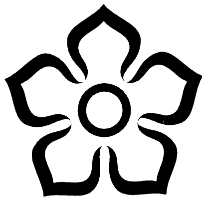


SPECIAL MEETING OF THE ADULT SOCIAL CARE SCRUTINY COMMISSION

DATE: **MONDAY, 1 JULY 2013**
TIME: **5:30 pm**
PLACE: **The Oak Room, Ground Floor, Town Hall, Town Hall Square, Leicester. LE1 9BG**

Members of the Committee

Councillor Dr. Moore (Chair)
Councillor Chaplin (Vice-Chair)

Councillors Alfonso, Fonseca, Grant, Joshi, Wann and Willmott

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contact *Mike Keen*
Democratic Support, Leicester City Council
Town Hall, Town Hall Square, Leicester LE1 9BG
(Tel. 0116 229 8817 Fax. 0116 229 8819)
(e-mail Mike.Keen@leicester.gov.uk)

INFORMATION FOR MEMBERS OF THE PUBLIC

ACCESS TO INFORMATION AND MEETINGS

You have the right to attend Cabinet to hear decisions being made. You can also attend Committees, as well as meetings of the full Council.

There are procedures for you to ask questions and make representations to Scrutiny Committees, Community Meetings and Council. Please contact Democratic Support, as detailed below, for further guidance on this.

You also have the right to see copies of agendas and minutes. Agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk or by contacting us as detailed below.

Dates of meetings are available at the Customer Service Centre, King Street, Town Hall Reception and on the Website.

There are certain occasions when the Council's meetings may need to discuss issues in private session. The reasons for dealing with matters in private session are set down in law.

WHEELCHAIR ACCESS

Meetings are held at the Town Hall. The Meeting rooms are all accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Take the lift to the ground floor and go straight ahead to main reception).

BRAILLE/AUDIO TAPE/TRANSLATION

If there are any particular reports that you would like translating or providing on audio tape, the Democratic Services Officer can organise this for you (production times will depend upon equipment/facility availability).

INDUCTION LOOPS

There are induction loop facilities in meeting rooms. Please speak to the Democratic Services Officer at the meeting if you wish to use this facility or contact them as detailed below.

General Enquiries - if you have any queries about any of the above or the business to be discussed, please contact Mike Keen, Democratic Support on (0116) 229 8817 or email Mike.Keen@leicester.gov.uk or call in at the Town Hall.

Press Enquiries - please phone the Communications Unit on 252 6081

PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda, and/or indicate that Section 106 of the Local Government Finance Act 1992 applies to them.

3. ELDERLY PERSONS HOMES PROPOSALS **Appendix A**

To consider the following reports, attached, and raise questions with the officers, and to gather evidence from Trade Unions to feed into the 11th July meeting.

1. Final report from previous Adult Social Care and Housing Scrutiny Commission review (2011)
2. Response of the then Assistant City Mayor (Adult Social Care and Housing).
3. Proposals for the future of the Councils Elderly persons Homes
4. Elderly Persons Homes – Scrutiny Review Information report

4. ANY OTHER URGENT BUSINESS

This page is left blank intentionally.

Appendix 2

Response to Scrutiny Report: Elderly Persons Homes

Cllr Mohammed Dawood
Assistant City Mayor for Adult Social Care and Housing

Date: 6th September 2012

1. Summary

The report gives a further detailed response to the report of the Scrutiny Commission entitled “A review of the consultation process and proposals to change elderly person’s residential services provided by the Council. This follows an initial presentation to the Scrutiny Commission at the time of the report’s publication.

2. Main report:

The Scrutiny Commission has made recommendations around a number of key themes. These are set out below with the responses to each in bold.

2.2 Recommendations around Consultation Options

1) **That the Elderly Person’s Homes should remain open and run by Leicester City Council**

Response

In February 2012, the Executive considered the results of public consultation on the future of the Council’s in house Elderly Persons’ Homes. Following this, the Executive made a public announcement stating that change would be necessary, and this needs to be carefully introduced, and planned over the next few years. Working carefully with residents and their families the Executive has agreed that it will continue as a direct provider of residential care up to 2014/2015 whilst the best solution for each home is found.

The status quo cannot be maintained in the longer term for a number of reasons:

- Numbers of admissions into residential and care are declining across all sectors as people choose alternative services such as extra care and assistive technology. In addition the Council had made significant investment in services aimed at promoting independence such as reablement.
- People in Leicester have told us that they would prefer to live independently at home for as long as possible, and we need to continue to develop such services
- Continuing to run eight EPHS offers poor value for money for the Council
- It costs the Council £229 more per person per week to offer places in a Council run home compared to a home in the independent or voluntary sector
- As the numbers of older people increase this funding gap will become more and more pressured.

It is acknowledged that there will always be a need for some residential care in Leicester, particularly given the increase in people living longer with complex conditions like dementia and this will need to be addressed as solutions for change develop.

2) **That the Executive note the very good levels of care, the opportunities for social activity and the dedication of our staff.**

Response

The quality of care and dedication of staff is indeed recognised.

3) **That there should be maintenance programme for the Elderly Person’s**

Homes in the scope of the review (if necessary), based on the latest condition survey evidence.

Response

A detailed planned maintenance programme has been developed for EPH's from a number of sources, but mainly from the Condition Surveys carried out in November 2011 by external contractors. Maintenance requirements identified were initially re-prioritised according to LCC priority ratings, and then broken down into "landlord" or "tenant" works. For landlord priorities extensive work is planned from the Central Maintenance Fund this financial year. Initial cost estimates suggest this work will amount to approximately £375k across the sector, and work typically includes external decoration, external paving works, some re-roofing and boiler replacements. Adult Social Care also bid for capital monies on the strength of information contained within the Condition reports, and were successful in obtaining £462k from the capital programme for EPH works in 2012/13. A significant proportion of this will be spent on remedying structural issues identified in the reports. Approximately £100k has already been committed in this area, with further monies held in reserve pending the results of on-going structural monitoring.

The remainder of the capital will be spent on "tenant" items. All Homes managers have been consulted on their main priorities for the Units arising from the surveys, and an initial programme of works totalling £200k+ is almost ready to go out to tender. Works here are mainly internal redecoration, new floor coverings, bedroom refurbishment, bathroom/toilet refurbishment etc. In summary there will be considerably more spent on planned maintenance in EPH'S in 2012/13 than in recent years. This will by no means address all issues raised in the surveys, but will deal with all high priority items and should result in noticeable improvements to the environment of many of the units. Reactive maintenance will of course also continue, and officers do not anticipate much variation in expenditure levels from previous years in this regard.

4) **Specific feasibility work should be undertaken as to the suitability of any of the homes for conversion into extra care and intermediate care facilities before closure is considered.**

Response

In the event of a decision being taken to convert existing homes to extra care or intermediate care, feasibility work would indeed be carried out before closure was considered. This would include a full options appraisal of all homes.

5) **That the approach to maintenance of the council's EPHs is reviewed to improve standards, outcomes and efficiency and, if appropriate, considered as part of the maintenance service provided by Housing Services.**

Response

The approach to maintenance of the EPH's remains similar to previous years, but the detailed Condition Surveys have now given much better quality information on

which to base decisions regarding expenditure. Links with Housing regarding maintenance have been tried in the past without great success, but this will be looked at again to see if any joint working would be possible and beneficial.

6. **That intermediate care and re-ablement services should be invested in, maximised and increased where possible.**

Response

This is agreed and was a key feature of the rationale for change outlined in the consultation on the homes.

7) **The Executive needs to consider that handing over the homes to a third party provider is likely to result in significant worsening of staff terms and conditions, for large numbers of people, effectively pushing people onto the minimum wage.**

Response

Staff transferring to a new provider are legally protected by TUPE legislation which means that they transfer under their existing terms and conditions.

8) **As part of point 4 above the department should consider reducing the provision of single bed hostel spaces- reported to have surplus places- by closing Upper Tichborne Street Hostel and investing the saving into the development of EPHS.**

Response

In developing new services, it will be important to understand the range and detail of the new service models which will be required in the future. This helps to determine whether services can be delivered from existing buildings or purpose built sites.

2.3 Recommendations around the consultation process itself

1) **That when conducting a consultation based around costing (for example a rationale for a consultation based on the state of buildings and the costs involved in refurbishing them), there should be an agreed understanding of the costs involved from the outset based on up to date evidence.**

Response

It is accepted that more detailed information about the state of the buildings and the costs involved in refurbishing them would have been useful at the outset. However this does not detract from the key point made during the consultation that significant capital investment is required into the future to ensure the homes are fit for purpose. This was confirmed in the latest condition survey carried out by external contractors.

2) **That when providing options as part of a consultation, there should be a range of options which include re-investment into the homes to keep them**

open. Options around 'degrees of closing or cutting' should not be the only options available.

Response

The Executive agreed the consultation options which were based on the need for change. As such it was important that the consultation did focus on the potential for closing all or some of the homes in order to comply with good practice that requires Councils to be transparent in their approach to consultation.

3) That any consultation into the future forms and function of elderly persons' residential services provided by the Council should be appropriately resourced, taking resident's needs into consideration.

Response

The resourcing of any future consultation exercises will be carefully considered. It is accepted that Phase One of the consultation was not resourced effectively and because of this the Executive extended the consultation to include a second phase and to do more one to one work with residents and relatives.

4) That effective training should be given to those supporting the consultation of vulnerable people to ensure that personal views of carers/ interviewers don't influence the findings.

Response

The headline findings showed that people would prefer a no change option. This would tend to illustrate the fact that views were captured appropriately. A number of measures were put in place to ensure that the consultation was meaningful. A communication plan was developed for each resident to understand how they wanted to participate. This varied from direct participation, or nominating a relative to participate on their behalf. In the case of residents who did not have mental capacity to participate or relatives to act on their behalf an advocate from the Alzheimer's Society represented them. In all cases the notes from meetings were sent to participants for agreement to ensure that their views had been captured correctly.

5) That the impact of this review on the reputation of the Council's care homes should be considered to minimise any adverse communication.

Response

A key theme emerging through the consultation was that relatives and residents value the quality of care provided in Council homes. As a decision was made to undertake a public consultation exercise, the profile of the homes has been raised. It is clear that some people may be less likely to choose a Council run home until the long term position is clear, however a very small number of admissions are being made and the homes are advertised in the Directory of Care Homes for the City. Staff in the consultation team worked closely with the Corporate Communications Team to minimise any adverse effects of communication where possible.

6) **That the impact of further reviews into elderly person's homes be considered from the outset to ensure communications are effectively managed and to minimise any reputation damage.**

Response

In the event of any further reviews, staff will continue to work closely with the Corporate Communications Team to minimise any adverse impacts of consultation.

7) **That those planning the consultation should consider the impact on staff, residents and families to ensure that points 3-5 above are properly implemented. These are homes where people live and that should always be taken into account.**

Response

This point is well made and staff will continue to implement a good practice approach to consultation and communication on sensitive issues.

2.4 Recommendations around service redesign ideas and/or improvement to the quality of the service provided

1) **That permanent staffing levels in the homes should be improved and monitored to keep agency costs to a minimum.**

Response

Staffing levels in the homes comply with the standards set out by the Care Quality Commission. Whilst it is agreed that agency costs should not be used for long term provision, some agency costs will be incurred in order to ensure staffing levels are adequate. Current agency usage across all our homes is around 28% and we are seeking to reduce this to no more than 25%.

2) **That the Council make recommendations that staff in privately-run homes should be paid a fair wage and receive a high standard of training.**

Response

The Council works very closely with private providers but cannot directly influence the payment levels of staff in private care homes. This is because since the pay rates of staff are developed as part of each organisation's individual business model. However there is much scope to influence the quality of care delivered by the sector. The Care Quality Commission requires providers of care homes to take steps to ensure that staff are suitably qualified, skilled and experience regardless of the sector. They must also demonstrate that they are suitably supported in the care of residents, through training, regular supervision professional development appraisal. These requirements are built into contracts with the Council and monitored by the Adult Social Care Contracts and Assurance Team. The Council also works proactively with providers through our local Quality Assurance Framework which aims to drive up standards and performance in the independent sector.

3) **That the city council explores opportunities to provide apprenticeships to staff in care homes - in partnership with local colleges.**

Response

The Council provides training for care providers across a range of core skills and competencies for example safeguarding, as well as carrying out internal training. Staff in all sectors are enabled to undertake NVQ qualifications, delivered through local colleges.

4) **That homes that are best suited to alternative uses (not necessarily those with low occupancy rates) should be considered for intermediate care.**

Response

This point is agreed.

5) **That further consideration is given to redevelopment and a strategy for managing more specific cultural, linguistic and religious care needs of residents across the homes- specifically for the Asian and Asian British population which is currently 20% of over 60s in Leicester.**

Response

There is currently a very low take up of people from Asian and Asian British populations for older people's residential care homes both in house and in the independent and voluntary sectors. Residential care has traditionally not been an attractive option for people from these cultural backgrounds.

In Leicester needs can be met throughout the sector, with a small number of providers marketing themselves as Asian Lifestyle Homes.

Where services are provided, the Care Quality Commission requires providers to address the full range of cultural needs as part of high quality care provision.

In moving forward to develop future services it will be necessary for the Council to demonstrate how needs can continue to be met for the diverse communities of Leicester.

6) **That the homes' IT systems and broadband be reviewed and if necessary upgraded to improve efficiency of administrative duties and to provide access for residents.**

Response

The IT systems in the homes have now been reviewed. It is accepted that upgrading

is necessary and this will be in place by November 12. Whilst this will improve the efficiency of administrative duties, it will not facilitate access for residents. This is because this would require considerable changes to the IT infrastructure, and capital investment which may not be appropriate in the short term. Staff will work closely with any resident who shows an interest in IT to find other ways of addressing this in the short term, through the use of other Council services such as libraries. The specification of wireless technology capable of supporting Broadband and Assistive Technology will however be a key requirement in the development of future services.

