ITEM 4

NYCC Adult and Community Services and
NHS North Yorkshire and York

Care and Support In North Yorkshire

Shaping the Market

A Dialogue with the Independent Sector

Volume One

Main Report

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Foreword

Derek Law – Director of Adult and Community Services, NYCC

I am very pleased to launch this dialogue with the independent sector. The Council, the NHS and the independent sector in North Yorkshire face a set of unprecedented challenges in the delivery of social care in the months and years ahead. I hope that independent sector providers will take this opportunity to consider the issues that are raised in this dialogue and contribute to the debate about how we can best move forward together.

Jane Brown – Chief Executive NHS North Yorkshire and York

I welcome the opportunity for NHS North Yorkshire and York and the County Council to open a dialogue with the independent care sector. The demographic changes in the years ahead present real challenges to commissioners of services. It is therefore important that we work together with the Independent Care Group to ensure that we can deliver personalised services, giving people more choice and control over the services they receive.
I hope this dialogue will help us find a way forward together.

Mike Padgham – Chair of Independent Care Group & Chair of UKHCA

The ICG welcomes this open approach to engaging with the independent sector. We understand that commissioners are required to commission personalised services, to meet increasing demands, and to work with the market in a very challenging economic environment. ICG will continue to make representations to ensure that the importance of independent sector providers to the well being of the social care market is recognised. We strongly encourage all providers to look carefully at this discussion document and to give their considered responses.'

Introduction

North Yorkshire County Council (NYCC), its Adult and Community Services (ACS) and its NHS partner, NHS North Yorkshire and York (NHSNYY), need to ensure that there is a strong and thriving independent care sector that is able to respond flexibly to the changing needs of local communities in North Yorkshire and individuals within them.

The independent sector in North Yorkshire provides care and support for people who are vulnerable because of poor health, frailty or disability in their own homes or in care homes. In many communities independent sector care providers are significant employers contributing to the livelihoods of many individuals and families. Independent sector care providers are also substantial purchasers of services from their local communities ranging from groceries and equipment services to financial and legal expertise as required. The care sector is part of the fabric of North Yorkshire and one of its largest industries.

According to the respected analysts of the care market Laing & Buisson[1] the two main formal care sectors (residential and domiciliary care) are together worth in excess of £19.8 billion in England. This includes care and support purchased by public sector commissioners, by individuals funding their own care and the welfare benefits used to fund care. Based on this figure the social care market in North Yorkshire would be worth between £180 million and £200 million per year. The sector supports in excess of 13,000 people in care homes or in their own homes.

A number of public sector organisations have a variety of roles that interact with the independent care sector. The Care Quality Commission (CQC) is responsible for the formal regulation of services, including those of the local authority, in the sector. Local Authorities and the NHS have a broad range of responsibilities set out in legislation and guidance. Typically this would be providing needs assessments for those who receive public funding for their care together with advice, assessment and information for those meeting their own care needs. They will also purchase individual packages of care for people or enter into more substantial longer term contracts for whole services.

NYCC ACS and NHSNYY also have a responsibility to take a broader strategic commissioning role in the care market as a whole in North Yorkshire. This means that local authorities have to understand the demand side of the social care market and shape or influence the supply side of the market.

The demand aspect relates to making better use of local knowledge, demography and changing patterns of need to best understand how these can be catered for. NYCC and its NHS partners have recently published the Joint Strategic Needs Assessment (JSNA)[2] as the public statement of their understanding of the present and future needs of the people of North Yorkshire.

The supply side of the equation relates to the ability of the market to respond to the needs of those who purchase care services or arrange it on behalf of others. Increasingly local authorities have been encouraged to take a more active role in

[1] Laing and Buisson, Care of Elderly People Market Survey 2007
[2] North Yorkshire's Joint Strategic Needs Assessment 2008-2011.

influencing the care market in their areas. The Government circular Transforming Adult Social Care[3] sets out the expectation that local authorities should develop a clear approach to the social care market in their areas.

> *'Councils will also be expected to have started, either locally or in their regions, to develop a Market Development Stimulation Strategy, either individually or on a wider regional basis with others with actions identified to deliver the necessary changes'*

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It is in this context that the County Council and its partners is publishing this discussion paper to seek views from the sector as to how we can jointly work together to achieve a viable and vigorous social care market in North Yorkshire that meets the needs and aspirations of local people. A separate companion document summarises the available information on the market locally looking at current provision by category and locality and some indications of costs and expenditure. Comment on the usefulness of this information is also sought.

Following this period of discussion the Council will publish its plan in the form of a Care Market Statement which will include a procurement programme.

Structure of the material presented in the dialogue:

The material is presented in four volumes as follows:

Volume One	The Main Report
Volume Two	The Summary Report
Volume Three	Care Market Data Book, Population, Provision and Expenditure.
Volume Four	Response Pack

The Main Report sets out the background and the ways commissioners of care services can influence care markets. The key challenges facing the care market locally and nationally are presented and then proposals are made as to how they can be addressed. Each section contains a 'Dialogue Box' which invites responses to a series of questions relevant to that section. The Main Report then goes on to look at how Commissioners and Providers can work together more effectively and puts forward a series of proposals and questions upon which comments are welcomed. The time-frame and how to participate are then described.

The Main Report contains a fuller rationale for the proposals and includes a series of references and links to further information. Some case studies are also included. The Main Report is the principal vehicle for the dialogue.

The Summary Report is intended to provide a brief overview of the full document and the issues it raises. It contains an outline only of the proposals set out in the Main Report and gives an indication of the content of the Dialogue Boxes. For details of the specific questions in the Dialogue it is necessary to access the main document.

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[3] Transforming Social Care, Local Authority Circular (DH) 2009 (1), Paragraph 16

Volume Three, the Data Book, presents a summary of information about the local care market which has been collated from a range of sources. It covers population, current provision, patterns of expenditure and known indices of quality. Sources of the data are indicated.

Volume Four repeats the fourteen separate dialogue boxes and should be used to form the basis of the response from individuals, companies or other organisations to the dialogue.

Part One - Context

(a) Background to the Dialogue

'Commissioning' means how services are purchased or developed over time to deliver an agreed set of outcomes on behalf of those people in need of the services. Both NYCC and the NHS are being challenged to transform the way they commission and deliver services. The focus now and in the future will be increasingly on how they, together with other parties, have made North Yorkshire a better place in which to live. Attention will be given to how we have made a difference to the lives of people. This means there will be less attention given to inputs and service details and more attention given to how both the services have impacted upon and improved people's lives.

The dialogue with the care sector is a constant and ongoing one. There is routine contact between staff at a local level with the independent sector providers is they work together to meet the needs of individuals receiving services. There is also a more 'business' relationship between the sector and the staff in contracting and finance departments who authorise and make payments. The County Council and have supported the development of the Independent Care Group (ICG) as a means of improving dialogue and partnership working across the care sector.

ACS initiated a new phase of this dialogue in 2008 and into 2009 with the publication of two key documents locally. NYCC published Strategic Commissioning for Independence, Wellbeing and Choice[4] in 2007 which set out a 15 year strategy for social care in North Yorkshire. Putting People First in North Yorkshire[5] published in November 2008 set out a joint vision for social care services in North Yorkshire that was agreed by all the key organisations in the county including the County Council, NHS North Yorkshire and York, the North Yorkshire Forum of Voluntary Organisations and the Independent Care Group.

Workshops were held in each area of the county focussing on the themes raised in the Strategic Commissioning Plan and those in Putting People First about choice and more person centred services. In these workshops there was discussion about the changing shape of health and social care and how services could be commissioned differently in the future.

Both the local authority and the NHS are being required to deliver services in a more personalised manner. This shift in focus requires those involved in commissioning and delivering services to ensure that people have more control over their own lives and greater choice about the type of support they receive

The demographic changes in the years ahead, particularly the growth in the number of older people present real challenges to both commissioners and providers of services. Social care, if it continues along the same path with the current model of service provision is no longer affordable. The Council's strategic commissioning document set this out and projected the necessity of a 50% increase in the current volume of services

[4] Strategic Commissioning for Independence Well Being and Choice, NYCC, 2007
[5] Putting People First in North Yorkshire, NYCC,NHSNYY and partners 2008

by 2021 in North Yorkshire unless the pattern and range of service delivery was fundamentally changed.

The recently published Green Paper, Shaping the Future of Care Together[6], seeks to identify some of the solutions on the future funding of social care and sets out possible alternatives. This document has been the subject of consultation and a White Paper is promised in 2010.

The Care Quality Commission (CQC) is a regulator and performance manager of the entire sector, including the local authority and the NHS. They take a close interest in how all parts of the sector carry out their functions within the terms of the legislation and are increasingly measuring the performance of organisations on how they achieve better outcomes for people. It is therefore of critical importance that we all understand the difference between inputs and outputs and we start to focus on quality and improved outcomes for people who use services.

The emerging consensus is of an increasingly constrained public sector spending profile across health, social care set against a pattern of rising demand and increasing expectation. It is in this context that this local discussion document now seeks to capture some of the issues that are faced both by the statutory and the independent sector in the years ahead. It asks how a greater understanding of the implications can be developed and considers how to move forward to secure a strong and viable care market in the county.

(b) Purpose of the Dialogue

The purpose of this dialogue is to engage the independent sector in discussion and debate about the future direction that the care market should take in North Yorkshire.

It is intended to prepare the market to respond to the policy changes and commissioning imperatives which demand that ways are found of ensuring that individuals have more choice and control in their lives and about the support and services they receive.

The views of the sector are welcomed as to how more people can be effectively supported at home how positive outcomes for those individuals and their communities can be achieved. **This dialogue is intended to encourage innovation and to seek new solutions to old problems**. The challenge of doing this in more cost effective ways is something we would particularly welcome contributions on.

A growth in the domiciliary care market is foreseen and a levelling off or even a reduction in the use of residential care homes is anticipated as more robust alternatives become available. We would like to test the market's views on this assumption and use this dialogue to consider how the sector may best wish to respond.

There is also recognition that the way in which business is transacted may not always be the most cost effective, and views are welcomed as to how improvement can be made in this area. This would include contracting, invoicing and payment arrangements, electronic monitoring, and geographically purchasing home care.

