rated the information received as ok to very poor and 21% indicated that they couldn't remember.

191. 75% of residents advised that they mostly or always received information from the care home about things that affected their daily life such as changes to routines or staff or visits by professionals or details of meetings. 9% of residents indicated that they sometimes received the above information and 15% stated that they never received any information about changes that would affect their daily life.

192. On a positive note over 96% of residents indicated that they were well looked after by the care home staff with the remainder advising that they were only sometimes well looked after.

193. In terms of satisfaction with regard to how their medication was provided by care home staff, over 82% advised that they received the right medication at the right time with 4% of residents advising that they did not take any medication and 3% stating that they self medicated.

194. In response to a question with regard to the assistance received from staff during the night 54% of residents indicated that they always received the help they needed with 41% stating that they did not require any help from staff through the night.

195. In terms of the range of activities provided at the care home, 66% of residents indicated that there was an adequate range of activities provided. 37% of residents advised that they were given the opportunity to take part in activities outside the home with 29% advising that they preferred not to take part in activities outside the home.

196. 53% of residents indicated that they were given assistance to access the care home's garden when required and 40% advised that they received assistance to go to the shops or attend church.

197. Over 70% of residents indicated that they had an input into the care that they received and 91% of residents stated that the staff at the care home assisted them in retaining their independence.

198. In terms of the food available at the care home only 31% of residents advised that they were consulted more than twice a year with regard to the type of food they would like to see on the menu with 28% advising that they had never been consulted. However, 88% of residents had advised that there was a good availability of food available at their home and over 72% had stated they enjoyed the food they had at the home and that that there was enough choice and variety of food available.

199. Over 70% of residents rated the quality of the laundry service in their care home as good to excellent and 11% advised that their family did their laundry for them.

200. Over 91% of residents advised that they were treated with dignity and respect by the Care Home Managers with over 84% stating that they were treated with dignity and respect by staff at the home.

201. In terms of the number of staff available to deal with their needs, 61% of residents advised that there was enough staff available with 25% stating that there was adequate staff available sometimes and 13% stated that there was not enough staff, however, 91% of residents rated the quality of staff as good to excellent

202. 39% of residents indicated that they were asked for their views more than twice a year on the quality of service they received from the care home with 48% of residents stating that they had never been asked for their views. Over 78% of residents however had indicated that they were aware of how to make a complaint within the care home.

203. With regard to cleanliness of their care home, 92% of residents had rated their home as good to excellent. Over 71% of residents had stated that staff washed their hands before assisting them with personal care and 23% had advised that they did not require assistance with personal care. 44% of residents advised that staff assisted them with washing their hands after using the toilet and 52% advised that they did not need assistance.

204. Over 60% of residents advised that the care home allowed them access to their personal money when required and 37% stated that the care home did not hold any of their money.

205. 88% of residents had stated that the care home ensured that their spiritual/cultural needs were met. In terms of personal choice in relation to going to bed, getting up, adding their own possessions to their room, having a non alcoholic drink when they wanted, choosing the size of meals, having a bath or shower and access to a telephone for a private telephone conversation, over 80% of residents indicated that they were able to do these things whenever they wanted. Only 47% of residents had a key to their bedroom door and 68% indicated that they were able to choose the programmes on the television in the communal lounges.

206. Overall, 92% residents rated the quality of care that they received in their care home as good to excellent.

Social Care Reform?

207. As is described elsewhere in this final report, the viability of Social Care provision and its funding has probably never had a higher profile than it has at the current time.

208. Indeed, the Government is coming under increasing pressure to outline a new strategy which will make significant reform to the Social Care system.

209. In the Coalition Agreement from May 2010, there was a commitment to establish an independent commission to investigate in some detail the operation, legal foundation and funding of Social Care.

210. That Commission was duly established and became the Dilnot Commission, which is examined elsewhere in the final report. Following the Dilnot Commission, the Government undertook to publish a White Paper setting out its response and strategy for Social Care in spring 2012.

211. The Queen's speech in May 2012 outlined the Government's intention to publish a draft Bill that will put "people in control of their care and give them greater choice'. A key question, however, which remains unanswered is how the Government propose the necessary increase in Social Care capacity will be paid for.

212. As such, the Department of Health has announced that a Social Care White Paper will be published this year.

213. Whilst the Government said it is determined to address Social Care, it would take time to fully develop thinking and proposals. The response to the Queens Speech was somewhat mixed.