7) The possibility of a retirement village should be explored, as part of a portfolio of residential options for older people in Leicester, and as part of the Ashton Green development in the first instance.

Response

The design and development of Ashton Green is to have a village feel with a priority to meet the housing need of families. It has the potential to deliver 3000 units of accommodation between 5 – 15 years. Based on the Strategic Housing Market Assessment and evidence of need the indicative housing requirements for Ashton Green (from 2009) does include a substantial number of units for older people that includes a mix of affordable, market and supported housing. This means that social housing, home ownership and sheltered/supported housing for older people can be delivered on this site. This combination potentially could deliver 500+ units of accommodation for older people.

We are still at an early stage of deciding how the identified units of accommodation for older people are to be delivered i.e. a larger Extra Care Scheme, clusters of accommodation, co-location or interspersed across the site. There may need to be further consultation with older people, particularly home owners about potential services for older people on the Ashton Green site.

2.5 Recommendations around the wider funding issues surrounding adult social care and their impact on this review

1) The Executive in making any decision to keep the homes open do so for the next 5 years at least.

Response

In February 2012, the Executive considered the results of public consultation on the future of the Council's in house Elderly Persons' Homes. Following this, the Executive made a public announcement stating that change would be necessary, and this needs to be carefully introduced, and planned over the next few years. Working carefully with residents and their families the Executive has agreed that it will continue as a direct provider of residential care up to 2014/2015 whilst the best solution for each home is found.

The status quo cannot be maintained in the longer term for a number of reasons:

- Numbers of admissions into residential and care are declining across all sectors as people choose alternative services such as extra care type schemes and assistive technology

- People in Leicester have told us that they would prefer to live independently at home for as long as possible, and we need to continue to develop such services
- Continuing to run eight EPHS offers poor value for money for the Council
- It costs the Council £229 more per person per week to offer places in a Council run home compared to a home in the independent or voluntary sector
- As the numbers of older people increase this funding gap will become more and more pressured.

It is acknowledged that there will always be a need for some residential care in Leicester, particularly given the increase in people living longer with complex conditions like dementia and this will need to be addressed as solutions for change develop.

2) That a full and up to date detailed condition survey be carried out into the health of each home to better understand the costs associated with on-going maintenance and refurbishment to alternative use for each home and facilitate improved decision-making around each homes' future.

Response

Detailed Condition Surveys were carried out to all EPH's in November 2011 with the results reported to Scrutiny. This now provides much better base information on which to base maintenance expenditure decisions. Information in the surveys has also prompted a much higher level of maintenance expenditure in the Homes than recent years as detailed in 2.2.3.

3) That options for increased collaboration and efficiency be developed and considered around joint- working with the NHS, particularly around referrals and admissions processes.

Response

LCC works collaboratively with the NHS in a range of areas, including the provision of intermediate care, reablement services and equipment. Our shared focus is the provision of support which enables people to remain independent, within their own homes.

With regards to residential care, individuals have the right to choose a home which meets their assessed needs. Social workers will guide residents and relatives as to the type of services that are appropriate. Very often health professionals will have contributed to the individual assessment of need and consideration will have been given to whether nursing care is required. LCC's own admission process already requires that these assessments have taken place.

Local Authorities are not permitted in law to provide nursing care and neither is this locally provided by the NHS; it is delivered by the independent sector. Local Authorities are also required to ensure that anyone entering their own provision is eligible (this does not preclude self funders, who may be eligible, but unlike the independent sector, Councils cannot provide placements to self funders who are not eligible for residential care. This arises from the Chronically Sick and Disabled Persons Act)

There is felt to be scope for further collaboration with the NHS in relation to developing short term residential care for assessment purposes and rehabilitation, to ensure maximum use of Council provided services which promote independence. This is being progressed with health partners currently.

4) That a review of communications surrounding the marketing and admissions/ referral process of the homes be carried out to tackle the perceived negative reputation of Council-run homes compared to privately run homes and improve admissions and referrals.

Response

The consultation findings indicate concerns about private rather than Council lead provision. More information would be needed to understand why the Scrutiny Commission holds this view before a response can be given.

It is acknowledged that uncertainty about the future of the homes may be affecting choice with some people.

3. Options

4. Details of Scrutiny

This report is in response to the report produced by the Scrutiny Commission following its review in 2011.

5. Financial, legal and other implications

5.1 Financial implications

The financial implications associated with this review are set out in the Executive

report on EPHS.

5.2 Legal implications

The legal implications associated with this review are set out in the Executive report on EPHS.

5.3 Climate Change and Carbon Reduction implications

There are no climate change implications in relation to this report.

5.4 Equality Impact Assessment

A full equalities impact assessment has been carried out as part of the Executive report on EPHS.

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

None.

6. Background information and other papers:

Not applicable.

7. Summary of appendices:

Not applicable.

This page is left blank intentionally.

Appendix 3

Executive Decision Report

Proposal for the future of the Councils Elderly Persons Homes and the development of Intermediate Care Facility

Date:7th March 2013

Lead Director: Deb Watson

Useful information

- Ward(s) affected: **All**
- Report author: **Tracie Rees**
- Author contact details: **tracie.rees@leicester.gov.uk (Tel: 252 6812)**
- Report version number: 5.

1. Summary

1.1 This report seeks the Executive's steer on the future of the Councils Elderly Persons Homes (EPHs) and the development of an Intermediate Care facility.

1.2 The Executive is aware that the demand for residential care is declining, because the requirements of older people are changing.

1.3 The provision of community based services, such as supported living, extra care housing, assistive technology, adaptations and home care has meant that older people are able to remain in their own home and live independently for longer.

1.4 These changes are reflected in national[1] and local policy and local academic research[2]. The Council's vision for Adult Social Care (ASC) [3] also sets the direction of travel, which gives older people greater choice and control, including the support to live independently.

1.5 Therefore, the future of the EPH's needs to be considered in the wider context of services' for older people, balancing the needs of a relatively small number of residential service users, compared to the larger number of people needing ASC support. To support the wider agenda for older people, a 'blue print' for the next 25 years needs be developed across the whole Council, and with external partners, to ensure that relevant services are in place as the population grows older.

1.6 However, there is also recognition that some specialist residential/nursing care is needed, especially for people with dementia. As the Council cannot provide nursing care, further work is needed to jointly commission and improve the quality and accessibility of dementia care with NHS partners, as part of implementing the LLR Dementia Strategy.

1.7 Other key services that enable older people to retain their independence are intermediate care and reablement services. These provide support to prevent hospital admissions and to help people to retain their independence following a period of illness.

[1] Our Health Our Care Our Say (2008), Putting People First concordat (2007), Think Local Act Personal (2010)

[2] A Qualitative Assessment of the Housing Needs and Aspiration of Older People in Leicestershire - University of Salford May (2010)

[3] Vision for Adult Social Care Leicester City Council February 2012

2. Recommendations

2.1 The Executive is asked to:

a. Note these proposals have been developed to reflect the changing requirements of older people, including the increased availability of community based services.

b. Indicate if the Executive is minded to support any of the proposals for the future of the EPH's, subject to any further due processes, which might be required.

c. Agree to commission the development of a cross departmental 'blue print/plan' with partners to identify the service needs for an aging population over the next 25 years. This also needs to be underpinned with academic research.

d. Agree for further work to be completed with NHS partners to ensure that appropriate specialist care is available for people with dementia.

e. Approve the Intermediate Care and Short Term Care Commissioning Strategy (2013 to 2016), as detailed at Appendix A.

f. Agree the development of an Intermediate Care and Short Term Residential Bed facility, as detailed at Appendix B.

g. Wherever possible to proactively support the implementation of the Councils Independent Living & Extra Care Strategy to create more supported living options.

h. In due course, to consider any new findings that may be identified as part of feedback from residents and their families, particularly following consultation with new residents who have moved into the homes since the original consultation was completed.

i. To note that the numbers in the homes proposed for closure have remained consistently low for the last 6 months.

3. Supporting information including options for consideration:

3.1 In Leicester there are currently 37,000 people who are over the age of 65 years and 5,300 who are over the age of 85 years (2011 Census). The number of older people is projected to grow significantly by 2016, the number of over 65's will increase by 7% and those over 85 by 5%. Looking further ahead by 2031 the numbers of over 65's will increase by 48% and the number of over 85's by 53%.

3.2 Although the population is getting older, people want to remain in their own home with support. Support mechanisms include community based services, such as home care, assistive technology and adaptations.

3.3 The development of the Council's Independent Living and Extra Care Strategy (2012-2015), details the type of accommodation that is needed to enable people

to remain independent for longer. For example the Council has recently entered into a partnership arrangement with ASRA Housing Group to develop a 78 bed Extra Care facility at Abbey Mills. The Council will receive 100% nomination rights to 50 flats into perpetuity.

3.4 With the population of the city getting older, we cannot plan services purely from an ASC perspective. This is because ASC only supports a small number (4700) of the older people in the city. Other older people in the city will have a range of differing needs, which requires a 'whole systems' approach. Therefore, consideration needs to be given to developing a long term city wide 'blue print/plan' with partners to create a joined up approach. This would include a range of local organisations/services, such as health services, transport, housing, leisure etc.

3.5 The development of community support based opportunities reflects both national and local policy, as well as the Vision for Adult Social Care that was endorsed by the Executive in February 2012.

3.6 The increase in community based support services and independent living options, correlates with the decline for general residential care. This has affected both occupancy rates in the Council's eight homes and those in the independent sector.

3.7 On 25th January 2013 there were 161 permanent residents in the Council's EPH's, out of 282 beds. Generally, older people who go into residential care are frail elderly over the age of 85 years, who will stay for an average of 18 months and likely to need to move onto nursing care, which the Council is 'statute barred' from providing, (i.e. the Council is not allowed by law to provide nursing care).

3.8 On 25th January 2013 there were 107 vacant residential older person's places in the independent sector. A significant amount of work has been completed to establish the level of fees payable in the independent residential sector, which shows that the market is buoyant and with new providers developing new homes, such as Beaumont Hall (60 beds), which is additional to 107 vacancies noted above.

3.9 All residential homes are regulated by the Care Quality Commissioning (CQC) and monitored against a range of standards. In addition to the CQC monitoring the Council has its own Quality Assessment Framework (QAF) which has been developed in conjunction with the independent residential care home providers to improve the quality across the sector. The QAF does not replace the CQC requirements, but includes more qualitative data. This data will be collated into league tables and can be used by people seeking residential care to determine the quality of care. This provides an incentive for providers to improve their services to attract new clients.

3.10 In February 2012, the Executive considered the results of a public consultation exercise carried out in 2011 on the future of the Council's eight EPH's. Following this, the Executive made a public announcement stating that change would be necessary, and this needs to be carefully introduced and planned over the next few years. In the interim the Council would work with residents and their

families, continuing as a direct provider of some residential care until 2015.

3.11 The 2011 public consultation exercise concluded that the majority of residents did not want change. However, if change was necessary most residents would prefer the homes to be sold or leased to an alternative provider/s as a going concern. It should be noted that if individual's needs change and they require nursing care they are supported to move to a nursing home. This will continue to be the case, regardless of the future of the homes, as the EPH's cannot provide nursing care.

3.12 Therefore, the Executive agreed that a 'Soft Market Testing' exercise should be completed to understand what appetite there was from providers in the market place to buy the homes.

3.13 The soft market testing concluded that:

- There is interest in the market in acquiring some, but not all of the homes
- The capability to expand on site is critical to market interest
- The majority of providers prefer a freehold option
- Most providers expressed an interest in no more than one of the Homes
- No interest was expressed in Herrick Lodge, Nuffield House, Elizabeth House and Preston Lodge

3.14 The findings of the soft market testing are detailed at Appendix C.

3.15 A review of the Council's intermediate care service and the use of short term residential beds was completed to determine the future requirements and to understand if the Council's homes could be considered for this type of provision.

The headline conclusions from the review are:

- Intermediate care is crucial to rehabilitating people to maximise independence and preventing people from needing long term residential care
- Short terms beds are essential to providing respite care and providing short term care in times of crisis
- The current provision is fragmented and would benefit from a greater level of consistency, creating a more efficient service
- The provision of intermediate care and short term beds within a long term residential care setting is not a suitable environment for people needing rehabilitative services
- An increase in the city's population and demographic changes mean that

demand for intermediate care services will increase

- The provision of intermediate care and short term beds should be provided via a dedicated facility

3.16 The Intermediate Care and Short Term Residential Care Bed Commissioning Strategy can be found at Appendix A.

3.17 When considering the way forward for the EPHs, incorporating the need for intermediate care and short term residential beds, the following options have been proposed.