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[6] Shaping the future of Care Together, Department of Health, 2009

There are a number of care markets within a very large county like North Yorkshire. There are variations in the cost of care, the prices paid, availability of a workforce and in the mix of services offered to individuals and communities. If one is the holder of a personalised budget or a commissioner buying care on behalf of the wider population then there can be a disparity as to what can be afforded to be purchased and what is available. After the dialogue period a major procurement exercise will seek to reduce the widest variability and seek to reduce the supply problems within North Yorkshire's care market.

By sharing information on the structure of the market and the volume of care business that is transacted in Volume Three ACS seek to place a mirror to the care market in North Yorkshire. Compiling such information has not been straightforward as it is not routinely collected and the market's views on whether it is an accurate reflection of the situation in North Yorkshire would be valuable.

(c) Parties to the Dialogue

This dialogue has been initiated by North Yorkshire County Council Adult & Community Services, NHS North Yorkshire and York and the Independent Care Group. It will be of particular interest to those supplying care services in North Yorkshire and other partners such as District Councils, the wider County Council and those organisations on a local and national level who are keen to promote good quality care services. Many of the organisations will be registered with the Care Quality Commission for all or part of the service they provide and some will work with contracts from both the Adult & Community Services and the NHS. The latter will particularly be the case with organisations with registered services that provide nursing care.

Providers of care in North Yorkshire are predominantly in the independent commercial sector, ranging from small local companies to much larger national and international organisations. Some providers will be either third sector not for profit companies, specific charitable foundations or user led organisations. The County Council is a provider of care as well, currently supplying fewer than 25% of care beds and an estimated 39% of home care services. How the Council's resources are deployed has a significant effect on the care market.

The Council has undertaken a separate dialogue with the voluntary sector on how the future of that sector can best be secured. It is recognised that some companies or organisations may feel they have a legitimate interest in both conversations and are welcome to contribute to both.

The Council and its partners are also keen to encourage other public and private sector bodies that have not traditionally had a voice in the discussion around care markets. Of particular interest would be comments from those concerned with employment, training, economic development and those concerned with planning and transport where that is a factor in providing good quality accessible local services.

Whilst not aimed specifically at users of services and carers this discussion would benefit from their input particularly where people have used direct payments, personal

budgets or other means to design innovative packages of support and employ personal assistants (PA's).

Case Study

An elderly gentleman with complex care needs in a North Yorkshire village receives a direct payment enable him to continue to live at home. With the support of his daughter, who also coordinates and administers the arrangements, a small team of personal assistants provides care and support to meet his needs on a 24 hour basis throughout the week.

Some organisations and companies may have contracts with other local authorities where there have been placements into North Yorkshire or where they work across the boundaries with neighbouring local authorities. Many people purchase their own care and we understand that up to half of care home places in North Yorkshire are occupied by people funding their own care services. The County Council has undertaken a piece of work to further understand the needs of those who purchase their own care and will be doing further work in the months to come.

This dialogue is about securing the future of the independent social care sector in North Yorkshire. It is also about finding the most efficient way of spending public monies invested in care. It is about ensuring that the sector is robust enough to take advantage of new business opportunities as they emerge and can cope with the realities of the economic downturn. It is also about simplifying how the statutory sector and the independent sector can do business together and how competition and the allocation of public funding can be seen to take place in as transparent a manner as possible.

Part Two - Shaping the Care Market

a) The Role of Commissioners

The County Council has a general duty to meet the needs of the whole population of North Yorkshire as well as specific statutory duties to those people with assessed needs for social care. In order to achieve this ACS has to work with a range of partners to plan, commission or provide the necessary services to meet these needs.

The care market in North Yorkshire is a complex entity being a mixture of large and small organisations providing a diverse range of services, either across the county as a whole or in small local communities. Notwithstanding this diversity of provision the market must be able to respond to the needs of all those in the community 365 days a year and across all times of the day, evening and night depending on need. The role of the commissioner is to set out these expectations and the purpose of this dialogue is to engage with the sector on how we might best work together to achieve them.

The question then arises as to how commissioners can best influence the shape and the future direction of the market. The Council has its long term commissioning strategy in place and it sets out the direction of the travel over the coming years. In particular the market needs to realise that needs and demand are changing and increasingly users will have the power and the resources to purchase their own care.

Providers need to ensure they are providing a service which attracts the empowered user. It will be increasingly about providing bespoke individual solutions and there will be more personal assistants providing a support to an individual specification in their own homes

On their own changes to needs and demand may not be sufficient to shape or move the care market in the desired direction. Nor can the local authority simply set out or specify in detail what the market should look like, what providers should be doing and the precise volumes of service that are needed. Such an approach is resonant of a planned economy subject to central direction. This is likely to deny innovation and solution finding, limit choice and does not reflect the presence of multiple purchasers of care within the market – the number of which is likely to grow considerably in the years ahead as more people manage their own budgets.

b) Influencing the market

Thaler and Sunstein[7] describe how systems and markets work and how they can be changed by guiding people into informed choices that have beneficial outcomes for themselves and the wider community. **Commissioners cannot manage the care market directly but they can seek to shape and influence it**. **The question then arises as to how commissioners can do this and four possible ways are set out below**.

[7] Nudge, Improving Decisions about Health, Wealth and Happiness, Thaler and Sunstein, 2008

Influence One - Setting a Broad Structure for the Market

One of the principal roles of commissioners is to reflect to the market the needs, wishes and aspirations of those who are currently or may wish to receive services in the future. The Commissioning Strategy and the JSNA analyse need and set out the long term strategy. The local authority retains the statutory duty to undertake needs assessments for all those in the community who may require support and is able to aggregate and reflect these needs to the market. This will not be a simple catalogue of numbers of hours or bed spaces but will be a richer mixture of need, aspiration and choice.

Commissioners are working in partnership with service user groups, representative organisations, special interest groups, other statutory bodies and all those with a legitimate interest in the market for social care. This information is used to inform commissioning intentions and to help providers understand the environment they are working within. As many more people will be purchasing their own care and support statutory commissioners will have to have structures in place that support this.

Influence Two - Intervening in the Market

There are a series of more focused interventions that ACS could make in order to deliver the kind of market that is felt to be necessary for the communities in North Yorkshire. This could be, for example, to ensure that high quality, flexible and responsive services are available for personal budget holders and those paying for their own care. This could be on a countywide level where initiatives are undertaken to increase the support brokerage arrangements for instance for those arranging their own care or, at a local level to meet specific needs in individual communities.

To support the development of local solutions or to secure supply ACS might want to see a move towards preferred providers in individual areas**.** Equally commissioners may wish to stimulate the development of care home capacity in certain areas to reflect particular need whilst moving to reduce the dependence on care home based solutions in other parts of the area.

Influence Three - What the Council Does As a Provider

How the Council as a provider of services positions itself in the market is itself a direct intervention which informs the actions of other providers. The Council has decided that it will not be a provider of residential care in the longer term and is working in partnership with housing providers and district councils to deliver extra care housing as a replacement.

The majority of the Council's in-house home care provision will also change in a phased approach over the next two years. There is a strong body of evidence that a short term home care service that intervenes quickly, focuses on promoting independence and assists people to regain skills or confidence they have lost secures measurable benefits to the individual. It can often reduce the need for long term support. Typically this would be the service that would be offered first to people requiring support from ACS. This type of service is shown by research to be a more effective use of resources, realises better outcomes for users of the service and is more cost effective for

commissioners[8]. Based on the evidence, North Yorkshire County Council will transform the majority of its in-house domiciliary care service into a re-ablement and rapid response service and commission the majority of longer term support from the independent care sector.

Influence Four - Providing Market Intelligence

There is a need to develop a shared perspective of the supply and demand between commissioners and providers and to understand how local care markets are working. The information in Volume Three is the start of this process and commissioners are doing further work on understanding the care market which will be shared with the sector in due course. Commissioners will want to look at ways in which the provision of market information can continue and be widely shared and reflected upon.

Dialogue One

Shaping the Care Market

1. Four broad approaches to shaping the care market are set out above. Do they adequately describe the tools available to commissioners and, if not, what others might there be?

2. Does the information in Volume Three about the Care Market in North Yorkshire reflect your understanding? In particular is the overall size of the market estimated correctly and are the suggested numbers and percentage of self funders accurate?

[8] Benefits of Homecare Re-ablement for people at different levels of need, CSED 2009

Part Three – Meeting the Challenges

Introduction

This section of the dialogue seeks to identify the key challenges that the social care market faces and then poses some questions to stimulate the debate about how to move forward locally.

The two large commissioning agencies in the statutory sector (ACS and NHS NYY) realise that the social care sector faces the challenges of rising demand for services and ever increasing expectations as to the quality and responsiveness whilst the funding available grows at a much slower pace or even reduces. These challenges put a premium on innovation and flexibility and seeking more efficient ways of achieving the desired outcomes.

(a) Developing More Personalised Approaches

Personalisation means thinking about care and support services in a very different way. It means starting with the person as an individual with their own aspirations, preferences and strengths and putting them at the centre of the process of identifying needs. It requires that those assessing need and providing services enable individuals to make choices about how and when they are supported to live their lives.

The overarching aim is to give more flexibility as to how services are provided. The law now requires local authorities to make direct payments and to offer them to those eligible for services in all circumstances. Therefore direct payment should be discussed as a first option at each assessment and at each review. The number of people receiving direct payments has substantially increased over the last three years and will be increasing further.

Those with personal budgets or direct payments need to be able to purchase the support they require to meet their aspirations. Consequently it follows that they require information and advice as purchasers about what might be available and how they might access those services. Equally the providers of service need to understand what the individual needs and aspirations are in order that they might tailor their services to acquire the business. It is for commissioners to ensure that they have the infrastructure in place that allows the market to work.

In short, commissioning for personalisation means:

> *"Working together with citizens and providers to support individuals to translate their aspirations into timely and quality services, which meet their needs; enable choice and control; are cost effective; and support the whole community"* [9]

[9] Commissioning for Personalisation: A framework for local authority commissioners, Department of Health, 2008

In response to the Personalisation challenge ACS is radically changing its assessment and care planning processes in order that they are more responsive to individual's wishes and put those individuals in control of their care and support arrangements as far as is possible. All ACS assessment staff are currently undertaking a five day training course which will equip them to carry out the new tasks which will be supported by a new information management system. Staff will then be using the Needs Assessment Questionnaire which will calculate an Indicative Budget for each individual which will inform the Support Planning Tool and the development of a support plan. This is being introduced on a phased basis across North Yorkshire and, from December 2009, will be used for all new assessments when people approach the Directorate for support for the first time and for some reviews.

