



Business Development Project The future of older peoples provision in Surrey

Providers Guidance and Toolkit

November 2008

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PART ONE

Introduction

This project has been commissioned at a time when the vision for health and social care includes a challenging transformation agenda. The focus of this vision is a personalised approach which can be summarised as *“the way in which services are tailored to the needs and preferences of citizens”*. *“The overall vision is that the state should empower citizens to shape their own lives and the services they receive”* (Gordon Brown)

The purpose of this business development project is to contribute to the transformation agenda by encouraging and supporting current and potential providers of services to work with Surrey County Council (SCC) and Surrey Care Association (SCA) in developing new and existing services for older people in Surrey. The outcomes from the project will provide a resource to existing and potential providers of Older People Services which will enable them to engage in market development and service transformation with confidence.

The information used in this report has been gathered from a range of sources which includes national and local policy documents, Laing Buisson Market Research (2004) and discussions with key staff at SCC, Surrey Primary Care Trust (PCT), SCA and service providers. In addition discussions have taken place with key individuals involved in delivering or researching services for older people. SCC draft Older Peoples Commissioning Strategy which is currently out to consultation confirms the direction of travel and states *“SCC intends to move swiftly towards ways of delivering care that encourage independence, promotes greater choice and helps communities to develop networks of support that may both improve health and well-being and enable people to live independently for as long as possible”*.

The County Accommodation Strategy for Vulnerable People, the 50+draft strategy and action plan and the recent Request for Information ECH Initiative has provided some clarification of SCC's service requirements.

Surrey Primary Care Trusts Strategy for people with Long Term Conditions and their approach to the seven areas of acute service delivery described in Fit for the Future the Case for Change will require support for early discharge, intermediate and respite care to achieve this agenda for older people. The PCT are currently reviewing the role of the community hospitals in supporting this agenda the outcome of the review is expected in 2009. The outcome of this review could have significant implications for providers of social care in relation to providing intermediate care, supporting early discharge and prevention of hospital admissions.

This report makes no assumption in relation to the direction of travel but is a resource to inform the discussion with care providers in relation to future provision. It also provides a tool kit which is aimed at helping providers decide whether they wish to change their current services to address this agenda. The toolkit also provides a framework for planning future services

Background

The transformation of social care is a challenging agenda that will only be achieved by working across the boundaries of social care to include housing, transport and health. The need for the

statutory, voluntary and Independent sectors to work in partnership to deliver these services is also an essential component of meeting the agenda. Whilst Transformation is an England wide agenda the emphasis is on local interpretation and implementation.

The key objectives of this agenda are Personalisation, Early Prevention, Early Intervention, Choice and Independence. The introduction of individual budgets in new areas of public services is seen as a catalyst for change. Self- Directed Support (SDS) will provide the opportunity for people who receive state funding to take control of the social care services they receive. SCC draft commissioning strategy for older people confirms the council to supporting the introduction of SDS. The process of change is one of evolution not revolution with authorities expected to make significant steps to introducing revised systems by 2010/11.

Whilst the focus of the transformation agenda is about publicly funded services responses to consultation documents and national research about what older people want from services confirms that self funders have similar aspirations for future services.

Healthcare services are also being reviewed and again the agenda is challenging. The Health Minister Lord Ara Darzi is leading this review and the work focuses on care closer to home, choice and plurality of providers. The review is also proposing to give NHS patients with long term conditions a personal health budgets to spend on their healthcare needs. The combination of self directed support and health budgets for those living with long term conditions could have a significant impact on the both the scope and diversity of services provided.

The Purpose of this report.

This report aims to provide an overview of the transformation agenda, identify examples of alternative models of care and incorporate a tool kit to help existing and potential providers to decide whether they wish to change the nature of the service they are providing.

In selecting these examples of care models no judgement is made as to the appropriateness or effectiveness of the models.

Policy and Context

The change in the structure of the population is probably the most significant challenge of the 21st century. Currently those aged over 65 years outnumber children. It is anticipated that by 2022 twenty per cent of the population will be over the age of sixty five. This coupled with the development of strategies to support people with long term conditions to manage their own care, advances in medicine which means that an increasing number of people are living longer but with more complex needs such as dementia and chronic disease represents a significant challenge for both commissioners and providers of care.