Proposed Options

a. No change
The homes do not reflect that people want to live independently with support for as long as possible, as referred to in the ASC vision. In addition, low occupancy rates mean that the homes will continue to offer poor value for money and savings identified as part of the budget strategy would not be achieved. All eight homes were constructed approximately forty years ago and are now of an age where building related issues are inevitable. Continuing to run the homes would require substantial capital investment in terms of maintenance and modernisation. Current residents have said that they value the quality of care they receive more than the building they live in, but the expectations of future generations will be different. For example the sharing of bathrooms is unlikely to be acceptable in future. New provision comes with en-suite bathrooms as standard in line with customer expectations for greater privacy and the more recent CQC standards applicable to newly registering facilities.

b. Close all of the Homes
This is not immediately feasible as there may not be enough suitable and available vacancies in the independent sector for the 161 permanent residents in the homes. Vacancy levels in the independent market suggest that this could, however be implemented via a phased approach over a period of time. Closing all of the homes in the short term is not in line with the Executive's announcement that change will be carefully introduced and planned over the next few years, with the Council continuing as a direct provider of some residential care until 2015.

c. Sell or lease all of the Homes as going concerns
This is not viable because the soft market testing exercise showed that there is no demand to buy or lease all of the homes. On this basis, an exercise to sell or lease all of them is likely to be unsuccessful. Despite contacting 350 organisations, including twenty five major UK providers of residential care, only eight providers took part in a dialogue with the Council. Their interest was limited and there was no interest in some of the homes.

d. Phased approach
This option has two phases.

i. Phase 1 - would close three homes in 2013 (Herrick Lodge, Elizabeth

House and Nuffield House). These homes currently have a combined total of 30 permanent residents. No new permanent residents will be accepted into the Homes that are going to be closed.

ii. Phase 1 - would also seek the sale of two homes as going concerns, (Cooper and Abbey House) commencing in 2013/14. These two homes have 56 residents. The homes to be sold as a going concern will continue to accept new permanent residents.

iii. Phase 1 - would commence the development of a new intermediate care facility.

iv. Phase 2 - would be determined after an evaluation of phase 1, but would potentially include the sale of Arbor House and Thurncourt as a going concern and closure of Preston Lodge. Brookside Court would also be closed; as this is already an intermediate care facility and therefore no permanent residents will be affected by the closure. The intermediate care service would transfer to the new intermediate care facility in 2015, if a new facility is developed.

3.18 Appendix D provides an overview of the age profile of the permanent residents at each of the Homes.

3.19 This approach will give us the future flexibility we need and help meet existing residents requirements, as follows:

- Offering homes for sale as going concerns reflects what most residents said they wanted if change has to happen. The soft market testing indicates interest in the homes with more permanent residents. Therefore, it is recommended that Abbey House and Cooper House be sold in phase 1. Consideration be given to the sale of Thurncourt and Arbor House in phase 2, after evaluation of phase 1.

- Herrick Lodge, Elizabeth and Nuffield House would close in 2013. The soft market testing has shown that these homes were not attractive to potential providers and they have low numbers of permanent residents, particularly Herrick Lodge which has only 5. Elizabeth House has 9 residents and Nuffield House has 16. It is therefore recommended that these homes are closed. [Post meeting note - these numbers were as at 25th January 2013. These have now changed as at 2nd April 2013; Herrick Lodge 5 residents, Elizabeth House 12 residents and Nuffield House 13 residents].

- An assessment of the potential conversion of the homes into an intermediate care and short term residential bed facility has shown that none were large enough to convert into a 60 bed facility, or had the land available to extend to meet the required standards for an intermediate care service. Therefore, Appendix B provides an overview of the options to develop a purpose built facility.

- The Council will continue to directly provide services until 2015, in line with the commitment given by the Executive. The phased approach means that

Arbor House, Thurncourt and Preston Lodge would operate until at least 2015. At that time an evaluation of phase 1 would be completed to confirm the options for the remaining 3 homes.

- Residents from homes closing in 2013 could choose to move to a home of their choice, including any of the homes to be offered for sale if they wished to.

- The majority of the residents would not have to move if this option was successfully implemented. These are the residents at Abbey House, Arbor House, Cooper House and Thurncourt.

- A programme of consolidation of the workforce would be co-ordinated over the 3 year programme of closure and sale, to ensure the best fit of skills and vacancies. It is possible that the laws around TUPE transfer may apply in some circumstances and if this is the case then staff would transfer on their existing terms and conditions.

- This option will allow the three homes with the lowest occupancy rates to be closed during 2013 and then disposed of, and for those with the highest occupancy rates to be put up for sale as going concerns in 2013/14 and potentially in late 2015.

- Brookside Court is a dedicated intermediate care facility, and does not have any permanent residents. It has 27 beds, but due to its location cannot be extended further. In the longer term it will also require capital investment.

- Short term mental health respite services currently provided at Nuffield House will provided in our other homes or the independent sector, until the new intermediate care/short term beds facility is available in 2015.

3.20 The following information provides a summary of the proposed phased option

No. perm Beds	No. of perm res at 25/01/13	Name	Plan	Comment
38	9	Elizabeth House	Close in 2013 with site available for disposal	Low number of long term residents
31	16	Nuffield House	Close in 2013 with site available for disposal	Low numbers of long term residents. Specialist Respite care would be delivered elsewhere
40	5	Herrick Lodge	Close in 2013 with site available for disposal	Low number of long term residents.
29	28	Cooper House	Seek sale as going concern. Procurement to commence 2013, with sale anticipated in 2014/15	Soft Market testing indicates interest

No. perm Beds	No. of perm res	Name	Plan	Comment
33	28	Abbey House	Seek sale as going concern. Procurement to commence 2013 with sale anticipated in in 2014/15	Soft Market testing indicates interest
Evaluation of Phase 1				
Proposed Phase 2				
No. perm Beds	**No. of perm res**	**Name**	**Plan**	**Comment**
40	27	Arbor House	Consider sale as going concern, late 2015	Soft Market testing indicates interest
38	31	Thurncourt	Consider sale as going concern, late 2015	Soft Market testing indicates interest
27	N/A Intermediate Care facility	Brook-side Court	Will close when the new intermediate care facility opens	Intermediate care would be provided from one facility
40	17	Preston Lodge	Transfer intermediate care provision to new facility and consider options, including closure	Intermediate care would be provided from one facility.
N/A	N/A	Abbey Mills	New 78 Extra Care facility will open in September 2014	LCC will have nomination rights to 50 beds
N/A	N/A	New Inter-mediate Care facility	New 60 bed facility will open in 2015	Will replace current fragmented service, including Brookside Court

<u>Further Implications of a phased approach</u>

3.21 This option means that some residents would have to be supported to find other placements and to move from their existing home.

3.22 In 2013, based on current residency, 30 residents would need to move, and it is understandable that residents and their families would be worried about this change. However, staff are experienced in assisting older people to move to alternative accommodation and will ensure the good practice guidance produced by the University of Birmingham 'Achieving Closure' is implemented.

3.23 Every resident affected would be offered an individual approach to transition, ensuring their wishes on alternative provision were paramount in the change process. There would also be assurances provided via the approach to sale for the continued provision of services and cost of services to those residents that would transfer to a new provider.

3.24 The position for Preston Lodge would be confirmed after evaluation. It is recommended that Preston Lodge continue to take new residents until a decision is made and that permanent admissions cease in any of the homes approved for closure in 2013 to minimise the impact on resident moves.

3.25 There is also some impact on the workforce with phased approach. The closure of Herrick Lodge, Elizabeth House and Nuffield House in 2013 would place 56.56 (77 Headcount) full time equivalent staff at risk. This would be mitigated by offering relocation to other homes to replace agency workers. The 2 homes that would be put up for sale in phase 1 (Abbey House and Cooper House) and potentially in phase 2 (Thurncourt and Arbor House) currently have 9.5 full time equivalent agency workers. In addition a small number of staff could relocate to Brookside Court, as more intermediate care would be delivered from there.

3.26 The opening of a new intermediate care facility in 2015 will have a staffing requirement of approximately 40 full time equivalents. Staffing at Brookside Court is currently 28.34 full time equivalent posts.

4. Details of Scrutiny

4.1 The ASC and Housing Scrutiny Commission carried out a review of elderly persons' residential care in Leicester, and held meetings on 5th October, 20th October, 3rd November, 17th November and 8th December 2011 which were open to the public. A review was approved by the Scrutiny Commission on 8th December. The Report was also considered by the Executive and a detailed discussion then took place with the Scrutiny members. The documentation was then presented to the Overview Select Committee meeting on 15th December 2011.

4.2 Details relating to the soft market testing were also shared with Scrutiny on 1st November 2012 and these are attached at Appendix C.

5. Financial, legal and other implications

5.1 Financial implications – Rod Pearson Head of Finance (Adults and Housing)

5.1.1 The Adult Social Care Budget for 2012/15 included the following indicative savings arising from the EPH Review.

	2012/13 £000	2013/14 £000	2014/15 £000
Net Cost (Saving)	500	0	(2,000)

5.1.2 Whilst no detailed plans existed or had been agreed, these calculations were modelled on the basis that six of the eight EPHs might close over a two year period with the remaining two being converted to Intermediate Care.

5.1.3 In the event the proposals arising from the review (described at 3.17d above) are significantly different in content and timing. Revised calculations are shown below:

Savings based on updated proposals					
			2013/14	**2014/15**	**2015/16**
			£000	**£000**	**£000**
Savings based on updated proposals EPHs			(615)	(2,461)	(3,429)
Double running costs assumptions based on updated proposals			1,015	1,330	1,540
Net Cost (Saving)			(400)	(1,131)	(1,889)

5.1.4 In addition to the above, the Intermediate Care Facility is expected to achieve savings of £878k from 2015/16. This is already reflected in the Council's budget strategy.

5.1.5 Clearly the above savings figures are highly provisional. They are based on many assumptions and need to be closely monitored.

5.1.6 The above revenue costs do not include any one-off redundancy costs, or any internal charges for the use of capital.

5.1.7 Appendix B outlines the options that are being considered regarding the proposed intermediate care facility. Capital costs are likely to be in the region of £6.77m. The Council currently has £3m available in the ASC Capital Programme. In addition NHS funding of £1.231m is available (subject to agreement) together with an estimated £1.810m of capital receipts from the sale of EPH sites (subject to formal Executive approval). This makes a total of £6.041m. Based on current estimates there is likely to be a shortfall of £0.729m.

5.1.8 This would need to be found through one or more of the following options:

- Reducing the capital cost
- A re-direction of resources from the current approved capital programme
- A bid for further corporate capital resources

5.2 Legal implications

5.2.1 General implications - Legal Services has been consulted throughout and continues to provide advice to ensure that the Council manages the process in a manner that is legally compliant and protects the interests of the public and of the Council. This includes, inter alia, consideration of community care, public law, employment, procurement and property considerations

5.3 HR Implications

5.3.1 The workforce implications for the various options presented are either TUPE transfer or redundancy. In either case sufficient time will need to be factored into consult with both trade unions and staff as outlined in the legal comments above

and a further period of time following consultation to allow for notice and redeployment procedures to be actioned. Depending on the options chosen and the numbers of staff involved this could take overall up to 6 months.

5.3.2 A number of care staff have already left on voluntary redundancy and their vacancies have been covered through a contingent workforce (agency/casual/overtime). This has presented problems around continuity of care and the covering of shifts that fall outside of operational hours. The Adult Social Care Leadership team has therefore decided that some of these arrangements need formalising into fixed term contracts to cover the intervening period. The advantage of continuing with an element of contingent workforce is that these vacancies could be released and staff at risk of redundancy and offered transfers to homes that are remaining open so reducing the need for compulsory redundancies in the short term. However this exercise would also require a period of consultation with trade unions and staff as existing contracts of employment are for particular residential homes and so as outlined in the legal advice above this is still a redundancy situation and we would offer the opportunity to work at the remaining homes as a potential reasonable alternative to redundancy. Many staff, however, may not select this option due to the additional distance and time to the new workplace being either non-drivers or working anti-social hours e.g. nights.

5.3.3 An open dialogue with HR should be maintained in order to develop and monitor a suitable plan for HR processes.

Nicola Graham, HR Team Manager
Ext 39 6272

5.4 Equality Impact Assessment

5.4.1 A full Equalities Impact Assessment (EIA) has been completed in relation to the options arising following the public consultation in 2011. This was considered by the Executive in February 2012. There a currently 161 long term residents in the Homes (as at 25/01/13). Residents are predominantly White British and female. 92% are White British with 8% from BME communities. 71% of residents are 86 years and older. 32% have dementia, 19% have mental health needs and 34% have physical disabilities 15% are frail/temporary illness.

5.4.2 The EIA demonstrates a positive impact for residents in relation to selling the homes, since it ensures continuity of care for all protected groups. This is because the workforce would transfer to a new provider under TUPE legislation. The EIA also recognises that some residents and relatives do have some anxieties about ensuring that new providers deliver high quality care. In the event of any procurement being agreed by the Executive, a process would be designed to enable some involvement of residents and relatives in the procurement, to increase confidence levels in potential new providers.

5.4.3 There are particular concerns amongst all residents about the idea of moving from their home to a different home in the independent or private sector. This is particularly the case for the residents of Herrick Lodge who feel that their cultural needs cannot be met elsewhere. The EIA addresses this concern and describes how the Council would work with residents and carers to reduce negative impacts.

5.4.4 As solutions begin to emerge for each home, the equalities implications will be reviewed, with an appropriate action plan produced for each home.

5.4.5 An equalities impact assessment has been completed for the closure of Brookside Court and re-provision of services in a single location serving the whole city. Brookside Court will not close until a new facility is in place. There are no permanent residents in Brookside and therefore no negative individual impacts. The overall impact is positive since future residents will benefit from improved facilities in a larger facility. Staff currently at Brookside are likely to have a calling on posts in this new establishment however they may deem them to be unsuitable due to the location and their own domestic arrangements.

Angela Hepplewhite
Business Transition Manager
Ext 29 8733

5.5 Climate change and carbon reduction implications

5.5.1 Elderly Persons Homes are large consumers of energy, particularly in the heating of these buildings. The sale of Thurncourt, Arbor House, Abbey House and Cooper House will result in a significant reduction in the carbon footprint of Adult Social Care; based on previous consumption figures, just under 670 tonnes of CO_2e would be saved per annum. The closure of Nuffield, Preston Lodge and Elizabeth House would save around 550 tonnes CO_2e per annum based on previous consumption figures. In total the closure and transfer to private ownership of the EPHs as discussed in the Report would save around 1,200 tonnes CO_2e per annum. This is in a context of an overall Council carbon footprint of just under 70,000 tonnes CO_2e per annum so achieving nearly a 2% reduction in the Council's total carbon footprint which will help the Council move towards achieving its carbon reduction targets. Of course, those EPHs that are sold and remain open will still be emitting similar levels of carbon as they were under Council ownership and so although the proposals will result in a reduction in the Council's carbon emissions it will not result in a reduction in city-wide carbon emissions.