It is also essential that care home providers understand the implications of personalisation and are fully engaged with the changes and rising expectation that will come with it. Whilst personal budgets are not able to be used to purchase long term residential care providers of Care Homes will need to reassure themselves that they have the understanding of the needs of the local communities they serve and that they are able to respond flexibly to these needs.

Managers will have to ensure that they are running care homes in a truly personalised way, responding to individual needs and wishes. Key areas that need to be addressed include:-

- Access to advocacy services
- Residents having access to information to enable them to make informed decisions.
- Encouraging an open and enabling culture rather than a paternalistic one

This transition will be supported by commissioning practice. Not only will these requirements be reflected in contracting arrangements they will be a central part of Quality Assurance programmes that the Council are planning. Being able to indicate best practice in this area will be a key factor in individuals making a positive choice to select a particular home when that becomes the appropriate course of action. Care home providers may wish to gain more information on the impact of personalisation from the Social Care Institute for Excellence (SCIE)[10] .

[10] Personalisation briefing, Implications for Residential Care Homes, SCIE, 2009

Dialogue Two

Personalisation Dialogue

1. Providers are likely to have to deal with a wider range of purchasers of care than just the local authority. What implications will this have for independent sector providers?

2. Personalisation presents risks as well as opportunities for providers. These might include loss of steady income streams, staffing issues and the need to change current business models. How well do you feel the sector is prepared to meet these challenges and what might be some possible collective solutions to them?

3. Purchasers of care services will need to know what exists in the market place which may be suitable for them. How might an independent sector provider market their services in this changing environment and would you market yourself as a supplier of personal assistants?

4. People can recruit their own personal assistant (PA) rather than purchasing their care from a registered care provider. In the light of this how might the sector retain its workforce or diversify services to offer training, management, employer support services to people employing their own personal assistants?

5. The types of support that people who use services say they need are not confined to personal care alone. It could include a range of other services such as domestic help, household management, gardening and home maintenance. Should the independent sector providers move directly into this area or should they perhaps develop alliances with existing voluntary sector providers to do this or create new trading entities in order to do so?

6. Care homes will increasingly have to demonstrate that they are able to offer care in a more personalised way. What do care home managers feel are the main challenges presented by this and what might be the key opportunities? Are there are examples of best practice you may wish to share?

7. In what ways can ACS or others assist providers in any of the above?

(b) Investing in Prevention

A considerable amount of public funding is invested in care and support services which respond to crises in people's lives. A sharp deterioration in an individual's social and health circumstances can be brought upon by illness, accident or by the worsening of a long term condition and this can necessitate urgent intervention. This often results in the need for long term care and support.

Commissioners recognise that there has been insufficient investment in early intervention and prevention and that there is rising evidence that the crises that change people's lives for the worst can be prevented or delayed by timely intervention. Thus a preventable hospital admission can lead to a care home placement that neither the individual nor the commissioners of service want.

There is a growing body of evidence[11] that prevention works and some of the key messages about making a strategic shift to prevention and early intervention include:-

- That promotion of independence and quality of life are priority outcomes which can reduce long term expenditure
- People value practical support to maintain independence
- Prevention is an approach which is relevant across the full spectrum of need - the agenda is not just about 'low level services'
- There needs to be a balanced investment across the full range of possible interventions
- Information and advice is important for people, including for those who can afford to fund their own care.

North Yorkshire was one of the original pilot sites nationally for the Partnerships for Older People Project (POPP) that demonstrated that preventative approaches can be effective[12]. The most successful of these local projects have continued and further investment in targeted prevention projects has been made in partnership with Age Concern North Yorkshire. Building on national and local evidence of best practice commissioners will want to invest further in this area of work.

Dialogue Three

Prevention and Early Intervention

Based on the local and national research evidence there will be a shift from investment in high-end acute services to services that can demonstrate the effectiveness of early intervention and prevention.

1. Few will argue against the need to invest in services that prevent a loss of health, well-being or independence, but what are the issues and concerns from the independent sector around this?

2. What are the areas of best practice that you may wish to incorporate into the way your organisation provides services ?

3. Many preventative services are provided traditionally by the voluntary sector. What role might the independent sector play in this form of provision?

4. Would independent providers welcome the opportunity to be able to subcontract part of their work to a third sector organisation in the interest of efficiency and securing a better outcome for an individual?

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[11] Department of Health Care Networks 2009, www.dhcarenetworks.org.uk/Prevention/
[12] National Evaluation of POPP Programme, Second Interim Evaluation Report, PSSRU, 2008

(c) Developing Re-ablement Services

There is growing national evidence that investment in services that promote rehabilitation and re-enablement are effective in reducing or delaying the onset of the need for long-term care and support. These interventions are focussed and short term with a view to maximising a person's independence; restoring self-confidence and helping someone regain as active a life as possible. This approach has demonstrably improved the outcomes and well-being of individuals but has also proved to be a more cost effective solution for commissioners of service. This is because the rapid restoration of social functioning and independence with a targeted short-term investment is actually cheaper than long-term care and maintenance support. More detail on the effectiveness of these services can be obtained through the Care Services Efficiency and Delivery Unit (CSED) at the Department of Health [13].

Based on the evidence CSED conclude that '**the question now is why would any Council not provide Homecare Reablement'**[14]

As was set out in Part Three, ACS is responding to this evidence by radically changing the function and structure of its own in-house homecare provision. The majority of this provision (approximately 80%) will become a short-term re-ablement service providing focused short-term intervention of up to six weeks to all new situations where care or support is felt to be necessary. This will be across all service user groups. In order to retain an ability to respond quickly with adequate capacity the need for any long-term care and support will be commissioned from the independent sector.

This transformation will take place on a phased basis over two years across the whole county. The current plan is that this will start in Selby, then in Harrogate and Craven followed by Scarborough and Ryedale and then the rest of the County. The whole process will require a significant procurement programme to ensure there is sufficient capacity in the independent sector to take on the work of supporting individuals currently receiving an in house service. From the analysis undertaken to date of capacity the local care markets in the following Districts in particular will need to be strengthened:

- Craven
- Hambleton
- Richmondshire
- Ryedale
- Parts of Harrogate Borough
- Parts of Scarborough Borough, including Whitby.

Therefore over the next two years there will be a major procurement programme to strengthen capacity in home care markets and a fundamental change in the role of the in house home care service. The majority of support purchased from the independent sector in the longer term will be for individuals who have already had the opportunity to benefit from the re-ablement service. Independent providers will therefore be expected to demonstrate that they can work in a way that will complement this

[13]Retrospective Longitudinal Study, University of York/CSED, 2007
[14] The Benefits of Reablement, CSED 2009

service. This means they must be able to respond flexibly to need, promote independence and negotiate individual solutions with those receiving support.

Dialogue Four

Re-ablement

The Council intends to transform the majority of its in-house homecare provision into a short-term re-ablement service.

1. What type of changes may you have to make in your organisation to deliver a service that will complement the Council's re-ablement service, i.e. deliver a service that promotes independence?

2. What steps do you think you may have to take to demonstrate this if you chose to participate in a procurement programme?

(d) Increasing the Use of Telecare and Telehealth

Telecare is increasingly being used to help people remain more independent, promote dignity and well-being and more effectively manage risk. Not only does telecare improve outcomes for people, it is demonstrably cost effective as well.[15]

Telecare services range from pendant alarms to unobtrusive monitoring that can alert people to environmental dangers or trigger responses to untoward incidents. Over 2000 people are supported by these types of telecare in North Yorkshire and the Council is one of the most advanced in the region in the use of telecare services.

It is also possible to use technology to manage long-term conditions people may have in their own homes, commonly called telehealth, and NHSNYY are currently trialling this in a number of areas.

Provision of telecare will increasingly be the default position when responding to an individual's need. This means that telecare solutions will be looked into in each circumstance and providers will be expected to consider how telecare may improve the quality of the care services they provide and the outcomes they achieve for the people they are working with.

Robust evaluation in North Yorkshire has demonstrated that telecare can deliver improved quality of life through improved dignity, choice and control for people. It is also shown to be a more efficient use of staff resources and to be cost effective to providers of service. Providers will be asked to recognise the importance of telecare and consider its use to support people. In future this will be a contractual requirement for all organisations working with the County Council.

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[15] Telecare outcomes and mainstreaming, Department of Health, Telecare LIN, November 2008

Telecare can be used effectively in residential care settings as well. ACS has invested in telecare in its remaining Elderly Persons Homes and is working with one care home provider to integrate telecare fully into the care of residents in the home. The majority of residents now have the benefit of bed occupancy sensors, falls detector or environmental monitoring equipment, dependent upon their circumstances, and there is emerging evidence that this improves the experience of those people living in the home and is cost effective for the provider.

The evidence is that telecare, in partnership with a response system involving agency staff, family or neighbourhood networks can reduce the amount of direct care required and the associated costs. This provides both an opportunity and a threat to traditional providers of services.

Some case studies highlight the opportunities offered by telecare.

Telecare Case Study 1

The management of personal laundry in communal care settings is often problematical and upsetting for individuals when items are lost. Installing a tiny radio frequency identifier (RFID) in each item which is individually coded can ensure that no items are lost. This can reduce losses of laundry, improve throughput, assist with responding to particular needs (eg: skin sensitivity to detergents), and may reduce costs.

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Telecare Case Study 2

A gentleman of 75 who has Parkinsons Disease is prone to falling. He lives alone and has some mobility problems and uses a tripod frame in the house. He has been issued with a fall detector which he says he is happy to wear as it gives him peace of mind. The first weekend he had the fall detector he fell whilst walking from his living room to the kitchen and was unable to move. He was wearing his falls detector and this summoned an emergency response. Had he not had this then he would have been left on the floor until after the weekend, until a planned visit would have been made on the Monday.

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Telecare Case Study 3

An elderly lady is admitted to a care home. She is prone to falling and has some memory problems. A bed occupancy sensor and fall detector is used which alerts staff in the home, should she leave her bed in the night and does not return quickly, or if she has a fall whilst in her room or moving around the home. This enables staff in the home to respond appropriately and quickly and not have to keep checking her just in case something has happened.