214. The Chair of the Local Government Association, Sir Merrick Cockell said

“Councils across the political spectrum are united in now calling on Government to work with us to truly undertake radical reform by adopting a cap on the amount of risk individuals will be exposed to when planning for their care costs, introducing integrated health and social care commissioning to ensure a better quality of care, and addressing the shortfall in funding.

"We understand that reform is not an easy problem to solve and we know that reform comes with a price tag. But we believe it's a price worth paying. Along with our partners, we will shortly be setting out the local government offer to central government on how councils can play their part and make Dilnot's proposals manageable.

"The Prime Minister recently acknowledged that social care is "one of the biggest things we've got to get right in our public services". It's now time for all parts of government to come together to ensure reform, with appropriate funding, is done right. "[45]

215. The Chief Executive of the Patients Association said

“*Adult social care will be a pivotal issue in the next few years as we come to terms with providing the care and support a growing elderly population will need. We are encouraged that the issue of adult social care was included in the Queen’s Speech, but what was not said was deeply worrying. It will be impossible to effectively reform social care without tackling the all important issue of funding. Sir Andrew Dilnot’s report last year spelled out the problem and all the parties pledged to work together towards a solution. Yet since then there has been very little announced publicly on the issue. We urge the Government to publicly clarify the issue of funding for social care and give a clear indication of whether any legislation being considered on the issue will address changes to funding for social care.”*[46]

216. It is, therefore, important to note that amongst those closest to Social Care, a consensus seems to exist that the system is currently ‘soldiering on’ and is far from fit for purpose. It seems that there are a few issues that the Government is required to address in its White Paper, when it is released later in 2012. Firstly, the Government has outlined a priority for people to have a greater say/choice over the care they receive and to have it shaped more to their requirements. The Government has also expressed a desire to simplfy the legal landscape around Social Care, which does seem to be served by ten to 12 Acts of Parliament. The point should be made, however, that the key point that the Government White Paper should broach is the additional funding that is required to support a system that is creaking and specifically, where that funding will come from. The requirement for additional funding is supported across the political spectrum in local government. Indeed, it appears clear that it is the biggest issue facing the sustainability of social care. The Panel highlights one of the Dilnot

[45] http://www.local.gov.uk/web/guest/health-wellbeing-and-adult-social-care/-/journal_content/56/10171/3515646/NEWS-TEMPLATE
[46] http://www.patients-association.com/default.aspx?tabid=80&Id=71

Commission's major points: The current system is trying to operate within a set of rules that were designed for 1948.

217. It should be noted, in the Panel's view, that whilst local authorities should be held to account for the effective delivery/commissioning of social care in their areas of responsibility, they can only work within the legislative framework given to them. It is clear to the Panel that local authorities around the country require national government to update the national social care framework. This would include providing clear direction on how social care will deliver for today's population both in terms of need and scale of need. Until national government performs this task, local authorities will increasingly be attempting to avoid collapse in coming years.

218. The Panel, along with all others interested in Social Care, awaits the Government's White Paper with interest.

Conclusions

219. Whilst this report has focussed on Social Care in Middlesbrough, it is important to recognise that there are significant and well founded concerns over the sustainability of our national model of Social Care. It would appear that all expert practitioners and commentators, irrespective of political persuasion, consider that our national system of delivering and funding social care is fundamentally flawed and belongs to a time when society did not face the population challenges that it does now. Middlesbrough is a town and local authority which is part of a wider national system and is, therefore, materially affected by how national social care policy develops. It will be important for Middlesbrough Council to monitor how national policy around Social Care, and particularly its sustainable funding, develops and the implications of that policy development for Middlesbrough. Nonetheless, the local authority is a market manager and a significant commissioner of social care in the town and will require sufficient in house expertise to ensure that new national policy is effectively and equitably implemented in Middlesbrough.

220. On the strength of the evidence considered by the Panel, Middlesbrough has more than sufficient beds in care homes to meet the needs of its population, in pure numerical terms. It should also be noted that Middlesbrough is a net importer of people, who use care homes in Middlesbrough. Whilst Middlesbrough has a substantial number of beds in simple numerical terms, it should be noted that it does not have sufficient beds to deal with the challenges brought about by an ageing population, which will probably require a significant shift in focus from residential beds to nursing beds.