Helen Lansdowne
Senior Environmental Consultant
Ext 29 6770

7. **Summary of appendices:**

   Appendix A - Intermediate Care and Short Term Residential Care Commissioning Strategy (2013 to 2016)

   Appendix B - Options for the provision on a dedicated Intermediate Care and Short Term Bed facility

   Appendix C - Results of Soft Market Testing

   Appendix D - Age profile of existing residents

8. **Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?**

   Yes.

9. **Is this a "key decision"?**

   Yes

10. **If a key decision please explain reason**

    This is a key decision with major financial implications following statutory consultation.

Appendix 4

Adult Social Care Scrutiny Review Information

Elderly Persons' Homes

Contents

Understanding the Independent Market

1. Level of provision for residential and nursing care for elderly people (number of homes, location & level of vacancies in the city)
2. Numbers of people funded by ASC over the last 10 years
3. Stability of the local market (number of care homes that have closed or opened in the city in the last 3 years)
4. Financial stability of the market (risk assessment based on the likelihood of financial failure and the potential impact of the number of available bed spaces in the city)
5. Role of EMCARE

Quality of provision

1. Registration and the role of the Care Quality Commission (CQC)
2. CQC standards of compliance
3. CQC inspection process and remedial actions
4. LCC contracts and monitoring process for the independent sector homes, which would also apply to any LCC homes that are sold as going concerns
5. LCC inspection process and remedial actions
6. Quality Assurance Framework (QAF)

Supporting People in the Community

1. National and local research into the needs of older people
2. Growth of domiciliary care over the last 5 years
3. Provision of supported housing and Extra Care
4. Use of adaptations
5. Use of assistive technology
6. Use of reablement
7. Use of Shared Lives scheme
8. Reducing social isolation

Intermediate Care and Short Term Beds

1. Benefits of intermediate care
2. Limitations of existing provision
3. Demographic growth
4. Future need for a 60 bed facility
5. Options explored and rationale for a proposed new build facility
6. Potential issues relating to the disposal of the EPH sites and capital monies

How would the financial gap be managed if the homes were not closed?

1. Introduction
2. EPH proposals and associated savings
3. The Council's overall position
4. Alternative options

5. Issues and options within Adult Social Care

Understanding the Independent Market

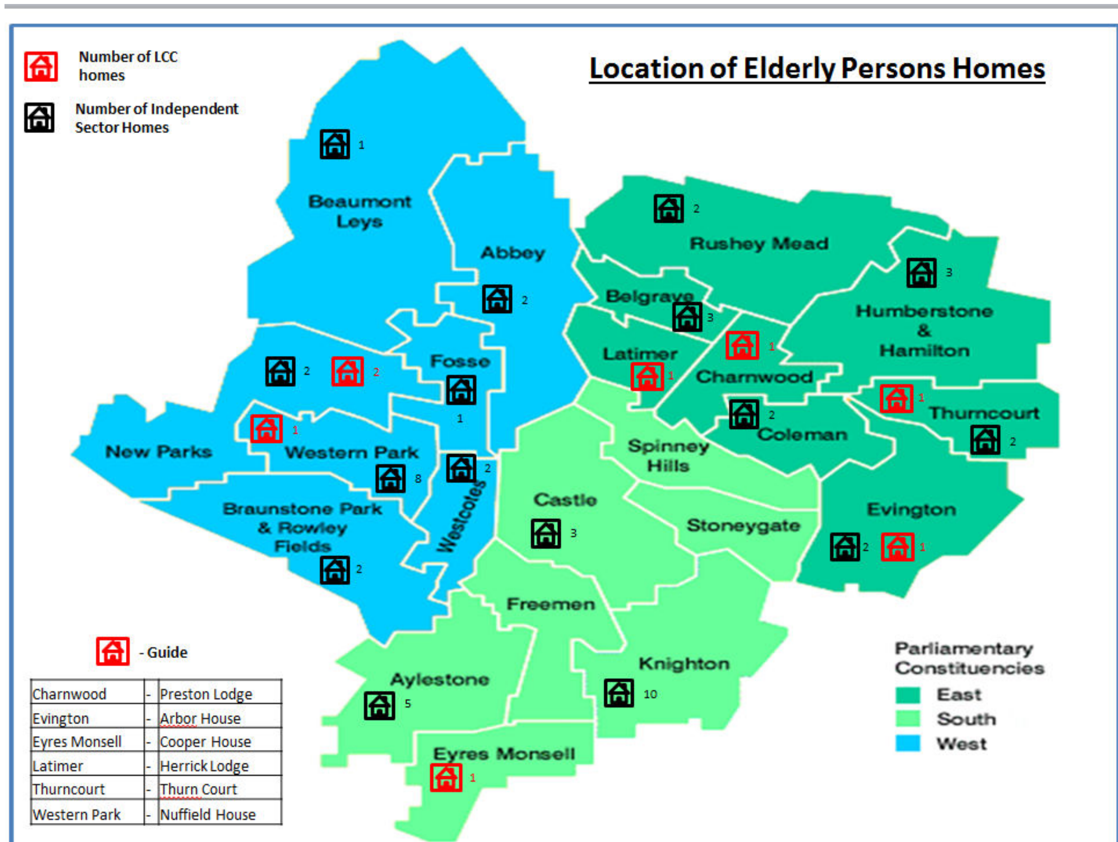
1. Level of provision for residential and nursing care for elderly people (number of homes, location & level of vacancies in the city)

Homes, Residency & Vacancies across the City

Independent Sector Homes				
Wards	Number of Homes	Capacity of Homes	Number of Vacancies	Number of LCC Placements
Abbey	2	93	0	13
Aylestone	5	188	8	80
Beaumont Leys	1	44	0	19
Belgrave	3	64	3	31
Braunstone Park Rowley Fields	2	144	5	28
Castle	3	74	5	20
Charnwood	0	0	0	0
Coleman	2	98	11	23
Evington	2	93	3	42
Eyres Monsell	0	0	0	0
Fosse	1	22	3	10
Humberstone & Hamilton	3	110	4	27
Knighton	10	350	14	100
Latimer	0	0	0	0
New Parks	2	29	2	4
Rushey Mead	2	86	0	35
Thurncourt	2	52	4	19
Westcotes	2	37	1	12
Western Park	8	214	13	104
Grand Total	50	1698	76	567

LCC Homes				
Number of Homes	Homes	No of Permanent Beds	No of Permanent Residents	Number of Vacancies
1	Preston	40	15	25
1	Arbor	40	26	14
1	Cooper	29	28	1
1	Herrick	40	5	35
2	Abbey&Elizabeth	71	38	33
1	ThurnCourt	38	32	6
1	Nuffield	24	16	8
8		282	160	122

6.
7.
8.



2. Numbers of people funded by ASC over the last 10 years

Year	Average number of residents support by LCC in our own homes	Number of residents supported by LCC in independent sector homes	Number of residents supported by LCC in nursing beds.
2003	262	774	192
2004	249	722	198
2005	236	803	187
2006	238	728	194
2007	241	675	207
2008	227	656	192
2009	224	632	154
2010	211	600	136
2011	154	586	149
2012	140	582	150
2013	161	Not yet available	Not yet available
Source :	*Carefirst*	*LCC Statutory Return*	*LCC Statutory Return*

3. Stability of the local market (number of care homes that have closed or opened in the city in the last 3 years)

The current number of Elderly Persons Homes in the independent sector within Leicester City that Leicester City Council contracts with is 50. They have a combined capacity of 1698 beds. The homes are listed below.

Name of Home	Capacity
Abberdale House	24
Aberry House	38
Acorn Hill	49
Agnes House	26
Alston House	19
A S Care	25
Ashleigh	21
Ashton Lodge	27
Asra House	38
Beaumont Hall	60
Braunstone Firlands	24
Clarendon Mews	40
Diamond House	33
Diwali Nivas	16
Fosse Court	22
Foxton Grange	36
George Hythe House	44
Glenfield Woodlands	17
Gokul Nivas	10
Goodwood Orchard	18
Grey Ferrers	120
Groby Lodge	12
Harley Grange	34
Harley House	28
Hayes Park	49
Hollywell Court	12
Langdale View	34
Leaholme	17
Manor Nursing Home	49
Mauricare	17
Meadows Court	66
Melbourne Home	17
New Wycliffe Home For The Blind	46
Pendene House	12
Pilgrim Home for Elderly Christians	30
Pine View	15
Rushey Mead Manor	40
Scraptoft Court	34
Silver Birches	16
South Lodge Care Home	106
Spencefield Grange	63
St Bennetts Care Home	27
St Georges Care Centre	36
Stoneygate Ashlands	37
Stoneygate Oaklands	44
Vishram Ghar	40
Vrandavan	16
Welford Court Residential Home	14
Westcotes Rest Home	20
Western Park View	60
Total Capacity	**1698**

The market is very stable, with the number of beds coming into the market exceeding those leaving by 125, an increase of 8% over the period.

New Homes opened within the last three years

1) Southlodge 106 beds
2) Beaumont Hall 60 beds
3) Vrandavan 16 Beds

Homes closed with last three years

1) Glenholme 14 Beds
2) Skelton Court is closing in June; it has a capacity of 20, and currently has 7 residents.

Homes Reconfigured

Summervale closed with a capacity of 56, has subsequently reopened as Diamond House with a smaller capacity of 33

4. **Financial stability of the market (risk assessment based on the likelihood of financial failure and the potential impact of the number of available bed spaces in the city)**

In light of the collapse of Southern Cross an exercise was carried in 2012 to assess the financial stability of providers operating within Leicester City. We have revisited and updated this and can report as follows:

Methodology

There are 50 Elderly Persons Homes in Leicester City that Leicester City contracts with. The vast majority of these (46) trade as Limited Companies and as such financial information is within the public domain. We looked at profitability, net assets and levels of debt.

Outcome re the 46 incorporated homes

The vast majority, 43 or 94% are financially stable, and show no indications of failing.

There are three homes that could potentially have issues in the medium term. One of these homes was formally part of Southern Cross and is now managed by HC-One Ltd. HC-One took over the management of 238 former Southern Cross homes countrywide, it is too early for a full financial verification, however their credit rating is low, at 29% “Caution credit at discretion”. If a similar event to that of Southern Cross happened the likelihood is that the home in Leicester would not close, it appears well run, and would probably be taken over by another operator.

The other two homes that cause concern are both homes with less than 20 residents, small losses are being incurred. A similar sized home has closed within the last 3 years; the issue is around the economies of scale of operating smaller homes. If one or both of the homes close there is capacity in the market to cope.

Comment re the 4 Unincorporated Homes

No financial checks have been undertaken as no financial information is within the public domain. The four homes have a total of 86 beds, checks on CQC website indicate that one of the homes has not carried out work requested by CQC; this may or may not be a sign of financial weakness. We will request financial information from this provider.

Occupancy of Homes

Occupancy levels of 95% are typical with Leicester City. This is seen as an optimum level for providers, a lot of whose costs are fixed. Providers generally struggle financially if occupancy falls below 85% and it is noticeable that care home failures tend to occur in areas of lower occupancy.

5. Role of EMCARE

The East Midlands Care Association (EMCARE) is the 'trade' body that is purported to represent 40% of private Care Homes and Nursing Homes for both the elderly and younger adults in the Leicester, Leicestershire and Rutland region. The organisation is run by care home owners, and their role is to represent the views of providers at national, regional and local levels in all matters relating to care. The Council meets with both EMCARE and all City Providers on a quarterly basis to work together for example reviewing practice, development of new polices or practices etc.

Quality of provision

1. Registration and the role of the Care Quality Commission (CQC)

All Providers of regulated services including Care Homes have to be registered with the Care Quality Commission (CQC). The role of CQC is to:

- Set Standards of quality and safety that people have a right to expect whenever they receive care.
- Registering care services that meet their standards.
- Monitoring, inspecting and regulating care services to make sure that they continue to meet the standards.
- Protecting the rights of vulnerable people, including those whose rights are restricted under the Mental Health Act.
- Listening to and acting on stakeholder experiences; Your experiences.
- Involving the public and people who receive care in Their work and Working in partnership with other organisations and Local groups.
- Challenging all Providers, with the worst performers getting the most attention.
- Making fair and authoritative judgments, supported by the best information and evidence.
- Taking appropriate action if care services are failing to meet the standards.
- Carrying out in-depth investigations to look at care across the system.
- Reporting on the quality of care services, publishing clear and comprehensive information, including performance ratings to help people choose care.

2. CQC standards of compliance

There are 28 Outcomes under 6 Standards, these are listed below:

- **Information and Involvement**
  - Outcome 1 Respecting and Involving people who use services
  - Outcome 2 Consent to Care and Treatment
  - Outcome 3 Fees
- **Personalised Care and Support**
  - Outcome 4 Care and Welfare of people who use services
  - Outcome 5 Meeting nutritional needs
  - Outcome 6 Cooperating with other Providers
- **Safeguarding and Safety**
  - Outcome 7 Safeguarding people who use services from abuse
  - Outcome 8 Cleanliness and Infection Control
  - Outcome 9 Management of Medicines
  - Outcome 10 Safety and Suitability of Premises
  - Outcome 11 Safety, availability and suitability of equipment
- **Suitability of Staffing**
  - Outcome 12 Requirements relating to workers
  - Outcome 13 Staffing
  - Outcome 14 Supporting Workers
- **Quality and Management**
  - Outcome 15 Statement of Purpose
  - Outcome 16 Assessing and monitoring the quality of service provision
  - Outcome 17 Complaints
  - Outcome 18 Notification of death of a person who uses services
  - Outcome 19 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983
  - Outcome 20 Notification of Other incidents
  - Outcome 21 Records
- **Suitability of management**
  - Outcome 22 Requirements where the service Provider is an individual or partnership
  - Outcome 23 Requirement where the service Provider is a body other than a partnership
  - Outcome 24: Requirements relating to registered managers
  - Outcome 25: Registered person: training
  - Outcome 26: Financial position
  - Outcome 27: Notifications – notice of absence
  - Outcome 28: Notifications – notice of changes

3. CQC inspection process and remedial actions

CQC inspect care in hospitals, care homes, people's own homes, dental and general practices, and other services against the National standards, and they publish their findings on their website and in their inspection reports.