Dialogue Five

Telecare

1. As a provider, have you considered how telecare might assist your service provision and have you amended induction and staff training routines to reflect the importance of telecare? Is telecare discussed with users at review or other meetings?

2. Telecare improves the quality of care and enables the home to manage more people with complex needs. As a provider of residential care, have you considered how telecare solutions may have a positive impact on your business and have you approached any telecare providers directly?

3. If you have considered using telecare would you be willing to share your experiences and, if so, would you please provide examples for wider circulation?

4. How might the Council assist you as a provider in utilising telecare as part of the solution offered to your customers?

(e) Ensuring High Quality Services

The statutory partners are determined to ensure that all the services that are procured are of high quality and meeting all the required standards if they are a regulated service. Not all services across North Yorkshire are of such a standard and it would be the intention only to commission those services where the highest standards can be guaranteed.

Over recent months the County Council has suspended a number of providers from its preferred list because of unacceptable levels of services or breaches of standards of the most fundamental type. In addition to this, where concerns have become apparent, the Council and its partners in the NHS have worked together with providers to improve the service quality and to monitor any agreed action plans that have been developed.

The Council has held discussions with CQC about how the respective roles between the organisations of procurement and regulation can be effectively addressed. This dialogue will be continuing at a local level on a regular basis.

The Council will be strengthening its compliance and contract monitoring functions over the coming months and will be taking a more active role in ensuring that quality standards are met. This is intended to compliment the role that the CQC plays and will further inform the purchasing decisions that the County Council and its partners make.

There will be a North Yorkshire Quality Assurance framework and specification which will apply to both internal and external providers. This will be formed and agreed in partnership with representatives of the independent sector and ratified by the Market Development Board. **There are two implications within the proposal: in time NYCC will only commission services from providers who have acquired the North Yorkshire Quality Kite Mark and all who wish to be viewed as having 'Preferred Provider Status' will need to comply with this quality assurance framework.**

Where the Council decides action needs to be taken in respect of performance this will be done using a suspension policy that will be made available for all providers and will be administered in a fair and open manner.

Dialogue Six

Quality Standards

1. The County Council intends to only commission from regulated services that demonstrate they can meet high quality standards. What steps may you have to take to ensure you meet these standards?

2. How might 'excellence in service' provision be incentivised?

(f) Meeting the needs of those who fund their own care

To ensure the whole population of North Yorkshire have their needs met it has become necessary to rethink the approach taken to people who fund their own care. It is acknowledged that advice, information and support is lower for people who fund their own care and this imbalance needs to be addressed. **Access to information, advice and support must be available for all individuals using care services, and not just those receiving services directly from the Council or commissioned by the Council.**

In October 2007, the Commission for Social Care Inspection published a report entitled 'A Fair Contract With Older People?'[16], which explored the experiences of older people who had taken the decision to move into residential care. The report highlighted key findings, which were summarised by the following statement;

'Self-funders are disadvantaged by a lack of information, support and advice at every stage in making a decision about going into a care home'.

The report places a requirement on local authorities to investigate potential ways to improve the experience of older people who are self-funders and considering moving into residential care.

North Yorkshire has the highest proportion of people who fund their own care in the Yorkshire and Humber region and is towards the higher end nationally. A more proactive policy of providing advice and information and encouraging people to request an assessment of their needs has been taken. It is hoped that those individuals that are facing critical decisions about the future direction of their life following a change in circumstances or the onset of illness or infirmity will take the opportunity of an assessment of their needs and advice on how these could be met. This would enable individuals to explore how they can best be supported in their own home as long as this remains their wish.

[16] A fair Contract with Older People, CSCI, 2007.

For those entering a care situation it is crucial that they are signposted to the right financial advice and guidance and, for instance, whether they have considered care annuities as well as other options which may be available to them to meet their care needs. They will also need to have considered the consequences if their funding fails to finance their care as long as required.

In addition the Council will be working with partners in the sector to understand further the needs of those currently living in Care Homes will talk further with the sector about how we can best meet their needs together. Providers have recently been asked to complete a survey about the numbers of self funders in North Yorkshire
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Dialogue Seven

Self-Funders

1. The Council will be seeking to make more information available to those thinking of funding residential or homecare packages themselves. How do you think this can best be targeted and what support and assistance might the sector be able to offer?

2. The Council will be seeking to take a more proactive role towards those who pay for their own care and will offer an assessment of need as a means of helping an individual decide how they can meet their future care requirements. What are the implications of this for the independent care sector?

3. The current economic situation is likely to have a negative impact on the assets of those funding their own care. How might the independent sector and the council, separately or together, seek to identify those individuals at risk and take action to help protect their circumstances?

(g) Extra Care Housing and Care Home Provision

NYCC has taken a key strategic decision to invest, alongside housing providers, in extra care housing across the county. There are currently 11 schemes operating and further developments are planned. The Council will cease to be a provider of residential care services and will replace its existing Elderly Persons Homes with extra care housing over the next few years.

A strategic review of the extra care development programme is underway at the moment and will be seeking ways to accelerate the provision of extra care housing. There is increasing national evidence that such developments can meet a range of needs that are broader than just housing with care support. Schemes have become the focus of communities by providing a range of provision for a wider area and have been developed so that they can meet more complex and specialist need, including the needs of people with advanced forms of dementia and those requiring complex or palliative care. **ACS will want to expand the range of services it offers from existing extra care schemes and ensure that new schemes are capable of meeting a wider set of needs.**

The Council will be reviewing the way it provides housing support and care in its current extra care schemes and in future schemes. This is likely to lead to a smaller core of funding for the scheme with tenants receiving personal budgets to arrange their own care where required on top of the core element. Ways of integrating the support arrangements in extra care with those in the surrounding community, including those for people with very high support needs, will also be considered. This may mean changes in the care providers in extra care schemes or in the surrounding area dependant on local circumstances.

The Council set a target of a 15% reduction in the use of residential care homes this year and is on track to achieve this. A further increased reduction in residential care usage will be required over the next three years as North Yorkshire is in the upper quartile of authorities over-relying on residential forms of provision. The provision of care home places is not uniform across the county and some areas have a significantly higher number of places per head of population. There is further information about this in Volume Three, the Care Market Data Book.

Less traditional residential care services will be required as more housing based solutions come on stream and more people are supported in their own homes through telecare and other more innovative solutions. The likely requirement will be for a greater proportion of specialist provision in the Care Home sector to meet the needs of those people with high levels of complex needs. This is likely to include dementia nursing care, other specialist nursing provision and end of life care. Funding streams are increasingly likely to be jointly funded across health and social care including Continuing Health Care.

Dialogue Eight

Extra Care and Care Homes

1. Any procurement exercise for the care and support element of an enhanced extra care service will require the provider to demonstrate they can work across extra care housing, the wider community and provide specialist support, eg: palliative care, in order to maintain people in their own homes. What steps would your business have to take in order to effectively compete for this work?

2. The Council has said it will be purchasing less residential care in the future. Therefore the provision of residential care will become a smaller part of the overall care market in North Yorkshire and will be increasingly specialist. What impact will this have on your business plan and what changes may you consider making?

(h) People and Workforce

The shared objectives that commissioners and providers have of delivering improved outcomes for people using their services cannot be achieved without a confident, enabled and well equipped adult social care workforce. This workforce is made up of paid employees with a variety of roles, ranging from professional and managerial levels through to care workers in residential and homecare settings, along with increasing numbers of directly employed personal assistants.

According to latest figures in the National Minimum Dataset for Social Care (NMDS_SC) there are 5866 staff employed in the private sector and 2067 in the voluntary or third sector in North Yorkshire. About 58% of organisations have provided data for the NMDS-SC and so these figures will only represent a proportion of the workforce. However, it is clear that the majority of care staff work outside the public sector. It is, therefore, essential that workforce strategies take account of staff/volunteers in the wider social care sector (including carers and personal assistants) if the long term objectives set out in Putting People First are to be met.

North Yorkshire ACS is keen to support the independent sector in developing the skills of its workforce. For some time now independent sector staff has been able to access existing ACS training and workforce issues have been an established subject of discussion between representatives of the independent sector and ACS.

ACS and partners have been successful in securing funding for e-learning from the Learning Innovation Grant. Over171 bids were received with a bid value of over £13.4m against an available pot of £3m. ACS has have been allocated £100,000 which will be used to procure a suite of e-learning modules for social care which will be made available across the sector in North Yorkshire including to groups of social care staff in ACS. The funding will cover licence costs for 2000 users for 2 years as well as the provision of some IT equipment to assist access to e-learning.

A Care Alliance for Workforce Development has been established in North Yorkshire. This was a product of a successful funding bid to Skills for Care in November 2008 by the ICG, NYCC and the Wilf Ward Family Trust. It will secure a strong and sustainable partnership between employers, people who use services, carers, training providers and higher education institutions which will be able to provide advice and guidance on all workforce development matters relating to social care employers. A key aim of this partnership is to secure and attract funding into workforce development in North Yorkshire and the wider Yorkshire and Humber sub region.

Working together in partnership on workforce issues is an opportunity for the sector to look to common solutions and to support good practice and new innovations.

The Care Alliance for Workforce Development in North Yorkshire wants to be a trusted provider of advice and information on all aspects of workforce development which can be drawn on by partners in the sector.

Dialogue Nine

People and Workforce

1. Would you support the further expansion of the role of the Care Alliance for Workforce Development in North Yorkshire? What support would you want it to provide and what help could you offer to support its development?

2. The Council is considering whether it should lead the development of an integrated workforce strategy across the sector. Would providers support this initiative?

3. Should completion of the National Minimum Data Set form part of the Councils standard contract?

Part Four - Commissioners and Providers Working Together More Effectively

Introduction

The relationship between commissioners and providers of service is a crucial one. Although there is clearly a business relationship the nature of the social care market means this it does not always follow a traditional model of supply purchasing. The relationship will be further complicated by the introduction of direct payments and more individuals becoming purchasers in the market.

Statutory commissioners have the role of a traditional purchaser but they have to take into account the fact that support is being offered to very vulnerable people and that they operate within a framework of financial control that sits within a national and local accountability framework. There are wider objectives that relate to the wider needs of communities and to achieving the best use of public money.