Response to the consultation on the White Paper "Our health Our Care Our Say": a new direction to community services, the DWP research in Independent Living in later life and a variety of public conversations/consultations indicate that peoples expectation of the service is increasing as is the value they place on choice control and self sufficiency which includes support to live independently.

All the indications are that in the future those seeking support from social care providers will have very different views regarding the care they wish to receive to those currently receiving social care. It is also important to note that despite the welcome shift towards supporting people

to live independently in their own homes availability and standards of care in the care home sector will still be critical to older people especially those who access residential care when they are older, frailer and have more complex needs. Meeting the needs of this group of frail older people will require care homes to support and deliver a more complex package of care.

The Government in partnership with local government and the NHS have already developed the agenda for health and social care. These are outlined in key documents which include

- Putting People first,
- The Independent Living strategy lifetime homes lifetime neighbourhoods
- Our NHS Our Future NHS Next steps review
- Our Health Our Care Our say: a new direction for community services.
- Independence Well being and choice Green paper March 2005
- Prime Minister Vision for world-class public services.
- Securing good care for older people Derek Wanless

Current national policy and emerging strategies for social care have three key themes namely:

- Addressing the demographic changes
- Meeting the funding gap
- Personalisation.

Personalisation which includes early intervention and prevention is seen as the cornerstone to achieving the transformation of social care services. The Department of Health (DH) describe personalisation as meaning every person who receives support, whether provided by the state services or funded by themselves will have choice and control over the shape of that support in all care settings. For people to stay independent as long as possible they need to understand the choices that are available to them. This means that there is a need for better access to information and support to ensure that people can make informed decisions.

The report does not address the issue of the funding gap which is the subject of a separate consultation "*The case for change Why England needs a new care and support system*". In addition to the consultation document the Government is holding a number of stakeholder events between May – November 2008. The outcomes from these events and response to the consultation document will inform a Green Paper setting out the reform options.

Challenges for Providers

These are significant changes that will present a number of challenges for existing and new providers. These challenges will include:-

- Developing new models of care/ business
- Impact of Self Directed Support
- Workforce / skill set for staff
- Service User Information
- Leadership / change management skills
- Changes to Regulations from 2010.

Note

Although the Care Quality Commission will assume responsibility for the regulation of social care from April 2009 the sector will continue to be regulated as per the Care Standards Act

2000. Changes in regulation to address the requirements of the Health and Social Act 2008 will be introduced in 2010.

Other policy initiatives which will impact on the services provided include

- End of life strategy
- Dignity Campaign
- Health acquired Infections (HAI) Code of Practice (2010)
- Revalidation of non medical practitioners
- Registration/ Regulation of the care workforce.

This report focuses on the Personalisation agenda and explores examples of new and developing services. As well as including some practical tools to help providers explore whether they wish to make changes to the services they provide.

PART TWO

Local Perspective

Surrey County Council County Accommodation Strategy for Vulnerable People (2007) summarises the Key Outcomes to be delivered as

- Increased number of individuals enabled to live in their own homes rather than in residential care, through supported living initiatives.
- Increased number of older people able to access extra care housing each year as an alternative to residential care.
- Increased number of people enabled to maintain independent living in their own home, as a result of the provision of adaptations and equipment or telecare technology.
- Increased number of older people enabled to maintain independent living in their own home, through appropriate support for carers and the provision of more short – term break facilities.
- A demonstrable shift in and more cost effective use of financial resources supporting people at home rather than in residential care.
- A decrease in residential care home facilities and placements to reflect the increased provision and placement being made in extra care and supported living.

Achieving these outcomes represents a significant change in both domiciliary and residential care provision. SCC recent Request for Information on Extra Care Housing (ECH) Initiative (July 2008) confirms ECH as the model of choice and identifies the need for 565 additional ECH units across the County in the next five years. This figure relates to the number of units that will be required to meet the needs of SCC clients it does not include the needs of self funders. Funding this development will mean SCC reducing the number of residential places currently purchased. The indication is that SCC currently purchases 2000 residential placements across the County. These numbers will need to reduce year on year with a planned initial loss of 100 places in year one. The NHS Information Centre report published in October 2008 confirms that

across the country the number of beds purchased by Councils from the independent sector dropped by 4% between 2007 and 2008.