They currently inspect most hospitals, care homes and domiciliary care services at least once a year, and inspect dental services at least once every two years. They also re-inspect services that aren't meeting standards and will inspect services more often if they think they are providing poor care that might be putting people at risk.

Inspections are unannounced unless there is a good reason for them to let the service know they are coming. During inspections they:

- Ask people about their experiences of receiving care.
- Talk to care staff.
- Check that the right systems and processes are in place.
- Look for evidence that the service isn't meeting national standards.
- Sometimes their inspectors will be accompanied by clinical experts and Experts by experience (people who have experience of receiving care) who will also talk to people who receive care.

CQC judge services against the national standards which are the standards that people can expect when receiving health or social care. However they are now in the process of changing what they look at so that they answer the following questions about services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

<u>Types of inspections</u>

CQC carry out three types of inspections.

- Scheduled: these are unannounced inspections that focus on a minimum of five of the national standards, and they're also tailored to the type of care that is provided at the service.
- Responsive: these are unannounced inspections that are carried out where there are concerns about poor care.
- Themed: these inspections focus on specific standards of care or care services.

Working in partnership

When their inspectors find serious concerns, they may Work in partnership with other organisations throughout the inspection process to ensure that services make any necessary improvements. CQC work in partnership with organisations such as the he Council, other Local Authorities, Monitor, Ofsted, Healthwatch England, NHS England and more.

CQC findings

If the service is not meeting national standards, the inspector will decide whether there is a minor, moderate, or major impact on people who use it, and they may decide to take Enforcement action. You can see whether or not care service is meeting the national standards by visiting its profile page on the CQC website. The standards are grouped under five headings, with a green tick, grey cross or red cross beside it, which is updated every time a new report is published.

4. LCC contracts and monitoring process

All care homes are contracted through spot contracts; this is different to the majority of the other services in the adult social care market where a full tendering exercise is undertaken on a periodic basis. Under the Choice Directive all service users have a choice about which care home they want to live in, regardless of whether we already hold a contract and are often located outside of the city boundary.

Prior to issuing a contract with a new care home the Contracts and Assurance team undertakes a due diligence process. This includes the collection and review of intelligence in relation to performance of the home such as information is gathered from the CQC and the “hosting” Local Authority if outside of the city boundary. The Council currently holds a contract with all the existing city registered care homes.

If the Provider and the care home passes this check contact is then made with the Provider to agree the terms of the contract and to arrange for evidence for registration and insurance to be sent. Once a contract is issued for homes within the city boundary we will undertake a contract monitoring visit, this is regardless of the number of city users within the home. For care homes outside of the city boundary contract monitoring is undertaken by the ‘host’ authority.

As part of the wider information gathering role in contract monitoring the Contract and Assurance team chairs monthly Information Sharing Meetings with representatives from the Adult Safeguarding Unit. The purpose is to share intelligence about Providers and to ensure that all departments are aware of emerging issues and on-going concerns so that appropriate action is targeted to those Providers needing attention and or enhanced levels of support.

The Team also attends quarterly Information Sharing Meetings hosted by CQC. Attendees include representatives from Continuing Health Care, Leicestershire County Council, and Leicester Adult Safeguarding Unit. The meeting allows for discussion and sharing of trends, themes and intelligence about Providers and an open exchange of information about particular services, the nature of the concern and the current status of the service.

The Contracts and Assurance team is actively involved in partnership working within the Care Home Sector to drive up quality and standards and develop and share good practice. The team participates in the former Care Homes Advisory Group which has membership across Health, Social Care and EMCare. The remit of this group was to identify improvements in working practices across the sector for improvements. Recent activities included identification of safeguarding trends around food and nutritional intake and the linkages with pressure ulcer management. This Group has recently been re focused as the CHC/Care Home Clinical Quality Development Group led by the Quality team on behalf of the 3 CCGs and looking at performance of care homes which will identify areas of good practice and areas for improvement and provide outcomes to be shared with providers and with commissioners. Representatives from this group are currently working on updating the Health & Social Care Protocol which is a document that provides guidance to Health & Social Care Professionals including Care Providers about effective delegation of health tasks that with training and supervision can be carried out by Social Care staff.

The Contracts and Assurance team hosts the Independent Consultative Sector Forum which is a quarterly meeting held representatives from EMCare in which we discuss and consult on national and local strategy and policy changes and proposals for raising the standards of quality within care homes and contract compliance.

The Contracts and Assurance team also leads the Care Home Provider Forum in which all contracted Providers are invited to attend. Meetings are held quarterly, the agenda is to look at new polices or practices in development, share ideas and practice and look for joint solutions to problems, this may include guests invited to present. Recent topics discussed have been the introduction and roles of Clinical Commissioning Groups' within Leicester, Hospital Discharge, Health and Safety and the development of the Quality Assurance Framework (QAF).

During 2013 we will be implementing the regulated service Quality Assurance Framework which will replace our current monitoring and give a broader measurement of regulated services. This is aimed to allow the Provider to develop their on-going self-reflective practice through the use of a self-assessment tool allowing them greater input into the assessment process and broadens the assessment beyond contractual output to qualitative assessments in the care home.

The Provider Forum also forms an important function with regards to consultation of changes to contractual arrangements. In 2012 we have undertaken extensive consultation on the development of a new Contract Core Agreement to be implemented in and are undergoing a review of the residential care home fees paid by the Council to Providers.

5. LCC inspection process and remedial actions

Contract Assurance Monitoring

Once the Contract is signed and agreed the following methods are used to monitor the performance of the home;

- Analysis of Notifications of Concern
- Contract Monitoring visits (announced and unannounced)
- Collection of soft intelligence – networking with colleagues in Leicestershire, Continuing Health Care and CQC, Care management, Safeguarding, Environmental Health etc.
- Administration of a “Status” list which contains information in relation to on- going Safeguarding investigations and Contractual concerns
- Health and Safety Audits

Contract monitoring visits take place each year or more frequently if needed; these are either by planned or unannounced visits to the homes. At the visit we will review the following Outcomes;

- Contractual Documentation
- Involvement & Information
- Personalised Care, Treatment & Support
- Safeguarding and Safety
- Suitability of Staffing
- Quality & Management

Visits undertaken by Contracts Officers are usually conducted with the Manager or senior officer on duty. The visit is used to look for evidence to determine whether the care home is compliant in each of the above areas. This involves screening policies and procedures, resident’s case records and staff files. Verification of the application of these is undertaken through observation and through talking to staff, services users and their relatives on site. With staff the discussion is particularly checking out their understanding and application of the policies and procedures which support care delivery and to confirm that they know what the individual care needs are as identified in the residents care plans. In our conversations with relatives and residents we are trying to establish the quality of the care and support that is delivered and if they are not happy with this are they able to report their concerns and have them acted upon. At the end of each visit the Officer provides an initial

brief verbal feedback to the Provider and discusses with them any issues that we have evidenced. This is followed up with a formal report.

If a care home is judged to be non-compliant in one or more areas the report will indicate whether these are minor concerns, moderate concerns or major concerns. The report will contain an action plan of expected areas for improvements to be made and timescales for completion. Follow-up contact will be made to check on progress. The decision as to the nature of the contact will be made in accordance with the severity of the non-compliance and the nature of the actions.

Within the Core Agreement that the Council has with the care home failure to meet contractual obligations can result in a number of actions being taken. Depending on the severity of contractual breaches the Council may take the decision to serve a Notice to Remedy of Breach, this is a legal letter that holds details of the parts of the contract to which the council considers the Provider is breaching the contract. This will usually be accompanied by an action plan which will have greater details about what specifically they are required to do and by when. If the breaches in the contract relate to the safety and welfare of the residents then we ask that the Provider enters into a voluntary suspension of placements, this is an agreement from them that they will not take any new residents into the home regardless of funding streams until such time as the breaches have been remedied. Should the Provider refuse to voluntarily enter into a suspension of placements then we can impose a suspension on them, however an imposed suspension means that we are only able to stop them from taking city council funded residents and this does not safeguard self-funders.

The last sanction that can be placed on a Provider is termination of their contract as a result of failing to make the improvements as detailed in their Notice to Remedy of Breach. This is a last resort action that is very rare, most Providers engage with the Council and accept support from Contracts and Assurance Team or the Quality Improvement Team.

In addition to the planned contract monitoring visits the Contracts and Assurance team will also undertake responsive visits, these are usually as a result of investigations into serious concerns when an allegation of failure to safeguard individuals or as a result of a significant event. Responsive visits can take place at any time of the day or night and are most likely to be targeted to look at concerns of a specific nature. These visits are co-ordinated with Care Management teams and Safeguarding and will feed into multi-agency safeguarding conferences. As a result of a responsive visit if there is evidence that the Provider is in breach of their contract an improvement plan will be developed and the Providers will be monitored with regards to their progress towards achieving actions.

Involved in the oversight of care homes is the Quality Care Team. This team is based within the Adult Social Care - Safeguarding Adults Unit

and has one full time and three part-time social workers who complete the work. This team will consider whether identified care homes are providing good standard care and attention in the delivery of services at the care home establishment when meeting the various needs of the individuals that live there. The team are highlighted to referrals from within Adult Social Care based in locality or other teams, or by information that is presented, for example, by health colleagues, CQC, contract departments or other authorities. The Quality Care Team will look to determine if they have a role and if so will initiate with the care home that they attend the facility to work with them to initiate improvements in identified areas of concern. They can be part of the process that tracks and monitors progress toward improvements, but may also be a part of the process that might instigate Large Scale Investigation of more serious safeguarding concerns at the care home. Ultimately the Quality Care Team want to work in partnership with the care home provider to help enable and empower remedial and evidenced based activity that addresses the problems as identified

As part of the contract monitoring process, a standalone health and safety audit is undertaken in each home. The audit is completed by a specialist Health and Safety Officer and aims to support homes to develop their understanding of, and compliance with, health and safety legislation. Where moderate or major concerns are highlighted – this may be as a result of failings in one area or a number of areas, a Notice to Remedy a Breach will be issued. This is a legal notice that improvements are contractually required to be addressed. Failure to Remedy a Breach of contract could result in a suspension of placements or a termination of contract.

Guidance for Suspension of Placements with Contracted Providers of Care Services

Introduction

1. The aim of this guidance is to protect service users from significant risk of harm through omission, neglect or abuse. The guidance outlines procedures that Leicester City Council ("the Council") will follow where there has been a serious breach of contract by a Provider or other serious circumstances have arisen where the Council have contracted with the Provider to provide care services to vulnerable adults

2. The procedures that the Council will follow where there has been a serious breach of contract or other serious circumstances have arisen ("other serious circumstances") at the care services, are an informal suspension (Informal Suspension) or formal suspension (Formal Suspension) of new placements funded by the Council with the contracted Provider of care services.

3. Where there has been a serious breach of contract or other serious circumstances which place service users at significant risk of harm and/or the care needs of service users are compromised, the aim of the Council will be to work with the Provider and other agencies in an open and honest way to address and remedy the situation as a matter of urgency.

4. Providers should be aware that a suspension of placements is not a measure that the Council will take lightly. Examples of circumstances that are likely to result in a suspension of placements are provided in Appendix A.

5. The type of suspension imposed will be dependent on the circumstances of the case and the severity of the breach of contract or other serious circumstances.

Monitoring

6. The Council has a responsibility to monitor Providers of care services to ensure that Providers are meeting their contractual obligations for service users funded by the Council. In addition the Council has a role as the Lead Agency for the safeguarding of vulnerable adults in its respective administrative area as set out in the "No Secrets Leicester Leicestershire and Rutland Multi-Agency Policy and Procedures for the Protection of Vulnerable Adults from Abuse" ("Multi-Agency Vulnerable Adults Safeguarding Procedure") and "Leicester City Council's Safeguarding Children and Vulnerable Adults Guidance for Contracted Services" ("Leicester's Safeguarding Policy"). Accordingly in circumstances where the Councils are in the process of monitoring care services they will seek to work with Providers to ensure that self-funding residents in for example care homes receive the same level of service provision, quality and levels of protection as residents funded by the Council.

Informal Suspension

7. An Informal Suspension of placements is a procedure whereby the Provider has agreed with the Council to voluntarily suspend all placements at its service including for example local authority or NHS funded service users along with self- funding residents in a care home for a period of time.

8. The Council will forward a letter (the "Informal Suspension Letter") to the Provider together with an action plan to address the serious breach of contract or other serious circumstances identified within the service.

9. The Council will give additional advice in writing in relation to the contents of the action plan. The action plan will include a timescale for the actions identified within the action plan to take effect and

once the action plan is in place the Provider will need to provide evidence to the Council of satisfactory results from the implementation of the action plan.

10. The Provider must also confirm in writing within 5 working days of receipt of the Informal Suspension Letter their agreement to comply with the terms and conditions as set out in the Informal Suspension Letter.

11. Where an Informal Suspension has been agreed the following parties will be informed where applicable:

    a) Care Quality Commission (CQC).
    b) Other Local Authorities which are funding placements at the care service.
    c) NHS Bodies who are funding placements at the care service.
    d) Health colleagues providing services to the service users.

12. The timescale for completion of the action plan is likely to be a period of up to 12 weeks (or such other time period as determined by the Council dependent upon the perceived level of risk to service users) to address the issues. The Provider must be able to demonstrate and provide evidence that they are actively working with the Council to remedy the serious breach of contract or other serious circumstances and any other concerns about the service provision and demonstrate that the delivery of services meets service user outcomes within the allotted timescale.