221. An intention of the public policy agenda regarding the provision of care homes is the creation of a marketplace where providers compete for

clients, as in any other sphere of commercial activity. That market draws staff into what is, fundamentally, a relatively low wage economy. With a seemingly incontrovertible need to significantly develop increased capacity and expertise in dementia in Middlesbrough care homes, the panel would question how easy this will be to do in such a low wage economy. Essentially, the Panel would question whether people with substantial expertise and skill in dealing with people with severe dementia would be obtainable at the rates of pay typically offered by care homes. This is fundamentally a question for the local health and social care economy to consider, but sufficient attention needs to be paid to it, as it represents a clear challenge.

222. On the strength of the evidence received by the Panel, Middlesbrough's configuration of care homes and its associated skill mix is not where it needs to be, as yet, for the challenges of the next ten to twenty years. Middlesbrough is not unique in this regard, as it would appear most areas of the country are still trying to conceptualise what the local implications of an ageing population will be. Before attempts are made to stimulate development in Middlesbrough's care homes and its associated workforce, more detailed information is required on population projections specifically for Middlesbrough. The panel considers this piece of work, which should include projections on morbidity, to be absolutely critical and a pressing priority. The Panel considers that it would be difficult, to the point of being unwise, to attempt to develop the care home market's configuration/capacity, without a detailed assessment of Middlesbrough's specific future needs, dictated by the population changes.

223. The Panel considers the role and remit of the Care Quality Commission to be a cause for concern. The Panel invited the CQC to attend and speak at a meeting to discuss the quality of care homes on offer in Middlesbrough. That a Government established and appointed regulator of Health & Social Care could not, or would not, attend to provide its view on the quality of Care Homes in Middlesbrough remains a concern for the Panel and leaves the Panel feeling uncomfortable.

224. The Department of Social Care's brochure on Care Home providers in Middlesbrough was a largely impressive document and the Panel could imagine it would be hugely useful to prospective residents and their relatives, in making important decisions. The Panel considers that the document would be improved by including a list of questions that would be particularly useful for people to ask of homes, which may empower people to make more informed choices. Further, the Panel considers that the brochure should include any suspensions a home has had and reasons for that suspension. The Panel considers that high quality homes would have nothing to fear from this and it would probably drive up quality across the town.

225. Whilst it accepts that the current regulatory regime allows it, the Panel is very uncomfortable with a framework which seems to endorse, or at the very least allow, care providers to look after people with dementia without specialist skills. Evidence received by the Panel suggests that some care home staff are expected to care for people with severe dementia with relatively basic training. This does not seem fair to the staff involved, or those with dementia.

Recommendations

226. The Department of Social Care should complete or commission a piece of work, identifying the population projections for Middlesbrough for the next ten to twenty years, both in terms of age breakdown, as well as morbidity rates, with a specific focus on dementia. Until this essential piece of work is completed, with sufficient detail and rigour, care home provision and the associated skill mix cannot be reliably planned. The panel would look to the Executive and Department of Social Care to set a deadline for this work to be completed.

227. That following the completion of this work, a strategy should be prepared with sufficient political oversight and leadership, outlining how the implications/findings of the research will be put into practice with the development of the configuration and skill mix in care homes. The document should articulate how the Department of Social Care will manage the market to deliver on these needs, as well as contain appropriate milestones to chart progress against.

228. The Care Homes brochure, as produced by the Department of Social Care, should contain a section on good questions for people to ask when selecting a care home.

229. The Care Homes brochure should also contain details of any care homes suspension of placements and reasons for those suspensions.

230. That the local authority, at a political level, lobbies central government about the needs of a town like Middlesbrough, with relatively few self funders, when considering national social care reform.

231. That when the Government publishes its White Paper into Social Care, a detailed paper is prepared by the Department of Social Care, for consideration within the political domain, of its implications for Middlesbrough.

232. That the local authority, as a political entity, holds a debate about the prevalence of a low wage economy in care homes and any steps it may wish to take to address the matter. The Local Authority has a responsibility to promote good care and good employment practices. Better wages for such an important area of work would also help boost the local economy.

BACKGROUND PAPERS

- Age UK, Care in Crisis 2012, 30 January 2012
- NHS Information Centre for Health and Social Care*, Community Care Statistics: Social Services Activity, England* 2010–11, provisional release
- Fairer Care Funding – The report of the Commission on Funding of Care & Support, July 2011
- House of Commons Health Committee, Social Care, Fourteenth Report of Session 2010-12
- Department of Social Care – Brochure of Care Homes

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