Commissioners recognise that there is a mutual interest with providers in working together, coming up with joint solutions and working to secure supply and to reduce unnecessary risk. The commissioner will also stimulate new service development and encourage competition in an open way. This dialogue seeks to be transparent in describing the realities of such a relationship but also to maximise the areas where collaboration can be of mutual benefit.

(a) Contracting that Supports Personalisation

The move towards more personalised approaches will also lead to different models of procurement being used. The new contractual models that support the move to personalisation include:

- Framework contracts and approved provider lists – where people opt for the Council to manage their personal budgets and can draw upon a range of approved services. It is important that people have the information, support and guidance to purchase services outside these contracts if they wish and that they understand the implications of this.

- The development of person-centred contracting. This is where individual support plans are aggregated together as ‘mini-tenders’ and people in families are supported to be involved in evaluating successful bids to deliver the support they need.

- Individual Service Funds (ISF) – where the personal budget is held by the provider and the person using the services establishes the timing and actual tasks to be carried out.

Personalisation would provide significant challenges for commissioners, providers and people in receipt of support. Innovative solutions to them challenges would need to be developed and providers have a large role to play in achieving these. As well as the formal contracting arrangements, providers may be able to consider offering different

roles and services. These will include traditional care, the provision of low level help, assistance with care and support planning and brokerage services. These are also significant areas of opportunity for providers.

Dialogue Ten

Contracting That Supports Personalisation

1. What challenges and opportunities are afforded to providers by the move towards personalisation?

2. What contractual arrangements will support the introduction of personalisation?

3. What additional services will providers seek to offer?

b) Outcomes Based Contracting

If the health and social care market is to be as efficient as possible then both ACS and NHS North Yorkshire and York believe that there are things that need to change in the way that the statutory sector does business with the providers.

The sector itself is creative and innovative and might have lots of ideas about how to keep people healthy and well. To enable more of this creativity and innovation to be generated, both the local authority and the NHS must shift to more outcomes focussed contracting.

There will be a significant switch away from task and time-based contracting towards more outcomes-focused and person-centred approaches. This could include a reduction in block contracting where they exist, as they can reduce the choice available to people as the response to individual need is shaped by the requirements of the block contract.

The critical questions asked of health and social care in ensuring their performance will be **'have you helped more people to stay healthy and well?'** and **'can you demonstrate how you have made a difference?**' This means health and social care have to think in terms of investing in outcomes for people and will expect its own services and providers to be able to demonstrate how they have improved the health and well being of the individuals they are working with.

An outcomes-based approach helps to focus services around results and how they can be achieved rather than simply about providing a volume of service. Outcomes-based contracting encourages flexibility and innovation, allows service users to define more closely what they want to achieve. In doing so changes the balance of the relationship between the person providing the care support and the person receiving it.

North Yorkshire has taken part in a national pilot project for outcomes contracting which led to a tendering exercise and the establishment of an outcomes-based contract with a chosen provider. More information on this and on other aspects of outcomes-based approaches that is particularly relevant to the homecare sector can be found through the National Homecare Council.[17]

Dialogue Eleven

Contracting for Outcomes

1. Providers will see a number of advantages and disadvantages with a move towards outcome based contracting. What is your view as to whether the advantages outweigh the disadvantages and how can these be overcome?

2. Training is identified as being crucial to the introduction of this approach. What training issues will need to be addressed to assist the introduction of outcome based contracting?

3. What safeguards will be needed to ensure that there is accountability along with the flexibility of outcome based contracting?

(c) Securing Supply, Zoning and Pricing

North Yorkshire is a large mainly rural County. This presents challenges in terms of providing a consistent level of provision that is reliably available. It places great demand on providers of service and the workforce that they employ. Ensuring that there is a supply of high quality services and that this capacity is readily available is crucial in meeting people's support needs.

Currently the County Council has a provider list of organisations that have met some minimum standards and work is shared out amongst them on an ad hoc or availability basis. This mechanism has been reasonably successful but lacks robustness in terms of information about the quality of services provided, the efficient use of care workers who may be engaging in a lot of travelling, the associated costs of providing care in remote areas and sustainability issues. Clearly the organisation of how, where and when, and by whom, care is provided is something that both commissioners and providers have a joint interest in.

As part of this dialogue commissioners are keen to learn the views of providers on the current arrangements and how these could be improved. One idea that has been under exploration is to divide the county into zones. Providers would be invited to indicate which zones (which would be a mixture of urban and rural areas) they would wish to specialise in. Commissioning could then be centred on the approved providers for each zone which could lead to the provision of a more efficient service to the advantage of commissioners and providers.

[17] National Homecare Council, Conference presentation, Outcomes Contracting,16/10/2008. www.homecare.gov.uk/nhcc.

A further concern about the current approach is that it can lead to a substantial variation in price and availability across North Yorkshire. **The cost of an apparently very similar service can vary by as much as 50%.** It would be ACS's intention to move towards a narrower range of price variation across the county for similar interventions. This could include the development of a 'fixed price' for particular types of care or support.

Dialogue Twelve
Securing Supply and Zoning

1. What are the pros and cons of the current system for purchasing domiciliary care?

2. Is the suggested move to zoning a satisfactory way to address the disadvantages and what issues need to be taken into account from the provider view if zoning is introduced?

3. What are the implications of moving to a fixed price for care in North Yorkshire or a narrower band of price variation?

(d) Electronic Monitoring and Scheduling

Bringing together the complex administrative, financial and management processes that affectively delivers a member of staff to the front door of a service user has always been problematical for home care providers of all types. Each of the parties to the arrangements has a range of expectations that have to be met. The service user wants a timely, predictable and reliable service that is flexible enough to meet any unanticipated circumstance such as a hospital admission.

The user also expects there to be a reliable means of any charge for the service to be levied with the minimum administrative burden. The provider is anxious to deploy their staff as effectively as possible, minimise staff down time and ensure that they meet the contractual requirements of the person or organisation commissioning the service. In addition they need to generate invoices to receive payment for the services they provide and ensure that staff are paid the appropriate remuneration.

The local authority has all these requirements if it is the direct provider of service and as a commissioner and purchaser of service from the independent sector it also needs to know that it is receiving the service it is paying for. There is national evidence that electronic systems are able to deliver efficiencies for Commissioners of care services[18]

The Council has taken a decision in principle to acquire an electronic monitoring and scheduling system for the provision of its in- house service. This is the subject of a procurement exercise in the coming months and a provisional timescale would see a

[18] Electronic Monitoring and Scheduling of Home Care, CSED and London Borough of Havering, 2008

phased introduction across services in the 2010/11 time period. As a minimum requirement the electronic monitoring and scheduling system would manage

- Billing
- Charging
- Scheduling
- Management information
- Confirmation that visits and timescales are adhered to

This would necessarily entail some form of electronic data entry in the service user's own home with links to a central control system. Typically this could be done either by telephone or by a bespoke monitoring device linked by radio. Most systems require staff to log in to a service users home and log out as they leave, either manually or automatically in some more advanced systems. In some systems staff use multifunctional handheld devices which can support other care delivery needs.

A number of local authorities and independent providers are moving down the road of introducing electronic monitoring and rostering. It can deliver cost efficiency, improved outcomes for users and acts as part of a comprehensive management information and contract monitoring system. There are potential advantages of such as system being used more widely across the home care sector in North Yorkshire and the Council would want to encourage the wider market to consider the possible benefits of wider introduction and to raise comments and issues that need to be addressed.

Dialogue Thirteen

Electronic Monitoring and Scheduling

The Council is introducing electronic monitoring and scheduling within the own provider service and there are advantages of using such systems more widely across the home care market in North Yorkshire.

1. Should the use of electronic monitoring and rostering systems be encouraged for use by independent sector providers?

2. Does your organisation already have an electronic monitoring or scheduling system in place and, if so, which one is it?

3. Should the use of a system be a contractual requirement for doing business with the County Council?

4. Should there be a common system in use across North Yorkshire and, if so, how might this be achieved?

5. Investment in an electronic monitoring and scheduling system would require initial investment but would probably deliver longer term gains. It is appreciated that this may be problematical for providers in the current climate and would welcome views on how providers could be assisted in investing in such systems and what support and back up might be available within the sector.

6. Some local health and social care communities are further down the road in using electronic monitoring and scheduling and we would want to take advantage of the knowledge and expertise they have gained. To this end the Council will talk to other local authorities and we would welcome reviews of providers who have used such systems in other areas as to their experience and how the implementation phase was managed.

(e) Providers Working Collaboratively

One theme that comes through in this dialogue is a need to encourage collaboration and joint working, albeit in a competitive framework. The economics of the work place often results in service integration, new partnerships or even take-overs. We see this both within and outside the care sector and this can be about increasing profit or finding great efficiencies in order to survive as a business. There are other drives towards more integrated working. Organisations sometimes recognise they have complementary skills and portfolios of services which make them stronger and better able to deliver the service that they want to.

Issues concerning the workforce are generally seen to be of importance to all providers for instance as discussed above in Part Three about the Care Alliance for Workforce Development in North Yorkshire. There have also been examples locally of providers working together to share staff at critical times which has allowed the services of each of the providers to be deployed more flexibly.

Dialogue Fourteen

Collaboration Dialogue

1. In what areas could providers benefit from working together?

2. How would the collaborative work between providers be best taken forward to ensure that any benefits are widely distributed?

Part Five – Time Frame

(a) Timetable

The timetable has been designed in such a way as to allow providers the maximum opportunity to consider the issues raised and to respond as fully as possible. Equally, time is allowed for details of the responses to be made available and for ACS commissioners to publish a Market Statement and Action Plan.

- The dialogue will be open to responses from December, 2009 until the 28th February, 2010.

- During March and April, 2010 responses will be considered by commissioners in ACS and the NHS and will be discussed with the Market Development Board.

- In April 2010 details of the responses to the dialogue with the initial comments of commissioners will be made available. This will be through the dedicated website that will be established and through the normal communication channels from the statutory organisations and the independent care group.

- Between March and July 2010 using the responses of the consultation dialogue, commissioners from ACS and NHS NYY will develop joint approaches to commissioning that are judged to be the most effective way of securing the Council and the NHS' joint objectives.