The PCT strategy for Long Term Conditions and acute services will impact on the services to support older people it is not possible to indentify the impact this will have until the review of the Community Hospitals is published in 2009.

Part Three

Models of Care

Care Homes

In this report the term care home is generic and is used to describe all residential settings. Identifying the category of registration provides little information about the model of care delivered so this information is not included in the report. In practice the range of services provided can be diverse and include long term care, respite care, intermediate care and rehabilitation. Examples of new and existing care models that are currently being provided are detailed in Appendix 1.

Whilst these models go some way to providing choice, independence and addressing the challenges for Self Directed Support they do not include models to address the needs of the older frail person with multiple pathology.

Some of these models may have implications for Regulation/ registration and providers are advised to discuss this with Commission for Social Care Inspection (CSCI) or from April 2009 the Care Quality Commission (CQC). Providing care for this category of older person will have implications for staffing levels, knowledge and skills.

Telecare

Telecare is as much about supporting and encouraging dignity and independence as it is about equipment and services. Equipment is provided to support people in their own homes and can be tailored to meet their individual needs. Advances in technology has meant that the range of equipment and services available range from basic community alarms to the development of intelligent / smart houses where every aspect of the building and it services can be operated by technology. The introduction of technology has enabled people to live independently where previously they would have had to remain in acute or residential care.

In July 2005 the DH published its strategy for supporting the use of technology to enable more people to remain in their own home. The document Building Telecare in England outlines the support available to Council, how to apply and some case studies to demonstrate the effectiveness of telecare to respond to an immediate need but also its use in prevention. It also describes its use in telehealth, given the number of older people living with long term conditions this might be a service worth exploring.

The County Accommodation Strategy for Vulnerable People outlines how SCC has allocated their Preventative Technology Grant to partners who were committed to delivering telecare to residents. The project included

- Supplying people over 65 with free community alarm for twelve weeks following discharge from hospital.
- Increasing the use of devices such as flood, smoke and gas detectors, bed sensors and pill dispensers.
- Monitoring people with long term conditions to help them understand their conditions and to detect and intervene if there was any deterioration of their health.
- Piloting telecare equipment with people who have learning disabilities.

An exploratory study commissioned by Guildford and Waverley Borough Council and conducted by the University of Surrey examined the process of implementing six “pilot” telecare projects across these boroughs in an attempt to identify good practice and learn from the experience of implementing the pilots.

The evaluation report includes a number of recommendations for improving the delivery of telecare services which are

- **Training** – Review and improve training
- **Publicise telecare widely**
- **Referrals.** Improve the referral process and ensure there are clear guidelines
- **Reliability and usability of equipment.** Develop systems for reporting device problems and for formalising device assessments prior to and during the procurement process
- **Sustainability** Consideration should be given to how telecare can be integrated into mainstream care and funded to ensure that it is sustainable.
- **Call Centre Data** consideration should be given to introducing systems to capture and easily analyse call centre data. This would facilitate research into the benefits, costs and difficulties associated with telecare.

Whilst these are recommendations for future project that SCC might introduce they also provide a useful checklist for any provider wishing to introduce telecare products to their services. Many of these products could be used to enhance the lives and safety of residents in care homes.

Examples of other telecare projects are detailed in Appendix 2.

The purpose of this service is not only to provide more personalised care closer to home but also to provide interventions which reduce the frequency that people with long term conditions are admitted to hospital.

Domiciliary Care.