13. Where the Provider is able to demonstrate and evidence that progress has been made within the timescale allotted then the Council may extend the timescale for other actions to be completed. The Provider will receive written notification of this extension.

14. Relevant Council Officers will be available to discuss the contents of the action plan and issues leading to the Informal suspension and will work with Providers to address issues of non-compliance with the contract or other issues relevant to the provision of the service. Other agencies including NHS Bodies and CQC may put forward proposals as part of the Informal Suspension process which the Provider will be expected to implement. Relevant Council Officers will support the Provider to remedy a serious breach of contract or other serious circumstances so that any suspension can be lifted as soon as all of the issues identified have been addressed to the satisfaction of the Council.

15. Where the Provider is unable to demonstrate and provide evidence that progress has been made within the timescale allotted or in the event that further concerns have arisen in respect of the service whilst an Informal Suspension is in place, (whether or not an action

plan has been completed), the Council may elect to implement a Formal Suspension immediately.

Formal Suspension

16. A formal suspension of placements means that the Council will not make any further placements at the care services until the serious breach or other serious circumstances have been remedied and a settled period as assessed by the Council has elapsed during which no further concerns have been identified within the service.

17. A decision to implement a Formal Suspension will depend on the nature of the circumstances but will occur when the Council have come to a decision that a Formal Suspension is the only course of action available to them. A Formal Suspension may be made where:

    a. the severity of the breach of contract or the other serious circumstances are at a level where immediate action by the Provider should be taken to secure the health, safety and well-being of all service users;

    b. a serious breach of contract or other serious circumstances have occurred and an Informal Suspension is not deemed appropriate by the Council.

    c. an Informal Suspension has not resulted in a satisfactory outcome in the opinion of the Council.

    d. an investigation under the Multi-Agency Vulnerable Adults Safeguarding Procedure has made a decision that a Formal Suspension should be implemented.

    e. where attempts to engage a Provider in discussions and methods to address less serious breaches of contract or concerns about the service provision have proved unsuccessful.

18. The Council will work openly and honestly with Providers during the period when a Formal Suspension is in place.

19. The Council will notify the Provider in writing of the circumstances surrounding the imposition of a Formal Suspension and the reasons for the decision to suspend.

20. The following parties are likely to be consulted where the Council is proposing to impose a Formal Suspension:

    a. Care Quality Commission (CQC)
    b. Other Local Authorities which are funding placements at the care services
    c. The Police

d. NHS Bodies who are commissioning care services provided by the Provider
e. NHS Bodies who are providing health services to service users
f. The Provider

Following consultation with the above parties the details surrounding a serious breach of contract or other serious circumstances will be discussed between the Commissioning Managers of the Council in consultation with the Council's Legal Services where a final decision will be reached in relation to imposing a Formal Suspension on the Provider.

21. The Council will forward a Formal Suspension Letter to the Provider together with an action plan to address the serious breach of Contract or other serious circumstances and forward this to the Provider.

22. The Council will give advice in writing in relation to the contents of an action plan that is deemed necessary to address the issues. The action plan will include a timescale for the actions identified within the action plan to take effect and once the action plan is in place then the Provider will need to provide evidence of satisfactory results from the implementation of the action plan to the Council.

23. Where a Formal Suspension has resulted from non-compliance with the conditions set out in an Informal Suspension process, or where the Provider has been unable to evidence satisfactory progress of an action plan requested under an Informal Suspension process, a revised timescale of up to 12 weeks (such timescale to be as determined by the Council based upon the perceived level of risk to service users) will be given to the Provider to address the issues.

24. The Provider upon request and following written notification of a Formal Suspension being imposed, will make available to the Council information regarding other Local Authorities or NHS Bodies who are currently funding placements at the care services along with details of the individuals involved and also details of self-funding residents living within the care services within 5 days of receipt of the Formal Suspension Letter.

<u>Communication with other parties</u>

26. The decision to implement a Formal Suspension of new placements at a the care services will be shared with all service users (or their relatives as appropriate) funded by the Council and also other funding local authorities or NHS Bodies and self-funding residents of the care services. The aim of this process is to advise relevant parties of the situation and demonstrate to them that the Council are actively engaging with the Provider to remedy a serious breach of Contract or other serious circumstances and that the health, safety

and well-being of service users is being closely monitored by the Council.

27. The initial method of contacting service users (or their relatives), other funding local authorities and NHS Bodies and self-funding of care services will be by letter (“Letter of Notification”). The content of the Letter of Notification will inform the relevant parties that the Council have temporarily stopped making any further placements at the care services due to the concerns they have about the service provision. The relevant parties will be informed that the Council are working closely with the Provider to raise the standards of care currently being delivered and that the residents/relatives will be invited to a meeting at the care services to discuss the issues. The Provider will be expected to support the Formal Suspension process and will arrange a residents/relatives meeting (where necessary) to discuss the issues around service provision to which all service users/relatives will be invited along with appropriate representatives from the Council and other agencies. Where a service users/relatives meeting is deemed necessary, the timescale for holding the proposed meeting will be within 10 days following the date of the Formal Suspension Letter.

Protection of service users where placements have been formally suspended

28. The protection and safety of service users already placed within a care services where a decision has been reached to implement a Formal Suspension, is paramount. Where there are concerns that the safety of service users is at risk, the Council will seek the assurance of the Provider that they will remedy a serious breach of contract or other serious circumstances immediately.

29. The Council will closely monitor the service provided during the Formal Suspension period by:

    1. Implementing a review of individual service user’s needs by operational staff which will include where appropriate input from NHS Bodies.

    2. Carrying out announced and/or unannounced visits to the care services by Officers of the Councils and if required officers of NHS Bodies.

30. Where immediate action to remedy a serious breach or other serious circumstances is not forthcoming or not possible and there is an on-going failure by the Provider to address issues within the allotted timescale, it is likely that the Council will take the following action:

    - Share information with CQC for a decision to be made by CQC as to whether under the regulatory framework they need to impose

requirements on the Provider in respect of the service, or at its most serious whether they need to consider de-registering the Service.

- Consider whether after consultation with the Councils' Legal Services, the Council will look for alternative placements for service users.

- The termination by the Council of the Contract with the Provider.

Lifting of a Formal or Informal Suspension

31. Once all of the essential actions outlined in the Formal or Informal Suspension Letter and the resultant action plan have been addressed and a settled period of six months (or such other period assessed by the Council) has elapsed during which no further concerns have been identified within the Service then the Councils will write to the Provider to advise them that the Formal or Informal Suspension process has been lifted.

32. To ensure that continued service delivery is able to meet service user outcomes, a phased approach for the admission of new service users to care services will be agreed and confirmed in writing with the Provider. This information will also be conveyed to relevant operational staff and managers of the Council and other agencies.

33. Where the Council have implemented a Formal Suspension process and have since confirmed with the Provider that the Formal Suspension will be lifted then the Council will write to all current service users (or their representatives as appropriate), other funding authorities and self-funding service users, as relevant, to advise them that the Provider has worked positively with the Council and the previous issues have been resolved and accordingly the Formal Suspension of placements has been lifted

6. Quality Assurance Framework (QAF)

Quality Assurance Framework (QAF) Key Principles

- Overarching focus on positive outcomes for service users
- Supports both service users making care home choices and those making commissioning decisions
- Based on evidence from those who use the service, other key stakeholders and observational assessment
- Providers are clear what 'quality' looks like as defined by service users, their families/carers and how this can be achieved
- Partnership working between care homes and the city council to drive up quality

Key Principles Expanded

- *Overarching focus on outcomes for service users*

  All those using the service will have a strong voice; they are actively involved and have clearly contributed towards deciding what good quality looks and feel like, and measuring the service against these.

- *Supports both service users making care home choices and those making commissioning decisions*

  Provides a quality assurance model with information that helps people make choices and decisions about their care. Those commissioning services will better understand the needs and expectations of those using care homes. Information about QAF outcomes is to be available in a variety of ways to support transparency and ensure accessibility.

- *Based on evidence from those who use the service, other key stakeholders and observational assessment*

  Provides an overall assessment according to the experiences of those using the service, together with intelligence from others with an interest and uses observation to see the service in operation. Includes appropriate methods to gather the views of all stakeholders

- *Providers are clear what 'quality' looks like as defined by service users, their families/carers and how this can be achieved*

  Application of the QAF helps Providers to understand 'person-centred' service provision and its importance. There is a clear understanding of the needs and aspirations of those who live in residential care homes, their families and carers, how this can be achieved, evidenced and its success measured.

The 'Assessment' Standards

All care homes must meet statutory regulations; the Quality Assurance Framework (QAF) seeks to ensure that homes comply with quality standards alongside these basic requirements. The QAF consists of nine overarching 'assessment standards' which are split into two parts:

Part I:
These standards are a mixture of standards to compliment the CQC essential standards of quality and safety, and delivery of Leicester City Council's Contract Specification. These standards must be met in order to demonstrate contract compliance and focus mainly on 'hard outcomes' that relate to operational aspects of the service; so for

example look at evidence that can be found in files and policies/procedures. The standards are:

- Personalised care, treatment and Support
- Safeguarding and Safety
- Information, Policies and Procedures
- Suitability of Staffing
- Quality and Management

Part II:
These standards are outcome focused. They include a minimum Performance Level C that is expected for a service to demonstrate 'adequate' provision and contract compliance, but also allows for a higher level of service quality to be evidenced. These focus on 'person centred' and/or 'soft outcomes', so the changes, benefits or otherwise as a result of specified activities. These can be evidenced and or measured in a number of ways to provide an insight into how people feel about the service provided, so for example they feel more confident, happy and safe. The standards are:

- Voice, Choice and Control
- Good Relationships
- Spending time purposely and enjoyably
- Service and Organisational Factors

It is proposed later in the year the results of the QAF will be published to support service users and their families select the most appropriate provision for their needs.

Supporting People in the Community

1. National and local research into the needs of older people

The following information regarding the needs of older people is taken from the Census 2011, the Planning4Care Strategic Needs Assessment and other local intelligence.

Current numbers of older people with social care needs in Leicester

The population of Leicester who were aged 65+ at the time of the 2011Census was estimated to be 37,200.

- Of these, about 14,600 (39%) were estimated to have some level of social care needs. Of this cohort, about 10,300 were estimated to have 'moderate' to 'very high' needs, and 3,700 to have 'very high' needs.
    - Of the total 'very high' needs group, 2,700 were estimated to have a functional disability resulting from a high level of cognitive impairment (primarily dementia).

- 12,300 were potentially in need of formal care, whilst 2,360 are estimated to be well supported by informal care. The remaining cohort of over 22,000 people is not thought to have any care needs.

- 2,750 of those with 'moderate' to 'very high' needs received care funded by the Local Authority (1,510 of these were estimated to have 'very high' needs).

- 6,160 of those with 'moderate' to 'very high' needs were estimated to be either unsupported or funding their own care (including 1,870 with 'very high' needs).

- The proportion of older people across Leicester estimated to have some level of social care need (39%) is above the regional average (35%).

<u>Projections of social care need</u>

Based on Planning4care estimates combined with Census 2011 and published population projections, the number aged 65+ with some level of social care need in Leicester is projected to rise by 47% over the next 20 years (below the regional rise of 64% and below the national rise of 54%). The number of people in Leicester with 'very high' social care needs is expected to rise by 46% over the same period.

<u>Exploring the impact of changes due to healthy life expectancy and preventative initiatives on future social care needs in Leicester</u>

The potential impact of improvements in Healthy Life Expectancy and effective preventative care interventions on projected numbers with social care need is significant.

Healthy Life Expectancy (HLE) is an indicator of how many years a person can expect to live without disability. The optimistic '2-in-10' (HLE increases by two years every ten years) scenario results in 600 fewer people having any form of social care need by 2016 (160 fewer with 'very high' social care needs) compared to the 'base' projection, and 3,400 fewer people by 2031 (860 fewer with 'very high' social care needs);

The 'Preventative care 10%' scenario results in no change to numbers with any level of social care need, but a decrease of 390 people with 'very high' needs by 2016 compared to the base projection, and 540 by 2031. Note that the preventative care scenario is based on successfully stopping a proportion of people with 'moderate' needs progressing to 'high' needs, and people with 'high' needs progressing to 'very high' needs.

2. Growth of domiciliary care over the last 5 years

Age range	2011/12	2010/11	2009/10	2008/9	2007/8	2006/7	2005/6
18-64	736	736	671	622	556	629	596
65+	2810	2816	2766	2662	2668	2719	2680
Total	**3,546**	**3,552**	**3,437**	**3,284**	**3,224**	**3,348**	**3,276**

3. Provision of supported housing and Extra Care

In the last five years the City has developed two extra care schemes in the city, which has provided a total 120 units for older people. ASC has a well-established supported housing sector delivering support to people with mental health issues, learning disabilities and physical and sensory disability providing a total of 189 units across the city, of which 17 units were completed in 2011/12.

A further two schemes will be developed during 2014 which will deliver 130 units of extra care accommodation for older people and 50 to 100 supported living units for people with a learning disability or mental health needs.

4. Use of adaptations

	2009-10	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**
	£,000s	£,000s	£,000s	£,000s	£,000s	£,000s
Allocation	743	751	820	*919.4	843	847.7
DFG spend	1,565	1,557	1,713	1,540	1,935	**2,300

Notes

* Late on in 2011-12 the Government added a further £20m to the national ‘pot’ (originally £180m). Leicester’s allocation from that sum was an additional £76.4k.

** This is the disabled facilities grant budget figure. It was originally £1.8m but the NHS has provided a ‘one off’ amount of £500k.

In addition to the spending on disabled facilities grants we also spend some £1.2 - £1.4 million a year on adaptations to our public sector housing stock for disabled tenants.

Comments on disabled facilities grant provision

Age — Each year around 70-75% of all disabled facilities grants are provided to people aged 60 years or over. About one third of these are provided for people aged 80 years plus.