(b) Access to Information and Support

The Commission has recognised that it's important that provider organisations have access to the appropriate information and support they need in understanding the care market in North Yorkshire and how they might best change to meet the needs of that market. The ICG is part funded by ACS to provide support to the sector and their contact details will be available to their members.

The Council's website will also continue to provide information on commissioning plans and priorities of the County Council and NHS locally and will also direct users to other specific sources of information.

There are a number of national resources that support the delivery of health and well being outcomes for the people of North Yorkshire. These would include:-

- Care Services Improvement Partnership (CSIP)
- Care Quality Commission (CQC)
- Care Services Efficiency & Delivery (CSED)

Links to these websites and other sources are noted in the references.

Providers may also be members of local and national bodies who can supply information to their members

(c) Current Funding Arrangements

During the period of the dialogue the current ACS and NHS funding arrangements will remain broadly the same. Where there are specific longer-term or 'block' contracts these will continue as set out in the contract terms. The majority of care and support is commissioned on an individual 'spot' contract basis as a response to an individual's need and those arrangements will also continue.

The usual service review process will remain in place and changes that reflect the needs of service users will be actioned. Similarly where there are plans in place to change or develop services locally, they will not be delayed by this dialogue. New initiatives that substantially change the nature of the relationship between the NHS, the Council and its providers will not take place until the completion of the dialogue with the sector and its response other than in circumstances where a response to meet urgent or unanticipated need is required.

If you have any specific concerns relating to any current contractual arrangements, please contact the appropriate ACS or NHS commissioning officer that you normally deal with.

Part Six - How to Engage in the Dialogue.

Organisations and individuals are welcome to share their thoughts and contribute to the dialogue. The hope is that many will choose to answer some or all the questions asked in our dialogue boxes.
We would also welcome thoughts and proposals concerning the sector which we may not have considered and which could reasonably take us a further step forward as a sector.

Larger organisations might want to arrange discussions on some or all the matters which have been raised in this document.

Commissioners may be in a position to accept invites and join in a selection of these discussions if requested.

We would like to receive responses using the feedback sheet on the website page specifically developed for this purpose and highlighted below:

You can post your feedback sheet to:

Shaping the Care Market – A Dialogue With The Independent Sector
Strategic Commissioning and Partnerships
North Yorkshire County Council
Room 255 County Hall,
Northallerton,
North Yorkshire. DL7 8DD

or preferably email it to:

Strategic.commissioning@northyorks.gov.uk
Please can all responses please be submitted by the 28th February 2010

Website for access to this document and related material is:
http://www.northyorks.gov.uk/independentcaresector

Many thanks for your support in this dialogue exercise.

Part Seven - Glossary of Terms and Abbreviations

Care Quality Commission (CQC) – Responsible for the regulation of social care mental health and health services since April 2009

Care Services Efficiency and Delivery Unit (CSED) – Department of Health sponsored project to promote evidenced based initiatives which improve the quality and efficiency of social care services.

Care Services Improvement Partnership (CSIP) – Department of Health Unit that promotes innovative practice in social care.

Green Paper – A term generally used to describe policy proposals set out for public debate in advance of any government intention to make legislative change.

Independent Care Group (ICG) – An association that represents independent care providers in York and North Yorkshire.

Individual Service Funds. Where an individual provider organisation holds the personal budget of one or more people and manages it on their behalf. The provider is accountable to the individual holding the personal budget.

Joint Strategic Needs Assessment (JSNA) – Statutory duty of local authority and health commissioners to publish a statement of their understanding of the health and social care needs of an area.

North Yorkshire County Council (NYCC) **Adult and Community Services** (ACS), **NHS North Yorkshire and York** (NHSNYY) – the primary care trusts responsible for commissioning the services in North Yorkshire and York.

Partnerships for Older People Project (POPP) – An experimental pilot of preventative projects for older people which started in 2006. North Yorkshire was one of the original 19 pilot sites. Following the POPP pilots the need to invest in prevention has moved into the mainstream of social and health care policy thinking.

Personal Assistant (PA) – Used to describe an individual working as a personal support worker usually employed directly by the person who requires care and support.

Personalisation – A term designed to a range of initiatives to make services more responsive to individual choice and circumstances including personal budgets.

Re-ablement – A term that is now generally used to describe home care services that are designed to deliver improvement to individual's independence and wellbeing over a short period of time. The term rehabilitation is avoided as that is felt to have clinical overtones.

Self-Funders – Those paying the full cost of their care and support either through choice or by being excluded from state funding due to their level of income.

Skills for Care – The employer led authority on the training standards and development needs of nearly one million social care staff in England providing over £25 million in funding to support improved training and qualifications for managers and staff.

White Paper – A consultation document by the Government setting out its intentions to legislate or proposing policy changes.

Part Eight – References

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17. National Homecare Council, Conference Presentation, Outcomes Contracting, 16/10/2008. **www.homecare.gov.uk/nhcc**

18. Electronic Monitoring and Scheduling of Home Care, CSED and London Borough of Havering, 2008

NYCC Adult and Community Services and
NHS North Yorkshire and York

Care and Support In North Yorkshire

Shaping the Market

A Dialogue with the Independent Sector

Volume Four

Response Pack

Shaping the Market – A Dialogue with the Independent Sector

Dialogue Response Pack

Completed by: ………………………………………………….. (Name of person)

On behalf of: ……………………………………………………. Organisation/Agency

Address: ……………………………………………………………

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Shaping the Care Market

This relates to issues raised on Pages 13 and 14 of the Main Report

Dialogue One

Shaping the Care Market

1. Four broad approaches to shaping the care market are set out. Do they adequately describe the tools available to commissioners and, if not, what others might there be?

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2. Does the information in Volume Three about the Care Market in North Yorkshire reflect your understanding? In particular is the overall size of the market estimated correctly and are the suggested numbers and percentage of self funders accurate?

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Personalisation

This relates to issues raised on Pages 15 - 17 of the Main Report

Dialogue Two

Personalisation Dialogue

1. Providers are likely to have to deal with a wider range of purchasers of care than just the local authority. What implications will this have for independent sector providers?

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2. Personalisation provides risks as well as opportunities for providers. These might include loss of steady income streams, staffing issues and the need to change current business models. How well do you feel the sector is prepared to meet these challenges and what might be some possible collective solutions to them?

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3. Purchasers of care services will need to know what exists in the market place which may be suitable for them. How might an independent sector provider market their services in this changing environment and would you market yourself as a supplier of personal assistants?

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4. People can recruit their own personal assistant (PA) rather than purchasing their care from a registered care provider. In the light of this how might the sector retain its workforce or diversify its services to offer training, management, employer support services to people employing their own personal assistants?

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5. The types of support that people who use services say they need are not confined to personal care alone. It could include a range of other services such as domestic help, household management, gardening and home maintenance that will be in demand. Should the independent sector providers move directly into this area or should they perhaps develop alliances with existing voluntary sector providers to do this or create new trading entities in order to do so?

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6. Care homes will increasingly have to demonstrate that they are able to offer care in a more personalised way. What do care home managers feel are the main challenges presented by this and what might be the key opportunities? Are there are examples of best practice you may wish to share?

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7. Are there ways that NYCC can assist providers in any of the above?

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Prevention and early intervention

This relates to issues raised on Pages 17 and 18 of the Main Report

Dialogue Three

Prevention and Early Intervention

Based on the local and national research evidence there will be a shift from investment in high-end acute services to services that can demonstrate the effectiveness of early intervention and prevention.

1. Few will argue against the need to invest in services that prevent a loss of health, well-being or independence, but what are the issues and concerns from the independent sector around this?

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2. What are the areas of best practice that you may wish to incorporate into the way your organisation provides services.

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3. Many preventative services are provided traditionally by the voluntary sector. What role might the independent sector play in this form of provision?

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4. Would independent providers welcome the opportunity to be able to subcontract part of their work to a Third Sector organisation in the interest of efficiency and securing a better outcome for an individual?

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Re-ablement

This relates to issues raised on Pages 19 and 20 of the Main Report

Dialogue Four

Re-ablement

The Council intends to transform the majority of its in-house homecare provision into a short-term re-ablement service.

1. What type of changes may you have to make in your organisation to deliver a service that will complement the Council's re-ablement service, i.e. deliver a service that promotes independence?

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2. What steps do you think you may have to take to demonstrate this if you chose to participate in a procurement programme?

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Telecare

This relates to issues raised on Pages 20 -22 of the Main Report

Dialogue Five

Telecare

1. As a provider, have you considered how telecare might assist your service provision and have you amended induction and staff training routines to reflect the importance of telecare? Is telecare discussed with users at review or other meetings?

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2. Telecare improves the quality of care and enables the home to manage more people with complex needs. As a provider of residential care, have you considered how telecare solutions may have a positive impact on your business and have you approached any telecare providers directly?

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3. If you have considered using telecare would you be willing to share your experiences and, if so, would you please provide examples for wider circulation?

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4. How might the Council assist you as a provider in utilising telecare as part of the solution offered to your customers?

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Quality Standards

This relates to issues raised on Pages 22 and 23 of the Main Report

Dialogue Six

Quality Standards

1. The County Council intends to only commission from regulated services that demonstrate they can meet high quality standards. What steps may you have to take to ensure you meet these standards?

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2. How might 'excellence in service' provision be incentivised?

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Those funding their own care

This relates to issues raised on Page 23 and 24 of the Main Report

Dialogue Seven

Self-Funders

1. The Council will be seeking to make more information available to those thinking of funding residential or homecare packages themselves. How do you think that this can best be targeted and what support and assistance might the sector be able to offer?

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2. The Council will be seeking to take a more proactive role towards those who pay for their own care and will offer an assessment of need as a means of helping an individual decide how they can meet their future care requirements. What are the implications of this for the independent care sector?

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3. The current economic situation is likely to have a negative impact on the assets of those funding their own care. How might the independent sector and the council, separately or together, seek to identify those individuals at risk and take action to help protect their circumstances?

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Extra Care and Care Homes

This relates to issues raised on Pages 24 and 25 of the Main Report

Dialogue Eight

Extra Care and Care Homes

1. Any procurement exercise for the care and support element of an enhanced extra care service will require the provider to demonstrate they can work across extra care housing, the wider community in and provide specialist support, eg: palliative care, in order to maintain people in their own homes. What steps would your business have to take in order to effectively compete for this work?