The County Accommodation Strategy for vulnerable people in Surrey identifies as one of its key objectives the need to increase the number of individuals enabled to live in their own home through supported living initiatives. An appropriate and effective domiciliary care service has a key role to play in achieving this. The domiciliary care market has enormous potential to support the personalisation agenda both in terms of supporting people to remain independent but also as an early warning system when things start to deteriorate. The service provided is

diverse and addresses most aspects of the older persons pathway. The DH funded Partnership with Older People Projects (POPP) have provided evidence of what can be achieved through partnership working between care providers' older people, the independent / voluntary sector and the statutory agencies. The range of project is diverse and includes

- Better access to information and navigation of services
- Health Promotion activities
- Low level services for older people such as shopping /household repairs
- Proactive case management of those at most risk of losing their independence
- Support for early discharge
- Use of telecare
- Pathway redesign

The second interim report published in October 2008 includes key findings from the national evaluation team. Although many of the pilots still have another year to run and the findings may be subject to change the initial findings are positive. The pilot site still continues to have an effect on reducing hospital admissions. Older people are confirming the effect they have on improving how users perceive their quality of life. There appears to be an associated wider culture change and a greater recognition of the value of early intervention and preventative services. A final report is expected in the Autumn 2009.

Further information on some of these projects is included in Appendix 3.

The range of models of domiciliary care available to Surrey residents include services that provide personal care, support for activities in the community e.g. swimming, shopping, theatre, as well as garden and domestic services. Providers aim to be flexible enough to meet any demand.

The recent tendering of domiciliary care services whilst rationalising the service has created a number of problems and would benefit from an acknowledgement of the issues and an evaluation of the lessons to be learnt. Changing community demography will have a similar impact on these services as it has on the care home sector.

Community Villages / Extra Care Housing

Policy makers and commissioners have shown interest in housing schemes for older people which combine independent living with relatively high levels of care. There is no single blue print for these types of services although common aims shared by the schemes include:-

- Promote independence
- Reduce social isolation
- Provide an alternative to residential or institutional models of care
- Provide residents with a home for life
- Improve the quality of the life of the resident

The concept of this type of scheme is not new. Cohousing as defined by McCament and Dunt describes a housing arrangement developed in Denmark over the last thirty years. The concept has been increasingly adopted throughout Europe and North America particularly in urban areas. Whilst these developments have been in existence for some time very little evaluation of the model has been undertaken. Some of this could be attributed to the fact that community

villages and extra care housing are a concept rather than a model which makes undertaking any comparison or evaluation between the schemes difficult.

Extra Care Housing

SCC defines Extra Care Housing as housing which offers a home for older people to live in that consists of self contained flats (unlike residential care) and where flexible 24hour care is provided (unlike sheltered housing) The building design is geared for comfort and accessible for older people and there are opportunities for a range of social leisure activities. In the majority of cases Extra Care Housing provides a home for life. (Source SCC Information sheet) SCC is committed to increasing the number of extra care facilities and sees this as the model of choice to reduce the number of older people requiring residential care. To support this development it will be necessary to disinvest in some residential care provision. SCC has as its target a reduction of 100 beds during 2008/09. The indications are that the majority of the reduction will be made in care home delivering residential care.

As previously stated there is little in the way of evaluation or research of this concept of care. However two studies which provide some insight to the schemes are a case Study of Westbury Fields undertaken by University of West of England. Westbury Fields is a retirement village community in North West Bristol and is home to 200 older people. The study looks at all aspects of the scheme and includes an evaluation of how residents and staff understood the concept of the community and how it relates to the wider community.

A further study undertaken by University of York (2007) on behalf of the Joseph Rowntree Foundation provides a useful evaluation and comparison of seven schemes. These schemes are located in urban, suburban and rural areas and are operated by different provider organisations with different funding arrangements. One of the schemes is delivered across two sites. Whilst some of the schemes were purpose built others were adapted from existing buildings. This study provides useful insight for anyone contemplating developing Extra Care Housing or Community Villages.

Part Four – Reviewing your Service.

This section provides you with some basic tools to help you review your existing service explore other models of care you may wish to provide. In addition to the planning tools it includes SCC definition and requirements for Extra-care housing and a ten point check list to ensure that any services you plan meet the transformation agenda. Changes to existing services and /or providing new or additional services could have implications for registration / regulation and will require advising CSCI (or CQC from April 2009) of your plans.

The government has committed itself to introducing significant change in the way that both health and social care are delivered. Whilst the overall direction of travel has been agreed the emphasis is on local implementation and this is evolving.

This toolkit is the first step in supporting providers to review their services and assess the implications of the changing nature of services. In developing this toolkit we are aware that readers will include providers who have extensive business skills and knowledge as well as those who have limited experience and business knowledge. For this reason the toolkit includes the **basic requirements** for any planning or business development system. This will be sufficient for some providers whilst others will either develop this further or choose not to use it.