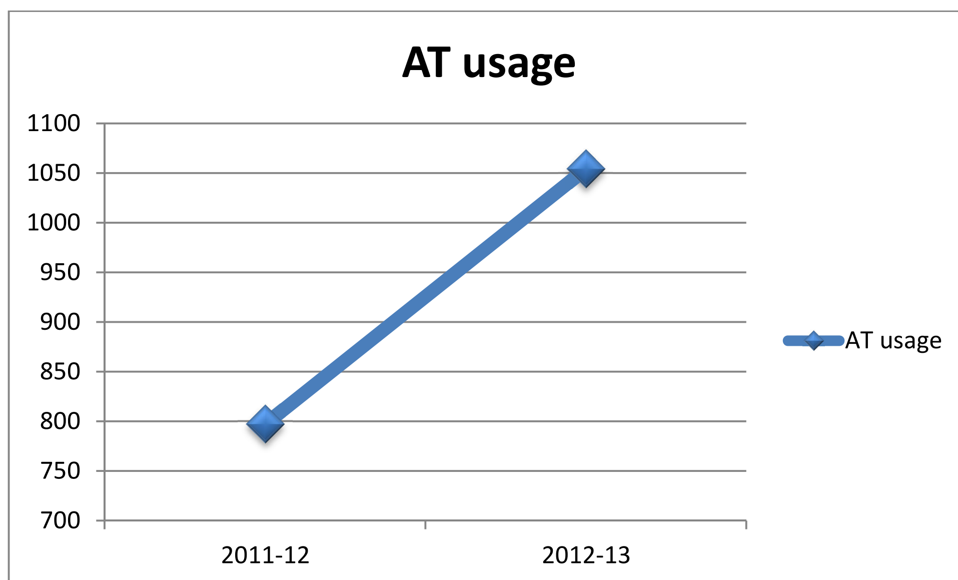
Tenure	About 90% of all disabled facilities grants are provided to people living in owner occupied homes. The 10% are to tenants, the majority of whom are housing association tenants (the others being private tenants). The number of housing association tenants seeking disabled facilities grant funding is increasing.
Costs	Average costs are reducing following adoption of Adult Social Care's preventative approach and a move to concentrate only on works that are 'essential'. The average disabled facilities grant was just over £10k but that has come down closer to £7.5k. The national average is more like £6k. We still have the legacy of some older cases still coming to completion which is affecting our average at present.
Works	Extensions are not provided except where essential and only after individual cases are considered by out Adaptations panel made up of senior officers from both Adult Social Care and Housing. Some 75% of cases include the installation of a shower and some 50% of cases include a lift of some description, be it a stairlift or a through floor lift. Both of these statistics have been fairly stable throughout the five year period under review. Increased use is being made of recycled lifts which has made a significant contribution to reducing costs. Home improvement agency service. Our in-house service is still the most popular way that people use to organise the scheme of work; to make application; and then for completion of works to a satisfactory standard. This takes all the 'hassle' off the individual and provides advice and pro-active assistance throughout the grant process.
Means test	There is a prescribed means test. The large majority of people who apply for disabled facilities grant are not required to make any contribution to the reasonable cost of works. This is one of the contributory reasons for our overall higher then national average grant awards.
Repayment	There are repayment conditions attached to all disabled facilities grants. The conditions run for 10 years from the date of completion of work. These conditions were adopted in 2009 and have not dampened demand for the grants. The first £5k is not repayable and the maximum repayment that can be demanded is limited to £10k. The first repayment cases have now started but to date only a very small amount of money has been repaid.

5. Use of assistive technology

In its simplest form, assistive technology can refer to a fixed or mobile telephone with a connection to a monitoring centre through which the user can raise an alarm. More advanced systems use sensors, whereby a range of potential risks can be monitored. These may include falls, as well as environmental changes in the home such as floods, fire and gas leaks. Carers of people with dementia may be alerted if the person leaves the house or other defined area. When a sensor is activated it sends a radio signal to a central unit in the user's home, which then automatically calls a 24-hour monitoring centre where trained operators can take appropriate action, whether it is contacting a local key holder, response service or the emergency services. These types of services are usually referred to as telecare.
Assistive technology also comprises standalone equipment which does not send signals to a response centre such as medication dispensers, picture phones and remote control plugs.

These items can assist both users and their carers to remain at home safely and with peace of mind.

From April 2011 to March 2012 there were 797 pieces of equipment ordered in the City. The following year saw an increase of 32% with 1,054 pieces of equipment ordered. These figures included telecare and standalone equipment. They do not include sheltered housing users who receive a telecare service. In some cases one user may have more than one piece of equipment.



Investment in these assistive technology services for 2012/13 was approximately £80,000. In addition, in July 2012 the executive agreed a 3 year investment of £650,000 in assistive technology in order to further develop the infrastructure, training and services.

An East Midlands Joint Improvement Partnership study of 96 telecare service users in Leicester carried out in 2011 showed that:

- Telecare was effective in providing support or managing risk for all telecare users in the study, with 47% of people receiving telecare to avoid or defer additional social care or NHS services.
- For 15 people telecare was felt to have avoided or delayed residential or nursing care placements.

For 47% of people in the study telecare was instrumental in avoiding or deferring the escalation of support requirements as follows:

- 33% (15) avoided or deferred an increase in Home Care
- 40% (18) avoided or deferred a Hospital Admission
- 4% (2) avoided or deferred a Nursing Home Placement
- 29% (13) avoided or deferred a Residential Home Placement
- 2% (1) avoided or deferred the need for Reablement
- 4% (2) reduced the need for Respite Care
- 2% (1) avoided or deferred the need for Supported Living Services

Fifteen service users were helped to remain at home through the use of telecare with home care and day care services. It was considered that if these service users had not had telecare support, their needs would have escalated to the point where a care home placement would have been necessary.

The report stated that telecare locally could be safely considered as a substitute or part substitute element of support for more people aged over 65 to help deal with the rise in demand for care from demographic changes.
It also found that the wider use of telecare at an early stage for people with dementia is predicted to prolong independent living and defer or avoid the need for additional services, including care home admissions.

This mirrors national evidence that suggests telehealth and telecare have the potential to play an important role in delivering more cost-effective care.

"Perspectives on telehealth and telecare – learning from the 12 Whole System Demonstrator Action Network (WSDAN) sites" reported in 2012 that through enabling a client-centred, integrated and home-based system, it is possible to support more people to live independently and so reduce the need for institutional care in a nursing home or hospital.

6. Use of reablement

Current Service Provision

The cost of the service is £3,381,300 per annum - a unit cost of £34.83/ contact hour. The service is expensive compared to traditional independent sector domiciliary care provision (around £13 per hour), but is designed to

provide a more intensive/therapeutic approach and to deliver longer term savings. The service is principally funded through adult social care's main budget (via diversion of resources previously used to provide specialist in house home care). There is capacity to deliver 2,000 contact hours each week for up to 250 service users during peak times. NHS support in total equates to approximately 4% of the total budget for the Service, providing support to occupational and physiotherapy.

Numbers using the Scheme

Table 1 demonstrates the needs of users engaged in the scheme.

Table 1

Primary Client Type	**Total**	**%**
Physical Disability	482	49.1%
Frail/Temporary Illness	375	38.1%
Other client groups	126	12.8%

Table 2 shows total outcomes for Leicester City Council's Reablement Service from April 2011 to March 2012 along with family authority comparable figures from Derby City Council.

NB: Figures set out below are based on outcome on leaving the service and cannot be cross-referenced to figures for outcomes at 91 days' after reablement, which ONLY include cases which were hospital discharges for service users over 65 years

Table 2

Outcome	Total	%	Family Authority Comparable Figures (Derby City Council)	
Fully Independent	399	41%	441	(50%)
Reduced on-going support	217	22%	151	(17%)
On-going support	98	10%	145	(17%)
Increased support required	93	9%	54	(6%)
Deceased	30	3%	68	(8%)
Residential	18	2%	16	(2%)
*Hospital	120	12%	Not Recorded	
Other (discontinued	8	1%	Not Recorded	
Total	983	100%	875	(100%)

*Hospital: Data includes re-admission and admissions via community routes
Of 983 closed cases the total number of hospital referrals was 805 (82%) and the total number of community referrals (which went live in October 2011) was 178 (18%). All those (408) in need of on-going support went on to receive a personal budget out of which 42 (10%) accessed direct payments.

This data demonstrates that a reablement intervention is very successful in keeping individuals out of residential care (i.e. 2%) and that the largest majority return home again. The 12% of those admitted to hospital is very low compared to other local authorities, where it has been known to be as high as 20% with Leicestershire.

Referral Process

Referrals are via a contact assessment from care management, alongside a support plan to describe how the person requires support at that point in time. The contact assessments are from the single point of access and localities and can be for those that are in hospital directly into the service to be a support following discharge.

Case Studies – Showing improved Outcomes

DC, 83, started on the Reablement Service with two calls every day. She had been in hospital for two weeks following a fall, which led her to need both hips totally replacing, and also has vascular dementia and Alzheimer's, causing a lack of orientation to time and place and difficulty in recalling things. Because of her cognitive decline DC was slow to initiate and sequence every-day tasks such as washing and dressing and required support with them. Goals to improve her kitchen activities and mobilise outside were established during the initial therapy visit; the therapist duly arranged for a perching stool for the kitchen, and for the handypersons' service to fit rails at the front door and raise the chair. A Social Care Officer paid DC a visit four weeks into her programme, during which DC stated that she felt that she would not need any further support once her time on Reablement had finished. She had taken to completing her personal-care tasks before the care workers arrived and had long been able to make herself a hot drink and carry out her kitchen activities independently. Within three days DC had asked for her Reablement package to be closed because she had maximised her independence.

AB was 57 and had spent ten weeks in hospital following post-surgery complications. Following the removal of his gall bladder he had experienced tissue breakdown and multiple organ failure. Prior to discharge he had many skin grafts and necrotic digits on his hands and feet. Understandably, AB was of very low mood and keen to come home at the point when he started with the Reablement Service after spending so long in hospital. He required assistance with his washing tasks and initially led a downstairs existence. Within a few weeks, following input from the Physiotherapist and the Handypersons' Service fitting a stair rail, he had managed to achieve his outcome of negotiating the stairs safely so that he could use the bathroom and sleep in his bedroom. An Occupational Therapist visited and demonstrated how to safely use a bath board, which AB adjusted to very quickly, meaning that he was independent in his bathing. Within six weeks he had regained his independence sufficiently so as to maintain a good quality of life without further input.

7. **Use of Shared Lives scheme**

Leicester City Council has a pre-existing and established Shared Lives Scheme. Shared Lives arrangements are provided by ordinary individuals, couples or families in the local community. People using the service and their Shared Lives carers enjoy shared activities and life experiences. Shared Lives enables a wide range of people who need support to live independent lives and have their health and wellbeing promoted. The service is provided from the carers own home.

Shared Lives in Leicester is currently used primarily by adults with learning disabilities (41 service users) and has a small number of placements for adults with mental health difficulties and physical disabilities (3 service users). We do not currently have any placements for service users solely from the older people client group; however a number of our service users in other primary client groups currently are from the older age group and we also support adults with learning difficulties who also have dementia. We are currently running a small pilot aimed at people with a diagnosis of dementia.

It has recently been agreed to double the size of the existing scheme to increase the number of benefits experienced by the citizens of Leicester. This will include further benefits to older people.

There are successful schemes around the country providing services to older people which include daytime activity, respite and short breaks, intermediate (reablement) care, support from hospital to home, support from hospital to home and longer term residential placements.

We have undertaken cost comparison work, comparing Shared Lives to other provision i.e., supported living and residential care. The comparison showed that where a person has a relatively low-level support requirement. Shared Lives is a more cost-effective way of meeting needs than residential care, and supported living costs are significantly higher.

There are many added qualitative benefits of Shared Lives. Carers are matched carefully with service users. There is a consistency of carer and environment so that as the persons old age, dementia or ill health progresses, there is a predictability about their care i.e. the person could receive a level of day care, moving onto respite stays, maybe developing into a longer term residential placement, in the same place with the same people for quite some period of their life.

8. **Reducing social isolation**

Adult Social Care currently invests £255,000 in the voluntary sector in a variety of services for older people and those with dementia including lunch clubs, support groups, and befriending designed to reduce social isolation. In addition there is over £200,000 invested in carers' services – many of whom will be caring for older people. Adult Social Care also invests £170,000 into information, advice and guidance services which older people can access to

advise them and signpost them to other services, benefits and support. These services provide valued opportunities that enable people to meet friends and get out into the community.

In March this year the Campaign to end loneliness reported on the Associated Retirement Community Organisation's survey which found that in a survey of over 1,000 older people, that people aged over-65s spend on average over 6 waking hours alone every day. Added up, this is equates to a significant 99 days a year.

The survey also found that 24% reported feeling lonely "some or most of the time" and 1 in 5 of respondents aged over 75 could go a whole weekend without seeing or speaking to another person.

Chronic loneliness – when someone feels lonely all or most of the time – has a significant and detrimental impact on our health. Last year, researchers in the Netherlands found that lonely individuals were more likely to develop Alzheimer's disease than non-lonely individuals. It is reported that loneliness is as harmful for our health as smoking 15 cigarettes a day, and is worse for us than obesity. Loneliness also harms our mental health by increasing our risk of depression.

In February 2013 the BBC reported that Psychologists at University of Chicago and Ohio State University have shown that people who are socially isolated develop changes in their immune system, which leads to a condition called chronic inflammation. If the inflammation persists in the long-term it can contribute towards cardiovascular disease and cancer.

Scientists found that lonely people find everyday activities more stressful than those who are not socially isolated. They measured levels of cortisol, a hormone that's produced when we are stressed, in a wide range of healthy people in the morning and evening. Lonely people released more cortisol. The scientists suggest that too much of the hormone causes inflammation and disease.