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2. The Council has said it will be purchasing less residential care in the future. Therefore the provision of residential care will become a smaller part of the overall care market in North Yorkshire and will be increasingly specialist. What impact will this have on your business plan and what changes may you consider making?

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People and workforce

This relates to issues raised on Pages 25 and 26 of the Main Report

Dialogue Nine

People and Workforce

1. Would you support the further expansion of the role of the Care Alliance for Workforce Development in North Yorkshire? What support would you want it to provide and what help could you offer to support its development?

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2. The Council is considering whether it should lead the development of an integrated workforce strategy across the sector. Would providers support this initiative?

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3. Should completion of the National Minimum Data Set form part of the Councils standard contract?

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Contracting that supports personalisation

This relates to issues raised on Pages 27 and 28 of the Main Report

Dialogue Ten

Contracting That Supports Personalisation

1. What challenges and opportunities are afforded to providers by the move towards personalisation?

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2. What contractual arrangements will support the introduction of personalisation?

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3. What additional services will providers seek to offer?

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Contracting for outcomes

This relates to issues raised on Pages 28 and 29 of the Main Report

Dialogue Eleven

Contracting for Outcomes

1. Providers will see a number of advantages and disadvantages with a move towards outcome based contracting. What is your view as to whether the advantages outweigh the disadvantages and how can they be overcome?

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2. Training is identified as being crucial to the introduction of this approach. What training issues will need to be addressed to assist the introduction of outcome based contracting?

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3. What safeguards will be needed to ensure that there is accountability along with the flexibility of outcome based contracting?

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Securing supply and zoning

This relates to issues raised on Page29 and 30 of the Main Report

Dialogue Twelve
Securing Supply and Zoning

1. What are the pros and cons of the current system for purchasing domiciliary care?

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2. Is the suggested move to zoning a satisfactory way to address the disadvantages and what issues need to be taken into account from the provider view if zoning is introduced?

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3. What are the implications of moving to a fixed price for care in North Yorkshire or a narrower band of price variation?

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Electronic Monitoring and Sceduling

This relates to issues raised on Pages 30 and 31 of the Main Report

Dialogue Thirteen

Electronic Monitoring and Scheduling

The Council is introducing electronic monitoring and scheduling within the own provider service there are advantages of using such systems more widely across the home care market in North Yorkshire.

1. Should the use of electronic monitoring and scheduling systems be encouraged for use by independent sector providers?

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2. Does your organisation already have an electronic monitoring or scheduling system in place and, if so, which one is it?

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3. Should the use of a system be a contractual requirement for doing business with the County Council?

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4. Should there be a common system in use across North Yorkshire and, if so, how might this be achieved?

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5. Investment in an electronic monitoring and scheduling system would require initial investment but would probably deliver longer term gains. It is appreciated that this may be problematical for providers in the current climate and would welcome views on how providers could be assisted in investing in such systems and what support and back up might be available within the sector.

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6. Some local health and social care communities are further down the road in using electronic monitoring and scheduling and we would want to take advantage of the knowledge and expertise they have gained. To this end the Council will talk to other local authorities and we would welcome reviews of providers who have used such systems in other areas as to there experience and how the implementation phase was managed.

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Providers working collaboratively

This relates to issues raised on Page 32 of the Main Report

Dialogue Fourteen

Collaboration Dialogue

1. In what areas could providers benefit from working together?

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2. How would the collaborative work between providers be best taken forward to ensure that any benefits are widely distributed?

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Responses

Please use the dialogue boxes to give us your comments on the issues raised in the dialogue. These are contained together in Volume 4 and can be printed and completed and posted back to:

Seamus Breen
Assistant Director
Commissioning & Partnerships
North Yorkshire County Council
Adult & Community Services
County Hall
Northallerton DL7 8DD

Or can be emailed to:-

strategiccommissioning@northyorks.gov.uk

Please ensure that all comments are received by **28th February, 2010.**

Thank you for taking the time to respond.

NYCC Adult and Community Services and
NHS North Yorkshire and York

Care and Support In North Yorkshire

Shaping the Market

A Dialogue with the Independent Sector

Volume Three

Care Market Data Book

Population, Provision, Expenditure and Quality

Population, Provision, Expenditure and Quality

Contents

1. North Yorkshire

2. Selby Area

3. Harrogate and Craven

4. Hambleton and Richmondshire

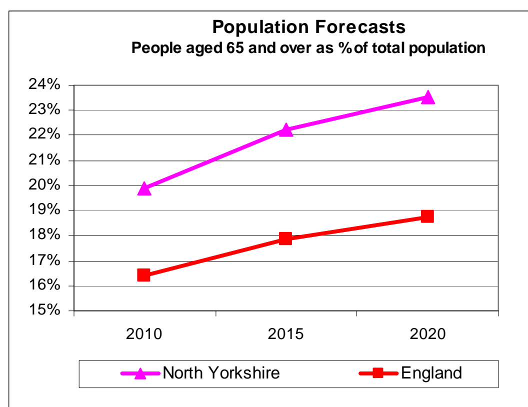
5. Scarborough and Ryedale

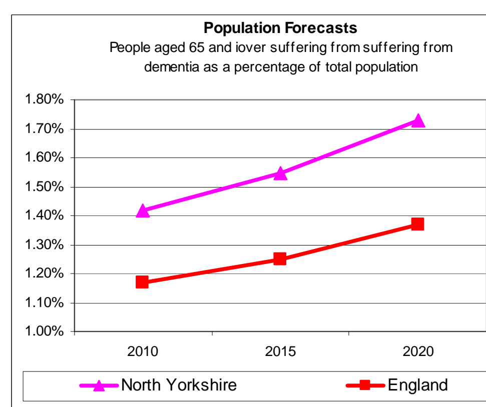
North Yorkshire

Population Data

Data from Projecting Older People Population Information (www.poppi.org.uk) and Projecting Adult Needs and Service Information (www.pansi.org.uk)

- The number of people aged 65 and over in the county is forecast to increase by 17% between 2010-15 and by 30% 2010-20, higher than average for England.
- The forecast number of people aged 65 and over as a percentage of the total population (20 in 2010, 22% 2015 and 24 in 2020) is the highest in the county and significantly higher than the average for England.
- The number of people aged 65 and over in the district suffering from dementia is forecast to increase between 2010-15 by 14% and by 34% between 2010-20.





What is provided

Residential Care

Figures from CQC July 2009

- The county has 82 privately/voluntary owned establishments providing 2249 beds (OP or dementia). There are also has 20 ACS operated elderly peoples homes providing 681 beds. This equates to 24 residential care beds per 1000 people aged 65 and over in the county.
  There are also a further 13 specialist establishments providing 247 beds for people with physical disabilities, mental health problems, sensory impairment, etc.
- There are 70 privately/voluntary owned establishments providing 617 beds for people with Learning Disabilities and four establishments providing 27 beds operated by NYCC.
- There are 73 nursing homes providing 3220 beds (OP or dementia) in the county. This equates to 25 nursing home beds per 1000 people aged 65 and over.

Residential and Nursing Homes - ratio of beds to the number of older people

Area	**Care homes** Older people & dementia beds per 1000 older people	**Nursing homes** Older people & dementia beds per 1000 older people
Harrogate and Craven	23	36
Hambleton and Richmondshire	15	23
Scarborough and Ryedale	34	14
Selby	20	22
North Yorkshire	24	25

Residential Care – Self-Funders

- Based on the number of residential and nursing homes beds available in the county and the number of people funded or part funded by ACS, approximately 50-55% of beds are occupied by people funding their own care or being funded by other agencies.

Extra Care

- The county currently has 11 purpose built extra care schemes that between them provide a total of 455 apartments for rent or purchase. Three of the schemes have an additional apartment or guest room that is used to provide short breaks.
- A further three purpose built extra care schemes are being developed at present that will provide a further 140 apartments for sale or purchase.

Domiciliary Care - Older People and Adults with Physical Disabilities

Based on figures for week commencing 23rd March 2009

- The total number of domiciliary care hours provided via ACS across the county is typically 30 thousand hours per week, equivalent to 1.5 million hours per year.
- The number hours purchased from registered private/voluntary providers is typically 18 thousand hours per week from 66 suppliers, equivalent to approximately 940 thousand hours per year.
- The number of hours supplied by NYCC in-house service is typically 11750 hours per week, equivalent to 611 thousand hours per year. This is 39% of the total domiciliary care hours organised for people by ACS teams across the county.
- Across the county during a typical week 3650 people received domiciliary care provided via ACS from a private provider and/or NYCC in-house services, 2015 people from private providers and 1855 from NYCC in-house service.

Domiciliary Care - Adults with Learning Disabilities

Based on figures for week commencing 23rd March 2009

- The number of care hours, including supported living, provided via ACS teams across the county for adults with Learning Disabilities is typically 26 thousand hours per week for 520 people, equivalent to 1.35 million hours per year.

- The number hours purchased from registered private/voluntary providers is typically 25 thousand hours per week from 63 suppliers, equivalent to 1.3 million hours per year.
- The number of hours supplied by NYCC in-house service is typically only 1,650 hours per week, equivalent to 85 thousand hours per year. This is 6% of the total care hours organised for people by ACS teams across the county.

Domiciliary Care - Self-Funders

Based on figures in “Who Cares Now?” published by the UKHCA

- Nationally local authorities typically purchase approximately 76% of care being provided by the private sector. The remainder being purchased by self-funders (18%) and the NHS (6%). These ratios suggest that the total number of care hours being supplied each week by private/voluntary providers for adults in North Yorkshire is approximately 56 thousand hours per week i.e. 43 thousand hours purchased by ACS and 13 thousand purchased by private providers and the NHS.

Direct Payments

- At the end of June 2009, 534 people in the county were receiving direct payments to allow them to organise services to meet their care needs

Expenditure

Residential Care

Total expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private providers on residential care for people it partly or fully funds is approximately £23.1 million per annum. Temporary residential care costs £795 thousand per annum.
- Forecast spending by ACS with private providers on Nursing Homes for people it partly or fully funds is approximately £11 million per annum. A further £850 thousand is spent on temporary nursing homes.
- Forecast spending on NYCC operated residential care homes is approximately £10.8 million

Domiciliary Care

Expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private/voluntary organisations on domiciliary care for older people or people with physical disabilities is forecast to be £13 million
- Spending on domiciliary care for people with learning disabilities is forecast to be £10.7 million
- Forecast cost of ACS in-house domiciliary care service is approximately £10.6 million

Direct Payments

2009/10 expenditure by ACS as forecast at the end of June 2009

- Forecast spending on Direct payments to people wishing to organise their own care is £4.4 million.