In addition to this toolkit any provider who needs help with any aspect of their planning should contact the SCA project manager by email on valeriemsmith@aol.com.

Undertake a SWOT analysis

The SWOT analysis is an extremely useful tool for understanding and decision-making for all sorts of situations in business and in organisations. SWOT is an acronym for Strengths, Weaknesses, Opportunities, and Threats. The SWOT analysis headings provide a good framework for reviewing strategy, position and direction of a company or business proposition, Completing a SWOT analysis is very simple, and can be used as analysis for business planning, strategic planning, competitor evaluation, marketing, business and product development and research reports.

These elements are crucial in assessing your current position. You want to build on your strengths shore up your weaknesses capitalize on the opportunities but be aware of the threats.

Strengths (internal)	Weaknesses (internal)
Opportunities (external)	Threats. (external)

Ten Tests for a new model of social care that meets the transformation agenda.

Consultation undertaken by Council and Care (2008) suggests that new models of care should satisfy these ten tests.

If you are thinking of introducing a new service / model of care assessing it against these criteria will enable you to identify if the model satisfies the Transformation agenda.

- Is it a person centred approach rather than a needs-based approach, informed by dignity and respect for older people? (Please see definition of Person centred care on page 20)
- Does it support the choice and the diverse needs of older people, their families and carers?
- Is it delivering independent living and active citizenship for older people?
- Is it clear what the state will provide and what the individual is expected to provide?
- Is it sustainable in the longer-term?
- Does it provide value for money – to whoever is paying?
- Does it provide good quality flexible care?
- Does it improve the skills and pay of the care workforce?
- Does it bring health and social care services together?
- Is it inclusive and progressive?

Taken from A Charter for Change Counsel + Care 2008.

Extra- Care Housing

Are you thinking of developing an Extra- Care Provision if so this information sheet will help you to ensure that you meet all the requirements that SCC want.

Extra-Care Housing in Surrey

What is Extra-Care Housing?

Extra-Care housing offers a home for older people to live in that consists of self-contained flats (unlike residential care) and where flexible 24-hour care is provided

What does Surrey County Council expect to see in an Extra-Care Housing Scheme?

Essential requirements:

- Self-contained accommodation
- Wheelchair accessible accommodation
- 24 hour flexible care
- Flexible support services
- Communal facilities
- Activities
- Involvement of staff and residents
- Staff facilities
- Secure entrance and exits
- Convenient location

Desirable features:

- Meals provided if required
- Accessible external space
- Accessible bathrooms
- Lifts
- Barrier free design
- 'Secured by Design' certification
- Resource to the wider community

Types of Extra-Care Housing

There are a variety of care models for Extra-Care in Surrey, which include;

- Purpose built Extra-Care Schemes with a range of community resources (e.g. shop, hobbies room, therapy room, etc.)
- Modern sheltered housing schemes with diverse community facilities, which have been re-modeled as Extra Care, with the provision of a 24-hour care service on site.
- "Core & Cluster" Extra-Care Scheme – a scheme similar to either of the two above but with outreach work from the care team to the wider community

SCC existing schemes are all for rent, but future plans include schemes with an element of leasehold housing and shared ownership.

Surrey County Council's Vision

Anyone who can no longer live independently in their own home should have the option of choosing to move to an Extra-Care scheme in an area of their choice and be able to select either rented, shared ownership or leasehold provision.

Developing a Plan

Providing this resource is not about oversimplify how to create a strategic plan but to assist your thinking in preparing a plan. This framework is useful in that it assist you by placing all the parts of the plan into three main sections which clearly illustrates how it all fits together. The sections of the plan are

Where are we now?
Where do we want to be?
How do we get there?

Where are we now?

As the title suggest this is about looking at your current service. Identify what is good about it and what needs to change. You might ask yourself whether your current services meet the requirement of transformation. This is where you look at what is happening internally and externally to determine how your business needs to change. Why does your organisation exist what are its values what are you and your staff really committed to. How is your organisation operating are you meeting your objectives. Look at recent audit reports particularly your latest CSCI report, complaints, and customer / staff surveys.