Low level preventative services which help people to avoid becoming lonely are crucial therefore in helping people to remain living independently in the community. As part of the voluntary sector preventative services review the need for additional support and resource in this area is being considered.
In addition ASC also provides social inclusion via day care support for 574 individuals aged 65+ which helps to avoid loneliness and social isolation.

The Big Lottery Fund Fulfilling Lives: Ageing Better programme aims to reduce social isolation amongst older people, improve their well-being and give them confidence and support so that they can be more active within their neighbourhoods. Leicester is one of 100 local authorities targeted by this fund and invited to bid for between £2 and £6m as part of a local partnership. A bid has been submitted and we await the outcome of this stage of the application process.

Furthermore, a bid has been made to the Big Lottery Fund People's Millions to develop a dementia friendly garden and facility in New Parks which aims to provide additional community resources in an area where there is a high population of older people, including single pensioner households.

Intermediate Care and Short Term Beds

1. Benefits of intermediate care

The Council has 41 intermediate care beds, which are based at Brookside Court and Elizabeth House. The average usage per month is 31 beds, this excludes the demand for respite which increases the need for more beds and is explained later.

A recent review of intermediate care identified a number of areas of good practice that reflected the national guidance and local priorities. However, the review also revealed areas for improvement, where change would provide a more consistent and cost effective service.

Areas of Good Practice

- There are experienced staff based at Brookside Court, including those with a clinical background
- Some of the service provide integrated therapy where health therapists provide treatment programmes that are then delegated to social care staff to undertake
- The average length of time for Brookside is 5 weeks, which is below the national average, which makes the service cost effective
- Outcomes for people who received intermediate care at Brookside Court were positive. For example of the 112 people who were supported during 2011/12
  - 29 went home fully independent without further services
  - 24 went home with on going home care support (minimum packages)
  - 22 went home with community based reablement services
  - The remaining people went into hospital, residential care or died
- Use of person centred planning
- Allocated care management workers are attached to the intermediate care beds, which provides consistency and social work support to individuals

2. Limitations of existing provision

Rationale for change

- A lack of bed capacity to support increased future demand
- Access into the current service is fragmented and inconsistent, due to the referral process, which leads to poor vacancy management
- Where the service is provided within the Councils Elderly Persons homes, the outcomes are not so good, as people stay too long or are admitted to

long term residential care. This can be attributed partly to the dual role that staff are required to undertake

- The current system is expensive
- There is a lack of a 24/7 crisis response service
- There is a lack of management information or specific targets, which makes it difficult to monitor the effectiveness of the service
- There is little use of Assistive Technology to support long term independence
- A person centred planning needs to be embedded across the service to promote independence
- A lack of generic job descriptions prevent opportunities for greater flexible working across the different disciplines
- Staff skills need to be increased for some client groups, such as those with a mental health issue
- Partnerships arrangements should be considered to provide a more integrated model across health and social care
- There is a lack of alternative housing options, such as Extra Care to support long term independence
- There is a lack of specialist home care services, such as dementia to support long term independence

3. Demographic growth

This section highlights the future demand for Intermediate Care and Short Term Residential Beds.

Demographic data - The 2011 Census population estimate for Leicester City is 329,900: An increase of 47,000 (16.7%) since the last census in 2001; 37,200 (11.3%) of the population are aged 65 and over, a decrease of 700 (-1.8%) in the over 65s since 2001; the overall population of Leicester has grown at a faster rate than that of England and Wales since 2001.

Older People - there are fewer older people than nationally, but the proportion of older people across the Local Authority with any level of social care need (39%) is above the regional average (35%). Needs are often complex and include for example isolation, poverty, frailty, increasing dementia. There are increasing numbers of older people, mostly women caring for others. Key issues to move forward are prevention, early diagnosis, care or carers, integrated care pathways and collaboration between health and social care.

Dementia – the Joint Specific Needs Assessment on Dementia estimates that there are 2,700 people aged 65 and over living with dementia, and this figure will increase to 3,700 people by 2030. There are 800 new cases a year being diagnosed. We expect to see about 70 younger people with dementia. Early diagnosis, care of carers, integrated care pathway, collaboration between health and social care are key issues.

A detailed analysis of current demand shows there is a requirement for approximately 60 Intermediate Care and Short Term Residential Beds across

the City by 2015. Therefore, any new facility needs to meet current demand, but also needs to provide flexibility in the medium term to address both demographic growth and any other policy or socio economic changes.

4. Future need for a 60 bed facility

Demographic changes alongside financial constraints, means adult social care has to reshape its intermediate care and short term residential beds provision to create a flexible model, that will not only provide bed spaces, but also the 'wrap' around services, such as minor adaptations, assistive technology, housing advice, community equipment etc. Therefore, the following analysis highlights the key elements for a new model that will deliver a flexible and cost effective service.

The proposed service model will provide: -

i. 24/7 support, which will focus on: Planned respite care; Crisis response; Interim support; assessment; intermediate care/promoting independence

ii. Reablement day provision where users receive a promoting independence service in a resource centre to enable them to remain in the community, focussing on: Assessment; Therapy intervention; Activities of Daily Living skills;

iii. Resource Unit: Drop in service; Assistive Technology suite; Equipment and adaptations; PCs to access the Councils website for resources, self-assessment; Shop selling Assistive Technology, equipment etc.; Early Intervention and Prevention advice, information, support; memory Café; Practical Help at Home service.

However, this service model will only work if it operates from one location. By co-locating intermediate care and short term beds together, it will provide an opportunity to achieve consistency, a streamlined care pathway through social care and health and economies of scale.

A flexible model would also achieve the following:

- Consolidated all intermediate care and assessment beds onto a single site which will allow more effective management of bed numbers and referrals and will reduce the number of vacant beds
- Allow closer links with the Council's Reablement service, providing greater efficiencies through integrating/flexible working

- Provide opportunities for partnership working with health, such as the provision of Mental Health Assessment beds, which could generate and income for the Council
- Provides planned chargeable respite services to fill spare capacity

The de-commissioning of the existing arrangements and investment in a single flexible resource facility will provide a more efficient person centred approach to rehabilitating people to maximise their independence.

The assessment element of the facility will create a suitable environment, with the support of the right staff, to complete robust assessments of people's abilities and needs. There is also the possibility of health using part of the facility to provide specialist assessment for people with mental health issues, including people with a dementia. Any spare capacity will be used to provide planned respite care.

Further savings are anticipated through a reduction in inappropriate hospital admissions, timely discharge from hospital, a decrease in the number of people admitted to long-term care, and a reduction in the use of on-going home care.

The analysis of future demand identifies the need for up to 90 beds by 2030. However, this calculation is based purely on anticipated growth in the over 65 population and takes no account of any other changes in service delivery in the next 20 years. It would therefore not be advisable to create a facility of this size as it would be under-utilised for a number of years.

Therefore, it would be more appropriate to create a 60 bed facility, which would provide the required number of intermediate care beds, with the remaining spaces being used for respite. As the demand for intermediate care increases then the in-house respite provision can be decreased and provided in the independent sector.

The inclusion of respite is therefore a key element of the new facility as this will allow vacant beds to be used more effectively thereby reducing the overall level of voids/vacant beds.

5. Options explored and rationale for a proposed new build facility

The option of refurbishing and/or extending an existing EPH was considered by officers from Property and Adult Social Care in August 2012, with technical assistance from Faithful and Gould.

None of the existing EPH's is large enough for conversion into a 60 en-suite bedroom facility within their existing footprint. Most also occupy residential sites which offer little if any opportunity for expansion.

6. Potential issues relating to the disposal of the EPH sites

Following any decision to dispose of vacant Elderly Persons Homes it is proposed that a sales process which achieves market value and avoids empty properties hanging around for several months which require expenditure on mothballing and security costs be employed.

Following the success of the sale by auction of the former Beaumanor residential facility in 2011, it is proposed to use the Auction method to dispose of any surplus units. This will give the Council the ability to set reserve values which take account of both existing use and development potential of the sites.

This would enable properties to be marketed quickly as regular auctions take place. Sale completion would then be achieved within one month of the auction date in accordance with the conditions of sale. Options are available for Auction Houses used and the timing of release of the various properties to ensure best return. Procurement implications for securing auction services are already under consideration.

Although the auction method would be a potentially quick method of disposal it is still likely that properties may be empty for a period. Property Officers have experience of securing similar sites in the past which may well include temporary alarm installation and security patrols, although the solution would be tailored for each site.

How would the financial gap be managed if the homes were not closed – what are the options/what other services would be affected?

1. Introduction

This briefing note provides short background information about the current EPH proposals and associated savings as well as the overall financial position for the Council as a whole. This information is intended to provide necessary context as well as responding to the specific question asked by ASC Scrutiny members,

2. EPH Proposals and Associated Savings

The proposed phased sale and closure of the Council's Elderly Person's Homes, currently out for consultation, is mainly in response to changing expectations and demand. There are many permanent vacancies in the Council's homes whilst demand for other types of social care (e.g. home care) has risen year on year and expenditure on other services has increased in line with the increasing volume of services used.

Although the EPH proposals have resulted from changing patterns of demand, there are none-the-less, savings to the Adult Social Care budget that are associated with the proposed changes. These saving are partly because of the high number of vacancies in the Elderly Person's Homes run by the Council and partly because the Council can procure equivalent residential care placements from independent care homes at a much lower cost per resident per week than the Council's homes currently cost.

The potential savings each year are set out in the accompanying report on EPHs and have been modelled based on the proposed phased approach to sale and closure but the actual savings will ultimately depend on the final decisions taken and on the timing of any implementation. Also, although the most important savings would be made from the revenue costs of running the homes, it is worth noting that, if the proposals are adopted, the Council would also avoid having to pay additional capital costs to bring the EPHs to a satisfactory standard.

3. The Council's Overall Position

Clearly Adult Social Care (ASC) is only one of many services provided by the council. It currently spends £90m of the council's total departmental budget of £250m. The impact of maintaining the status quo for Elderly Persons Homes needs to be considered in relation to the council's overall finances.

In addition to the £50m cuts already approved for 2013/14 to 2014/15 the council is expecting to have to find further cuts of £50m in the period to 2017/18. This is very much an indicative figure at the moment and may need amendment following the announcement of the Government's Spending Review at the end of June. There will also have been a general election by 2015.

The scale of existing and anticipated cuts is such that a substantial re-modelling of services across the Council is inevitable. At this point it is not possible to say what savings requirement will fall to Adult Social Care but, given that ASC accounts for a significant proportion of council expenditure, it is unlikely that the Council will be able to afford to ring-fence adult social care from further cuts. This is at a time when there is growing pressure on ASC budgets from increasing numbers of people needing social care caused, in part, by an ageing population.

4. Alternative Options

With the current level of uncertainty, it is not possible to give a definitive answer on how the revenue gap would be bridged if the EPH proposals are not accepted or if a very different configuration of change is agreed instead. Any savings not delivered would need to be made up from elsewhere and this would be in addition to any further reductions required as a consequence of the council's future financial circumstances (e.g. following the Government's Spending Review). There are many different options across all Council services.

However, what is clear is that the council already faces very tough decisions on all its services. The scale of reductions cannot be achieved by efficiency savings alone; if the EPH saving is not achieved then it will result in service cuts of the same value somewhere in the authority over and above those still to be found. It is not possible to say exactly where further savings would come from across the Council but the following section outlines the issues and options if the further savings were applied within adult social care budgets.

5. Issues and Options within Adult Social Care

The position in ASC is as follows:

There is little room for further efficiencies. These have very largely been released from earlier budget strategies. This includes efficiencies being driven out of external providers through tighter commissioning.

Almost all adult social care services are statutory in that the Council is required by law to provide social care for people whose needs are above the eligibility threshold. The majority of the expenditure is directly on service users in the form of residential and non-residential care. Residential fees are currently the subject of consultation but are not considered an area where significant future savings are likely. For non-residential care, it is difficult to further cut the size of care packages without a significant risk of failing to meet people's assessed need for social care, which carries an obvious risk to the wellbeing of individual vulnerable people as well as the risk to the Council of subsequent judicial review. The Resource Allocation System for adult social care has brought much greater consistency to the provision of care packages. New checks have been introduced to ensure packages are adequate but not over-generous and more consistency checks are planned.

It is likely, therefore, that additional savings would need to come very largely from non-statutory, mainly preventative, services. It is hard to be precise about how these would arise as existing budgeted savings plans already require substantial decommissioning in these areas. By 2015/16, following the implementation of previous budget strategies, the ASC non statutory budget will stand at £5.2m. and this includes services such as advice, counselling and advocacy services, welfare benefits advice service, alarms for elderly people who live independently, warden services, financial support to community based lunch clubs, voluntary sector services promoting independence and well-being etc. .Whilst it is not possible to say exactly which of these services would be cut if the EPH proposals are not adopted, it is hard to see how substantial cuts in this area could be avoided.

Also, it is very probable that any savings made from preventative services would only be short term because without these services more people would experience a deterioration in their wellbeing and independence. This, in turn, would drive up social care needs so that more people would become eligible for mainstream statutory social care where the costs would in the medium term out-weigh the savings.

Cutting preventative services is contradictory to the current direction of travel and current cost reduction strategy. It is also contrary to the requirements of the Care Bill (currently being debated in the House of Lords) which proposes to make it a requirement for Local Authorities to “arrange or provide services that help to prevent or delay people deteriorating such that they would need on-going care and support”. It would also be contrary to the expectations/requirements of the NHS via whom government funding is increasingly being directed. However it is hard to see where else it is possible to make savings in future years, despite this being potentially ‘short-sighted’.

The voluntary sector would probably be very badly affected as they are the main providers of non-statutory preventative services. This may raise challenges in relation to the ‘social value’ aspects of commissioning.

This page is left blank intentionally.