Where do we want to be?

Asking this question helps you to identify what your organisation / service will look like in the future. What is the future that you want? Where is the gap in the market? What can your organisation do better than anyone else? What are your unique selling points of your current services? Are these applicable to the new / developing service? What resources do you need? Remember this is about human as well as financial resources.

How do we get there?

Knowing how you will reach your goal is the most important part of your plan and often the most time consuming. You will need to consider the time factors involved and how quickly you need to achieve your final destination. You will need to consider what are the key activities you need to undertake and who will undertake they. Develop a set of short and long term goals this will help you put an action plan together.

Key Performance Indicators

Developing and measuring your performance against a set of key performance indicators enables you to monitor the efficiency and effectiveness of your service. Collecting this data is beneficial in two ways. Firstly it will enable you to make informed decisions. Secondly it will provide you with information to support your planning process and identify any fluctuations in service demands. It will also support you to make informed decisions about changes or developments you wish to make to your existing or future services.

It can also be used as an early warning system to alert you to possible trouble spots. This is not always a negative situation for example having current information on your costs and profit will enable you to benchmark your services against other local or national services.

Performance Indicator	Measurement	Calculation guidance	Benefit
Occupancy Rate	Number of bed voids	The occupancy rate is calculated by the total number of residents cared for during the month divided by the number of registered beds (or available beds).	This will enable you to plot any fluctuations in bed occupancy and identify any predisposing factors. E.g. seasonal or care group. Will enable you to make local and national comparisons.
Average Fees	Weekly fees by care group.	Average fees are calculated by taking the total weekly fees and dividing this by the number of residents at the time	Enables you to compare your fees to local / national average. Will provide basis for calculating fees for new / differing services. By comparing to average cost you can decide the profitability/ viability.
Payroll costs	Tells what portion of fees is attributable to staff costs.	Total of Gross wages, including NI costs and any agency cost, divided by total fee income. This can be calculated quarterly, half yearly, annually etc.	Enable you to identify payroll costs by staff group. This will assist with workforce planning and enable you to make local national comparisons. It could also highlight any inefficiency such as over staffing, agency staffing and help to instigate Cost improvement policy.
Non Payroll Costs	All other costs; fixed and variable.	These are calculated by dividing total costs excluding wages and NIC by total revenue. Both figures are taken from account at time of audit	Could highlight over spend and help to focus efforts on managing costs, such as renegotiating with suppliers.
Profit Margin (EBITDAR)	Tells the profitability of	Profit margin is calculated by dividing the profit EBITDAR	Enables you to identify the percentage of profit

	the business	(earnings before interest tax depreciation amortisation and rent) by the Revenue. Both figures taken from the accounts at time of audit	generated per £ of sale.
Break Even Point	The occupancy level(s) below which the business will start making a loss.	When the costs are equal to fee income. At this level the business is neither making a profit or loss.	It is important to know this in terms of fee income so timely remedial action can be taken in case of weak trade/ occupancy.
Average cost per bed per week.	How much it costs to provide the service	Total cost of the business divided by the average capacity (not the registered capacity) Using information from annual accounts will be beneficial.	You can make informed decision about at which rates to admit new residents or review existing resident's fees.

Key Performance Indicators - Industry Standards *

Performance Indicator	Measurement	Industry Standards
Occupancy Rate	number of bed voids	For Nursing around 89 % For elderly, dementia around 90 %
Average Fees	Weekly fees by care group.	For Nursing around £665 For elderly, dementia around £559
Payroll costs	Tells what portion of fees is attributable to staff costs.	For Nursing – 51.7% For elderly, dementia – 46.3%
Non Payroll Costs	All other costs; fixed and variable.	For Nursing – 16.1% For elderly, dementia – 16.4%
Profit Margin (EBITDAR)	Tells the profitability of the business	For Nursing – 27.9% For elderly, dementia – 32.7%
Break Even Point	At which occupancy/ fee levels the business can just afford to pay its bills.	This will depend on the cost structure, size of the business. A smaller home operated under management is likely to have high cost; as such the breakeven level will be high.
Average cost per bed per week.	How much it costs to provide the service.	As above.

* Source: Colliers CRE Healthcare Report Spring 2008. Figures relate to 2007.

Meeting the Transformation Criteria

Model	Personalisation	Prevention	Early intervention	Choice
Care Homes				
1 Close Care	X		X	limited
2 Joint Working	X	X		X
3 Intensive Team	X			X
4 Day Services	X	X	X	X
5 Outreach team	X			X
6 Partnership	X	X		X
7 Care Suites	X		X	X
Telecare				
8 Intelligent House	X		X	X
9 Sandwell Project	X	X		X
10 Adaption nurse Call System		X	X	X
Surrey Telecare Project	X	X		X
Domiciliary Care				
11 Health Enhancements	X	X	X	X
12 Partnership Team	X	X		X
13 POP Stop	X	X	X	X
14 My Life My Choice	X	X		X
15 Thameside Older Peoples Project	X	X	X	
Extra Care Housing	X	X	X	X

Person Centred Care

Recent policy developments highlight the importance of a more person-centred approach within community care services. The term is mainly used in the literature about older people particularly in relation to dementia care.

Although the exact term used varies there is general consensus that patient centred or quality care contains the following characteristics.

- It is user focused
- It promotes independence and autonomy rather than control
- It involves users choosing from reliable flexible services
- It is delivered by those working with a collaborative /team philosophy
- A good relationship between the service users and the staff is pivotal to person centred care.

Barriers to delivering person centred care relate to

- Bureaucratic structures
- Services that are service rather than user led
- Management practices tend to overlook the importance of relationships between frontline staff and service users.
- Frontline workers often feel they receive little support from management in their day to day work.

Source University of Stirling

APPENDIX 1

1. Close Care

The close Care concept is a model of care based on assisted living within the grounds of an established registered care home. This is not new it has been offered by some providers for the last ten years. It should not be confused with Extra Care Housing although it is very similar. The properties are individual units which can be provided in an attached or detached block of flats. The care home provides the residents of the flats with a full range of services including where necessary personal care. Residents who do not need these services can still access the restaurant and attend social events within the care home. The freehold ownership of the properties remains with the registered care home with units leased to individual owners. The service provision is linked to the care home which means that the provision of some services as specified in the lease are tied to the care home.

When the residents need to move into a care home they can choose to access the adjoining care home or sell their lease and purchase any alternative package of care.

This model meets the objective of the transformation agenda in respect of independent living and personalisation it is limited in respect of choice given the services provision conditions within the lease. There is also implication for registration/ regulation and CSCI have issued guidance on this. CSCI have developed separate guidance on close care services. This is available on CSCI website the reference for the document is QPM Document No; 306/06

2. Joint Working an NHS and local Authority Initiative to provide nursing care in residential homes

This model of care aims to meet the nursing needs of residents where they live and to train care home staff to provide basic nursing care. This is a joint initiative between the NHS and local authority and has been evaluated by a team from the University of West of England, Bristol and the University of Warwick.

The dedicated team of nurses and physiotherapists supported 131 residents in three local authority residential homes. The audit data suggest that the nursing and physiotherapy expertise combined with the support for developing new ways of working amongst designated care staff was able to avert a significant number of potential hospital admissions over a two year period. In addition twenty early discharges were facilitated. It also suggests that the team work prevented twenty vulnerable residents from being transferred to nursing homes. The evidence suggests that by enabling residents to stay in their own home when they were ill was preferred by care staff, managers and more importantly by residents who gained a greater sense of security from having continuity of care in a familiar environment. This approach helps to maintain the resident's independence and provided personalised care closer to home.

3. Joint working with Intensive Home Care Team and care home staff to deliver nursing care.

This model involves the commissioning of dedicated beds within a care home delivering nursing care which are supported by the care home staff and the intensive home care nursing team from an acute or community NHS Trust. Adopting this approach benefits resident in that they can be treated within the home preventing hospital admission and where hospital admission is inevitable the team supports early discharge. This system supports both nursing home residents and provides similar services for older people in the community by admitting them to the care home for a short period. This meets key themes for independence and personalisation

4. Day Care Services within Care Home (Nursing)

Some Care homes are providing day care services for older people in the local community. This enables them to join the community within the home and enjoy social activities whilst making new friends. It also provides welcome respite for carers. The service is flexible and operates seven days a week. This meets key aims for personalisation

5. Care Home outreach Team Yorkshire

This team of care home staff provide services for people in their own home. They offer a range of services across a comprehensive care pathway which includes personal care, preparing meals and shopping. This maintains people in their own homes and provides respite and personal time for carers. This meets the key theme for independence and personalisation.

6. Partnership with older people project Gloucestershire – Part of the Community.

A key aspect of this project is developing outreach services which will enhance the capacity of care homes to provide different types of care and support to an increasing number and a wider range of older people and carers in the community. The project includes a county wide care home support teams, outreach services, comprehensive care pathways and training and development for care home staff.

7 Care Suites

Care Suites is an innovation where prospective clients can buy a suite on a long term lease whilst being able to take advantage of any or all the services provided in the care home. These suites come in a variety of sizes and include studio and one bedroom facilities.

Telecare Application

8. Intelligent house in West Bromwich April 2008

This is a joint project between health and Social Care to refurbish a traditional Victorian terrace house using intelligent healthcare technology and access focused building design concepts. The aim of the home is to refine, improve and develop technology whilst raising awareness among providers and creating public demand. Whilst the Government is ensuring that new houses will be built to become lifetime homes this house addresses a more urgent immediate need. Taking this approach supports the independence and personalisation agenda.

9. Sandwell Telecare Project.

This project aimed to introduce technology aids to enable vulnerable elderly and/or disabled people to live independently in the community with added safety and confidence whilst reducing anxiety and risk. The project which was evaluated by University of Central England and published in the Journal of Integrated Care suggest that while the project has successfully demonstrated that electronic sensors have a valuable role to play in supporting the desire of many elderly people to continue to live independently in the community. It seems probable that the installation of telecare will become the norm in years to come. The project also demonstrated effectively that the use of technology has its limits as on its own it cannot actively compensate for the lack of human resources to provide back up to people in crisis situations.

10 Adaptation on Nurse Call systems

Work is currently in progress which includes demonstration sites to adapt the Omega Nurse Call system to a resident monitoring system. This would enable care home staff to monitor the resident movements throughout the home. The benefits of such a scheme are to allow resident particularly those with dementia more freedom whilst ensuring their safety. Senses install across the home would also provide information on patterns of the patient day and identify any changes to this pattern and the resident's behaviour.

Examples of Domiciliary Care Initiatives

Whilst the involvement of independent domiciliary Care providers to these projects is limited they do provide an indication of the range of services that Domiciliary Care agencies might wish to become involved in or develop similar services.

9. Health enhancement for older people and their communities.

This project aims to improve access to well being services and support older people and their carers in need of “a little bit of help” to access design and arrange services to meet the individual needs.

This project included:-

- An enhanced access team which included older people in specifying the needs and designing a service to meet that need.
- A Local Community Network - Improve the range of preventative services for self directed support.

10. Community Partnership Teams.

This project aims to improve access to information on wide range of advice on health and well being by supporting older people to get a little bit of help to get the services they required, promote healthy ageing by increasing the number of active people, Further develop a range of activities that older people can engage in through training support and advice.

11.POP Stop Croydon

This project provides a mobile unit seven days a week with a flexible timetable including evenings. The mobile unit provides

- Health Checks
- Information on keeping well in old age
- Advice on what is on
- Falls prevention
- Equipment
- Support/care for carers
- Nail cutting service
- Housing and benefit advice.
- This service has proved particularly useful for older people who are more difficult to access.

12. My Life My Choice - feeling good in Devon

The multi-disciplinary team works at primary care level to deliver older people a focused service which includes the full spectrum of need from low level to urgent need. A multi –disciplinary team provide this service.

The project has two key strands which include

- It works to simplify access to services and enable older people to have control over assessment.
- It helps people to be independent and healthier for longer provides support for carers, and reduces unnecessary hospital admissions by providing support.

13.Thameside Older People Project

This service provides a check and support service for older people. It looks at a range of services and includes such things as fall prevention, mobility, and medicine management as well as an information service

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