Quality

Care Quality Commission ratings July/August 2009

Residential Care

- The average Care Quality Commission (CQC) star rating of the 165 privately/voluntary operated care homes in the county was 2.3. Three homes were rated as poor (0 stars) and 58 as excellent (3 Stars). Eight homes had not yet been rated.
  The average star rating of the 24 NYCC operated care homes was 2.2. Eight homes received excellent ratings. One home has not yet been rated.
  The average star rating for all care homes in England was 2.0 stars.
- The average CQC star rating of the 73 privately/voluntary operated nursing homes in the county was 1.8, nine homes were rated as excellent.
  The average star rating for all nursing homes in England was 1.9 stars.

Domiciliary Care

- The average star rating for domiciliary care providers registered in North Yorkshire is 2.3 stars and for England 2.1 stars

Selby Area

Population Data

Data from Projecting Older People Population Information (www.poppi.org.uk) and Projecting Adult Needs and Service Information (www.pansi.org.uk)

- The number of people aged 65 and over in the area is forecast to increase by 20% between 2010 and 2015 and by 35% between 2010 and 2020, the highest forecast rate of increase in the county and significantly higher than the average forecast increase for England.
- The forecast number of people aged 65 and over as a percentage of the total population (17% in 2010, 19% in 2015 and 20% in 2020) is the lowest in the the county average but slightly higher than the average for England.
- The number of people aged 65 and over in the area suffering from dementia is forecast to increase between 2010 and 2015 by 17% and by 41% between 2010 and 2020, higher than the county average and significantly higher than the average forecast increase for England.

What is provided

Residential Care

Figures from CQC July 2009

- In the Selby area there are 10 privately/voluntary owned establishments providing 208 beds (older people and/or dementia). There are also two NYCC operated elderly peoples homes providing 62 beds. This equates to 20 residential care beds per 1000 people aged 65 and over, lower than the county average.
- There are two privately/voluntary owned establishments providing 12 beds for people with Learning Disabilities.
- There are 8 nursing homes providing 295 beds for older people in the area. This equates to 22 nursing home beds per 1000 people aged 65 and over, similar to the average for the county.

Extra Care

- In the Selby area there is currently one purpose built extra care scheme located in Brayton that provides 45 apartments for rent or purchase on a shared ownership basis.
- An extra care scheme is currently being developed in Tadcaster that will provide 50 apartments for rent

Domiciliary Care - Older People and Adults with Physical Disabilities

Based on figures for week commencing 23rd March 2009

- The total number of domiciliary care hours provided via ACS Selby area teams is typically 3800 hours per week, equivalent to 198 thousand hours per year.

- The number hours purchased from private providers is typically 2540 hours per week from over 11 suppliers, equivalent to 132 thousand hours per year. 90% of the hours are purchased from five providers.
- The number of hours supplied by NYCC in-house service is typically 1270 hours per week, equivalent to 66 thousand hours per year. This is 33% of the domiciliary care hours provided via ACS in the Selby area.
- During a typical week 430 people in the area received domiciliary care provided via ACS from a private provider and/or NYCC in-house services, 290 people from private providers and 170 from NYCC in-house service.

Domiciliary Care - Adults with Learning Disabilities

Based on figures for week commencing 23rd March 2009

- The number of care hours, including supported living, provided via ACS teams in the Selby area for adults with Learning Disabilities is typically 2470 hours per week, equivalent to 128 thousand hours per year.
- The number hours purchased from private providers is typically 2360 hours per week from 8 suppliers, 122 thousand hours per year. 99% of the hours are purchased from four providers,
- The number of hours supplied by NYCC in-house service is typically only 120 hours per week, equivalent to six thousand hours per year. This is 5% of the hours provided via ACS Selby area teams.
- During a typical week 55 adults with Learning Disabilities in the Selby area received domiciliary care provided via ACS.

Annual Expenditure

Residential Care

Total expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private providers on residential care for people it partly or fully funds is approximately £2.4 million. Spending on temporary residential care is £118 thousand.
- Forecast spending by ACS with private providers on Nursing Homes for people it partly or fully funds is approximately £1.5 million.
- Forecast spending on NYCC operated residential care homes is approximately £1.1 million

Domiciliary Care

Expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private/voluntary organisations on domiciliary care for older people or adults with physical disabilities is forecast to be approximately £2.0 million.
- Spending on domiciliary care for people with learning disabilities is forecast to be approximately £750 thousand.

- Forecast cost of ACS in-house domiciliary care service is approximately £1.3 million.

Direct Payments

2009/10 expenditure by ACS as forecast at the end of June 2009

- Forecast spending on direct payments to people wishing to organise their own care is £460 thousand.

Quality

Care Quality Commission(CQC) ratings July/August 2009

Residential Care

- The average Care Quality Commission (CQC) star rating of the ten privately/voluntary operated care homes in the Selby area was 2.0 (county average was 2.3). Three homes were rated as excellent (3 stars) and one home as poor (0 stars).
- The average star rating of the two NYCC operated care homes was 3 (county average was 2.2). Both homes received excellent ratings. The average star rating for all care homes in England was 2.0 stars.
- The average CQC star rating of the nine privately/voluntary operated nursing homes in the Selby area was 1.4. No homes were rated as excellent and one poor. The county average was 1.8.
  The average star rating for all nursing homes in England was 1.9 stars.

Domiciliary Care

- The average star rating of the five private domiciliary care operators supplying 90% of hours (excluding Learning Disabilities) purchased by ACS was 2.5.
- The average star rating of the four private domiciliary care operators supplying 99% of Learning Disabilities hours purchased by ACS was 2.0.
- The average star rating for all categories of domiciliary care providers in North Yorkshire is 2.3 stars and for England 2.1 stars

Harrogate and Craven

Population Data

Data from Projecting Older People Population Information (www.poppi.org.uk) and Projecting Adult Needs and Service Information (www.pansi.org.uk)

- The number of people aged 65 and over in the area is forecast to increase by 16% between 2010 and 2015 and by 29% between 2010 and 2020, slightly lower than the county average but higher than the average forecast increase for England.
- The forecast number of people aged 65 and over as a percentage of the total population (19% in 2010, 21% in 2015 and 23% in 2020) is slightly lower than the county average but higher than the average for England.
- The number of people aged 65 and over in the area suffering from dementia is forecast to increase between 2010 and 2015 by 14% and by 33% between 2010 and 2020, similar to the county average but higher than the average forecast increase for England.

What is provided

Residential Care

Figures from CQC July 2009

- In Harrogate and Craven there are 24 privately/voluntary owned establishments providing 807 beds (older people and/or dementia). There are also six NYCC operated elderly peoples homes providing 183 beds. This equates to 23 residential care beds per 1000 people aged 65 and over, similar to the county average..
- There are 46 privately/voluntary owned establishments providing 379 beds for people with Learning Disabilities and two establishment providing 13 beds operated by NYCC.
- There are 61 nursing homes providing 1565 beds for older people in the area. This equates to 36 nursing home beds per 1000 people aged 65 and over, the highest ratio in the county.

Extra Care

- In Harrogate and Craven there are two purpose built extra care schemes located in Knaresborough and Ripon that between them provide 80 apartments for rent or purchase on a shared ownership basis (Ripon only).

Domiciliary Care - Older People and Adults with Physical Disabilities

Based on figures for week commencing 23rd March 2009

- The total number of domiciliary care hours provided via ACS Harrogate and Craven teams is typically 11 thousand hours per week, equivalent to 572 thousand hours per year.

- The number hours purchased from private providers is typically seven thousand hours per week from over 25 suppliers, equivalent to 366 thousand hours per year. 85% of the hours are purchased from six providers.
- The number of hours supplied by NYCC in-house service is typically 3975 hours per week, equivalent to 207 thousand hours per year. This is 36% of the domiciliary care hours provided via ACS in Harrogate and Craven.
- During a typical week 1450 people in the area received domiciliary care provided via ACS from a private provider and/or NYCC in-house services, 760 people from private providers and 670 from NYCC in-house service.

Domiciliary Care - Adults with Learning Disabilities

Based on figures for week commencing 23rd March 2009

- The number of care hours, including supported living, provided via ACS teams in Harrogate and Craven for adults with Learning Disabilities is typically 5830 hours per week, equivalent to 303 thousand hours per year
- The number hours purchased from private providers is typically five thousand hours per week from 25 suppliers, equivalent to 260 thousand hours per year. 81% of the hours are purchased from seven providers,
- The number of hours supplied by NYCC in-house service is typically 840 hours per week, equivalent to nearly 44 thousand hours per year. This is 14% of the hours provided via ACS Harrogate and Craven teams.
- During a typical week 160 adults with Learning Disabilities in Harrogate and Craven received domiciliary care provided via ACS.

Annual Expenditure

Residential Care

Total expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private providers on residential care for people it partly or fully funds is approximately £9.1 million. Spending on temporary residential care is £196 thousand.
- Forecast spending by ACS with private providers on Nursing Homes for people it partly or fully funds is approximately £4.6 million.
- Forecast spending on NYCC operated residential care homes is approximately £3.3 million

Domiciliary Care

Expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private/voluntary organisations on domiciliary care for older people or adults with physical disabilities is forecast to be £4.9 million
- Spending on domiciliary care for people with learning disabilities is forecast to be £5.4 million
- Forecast cost of ACS in-house domiciliary care service is £3.8 million

Direct Payments

2009/10 expenditure by ACS as forecast at the end of June 2009

- Forecast spending on direct payments to people wishing to organise their own care is £1.7 million

Quality

Care Quality Commission ratings July/August 2009

Residential Care

- The average Care Quality Commission (CQC) star rating of the 76 privately/voluntary operated care homes in Harrogate and Craven was 2.4 (county average was 2.3). 33 homes were rated as excellent (3 stars), no homes were rated as poor (0 stars). Five homes have not yet been rated.
- The average star rating of the eight NYCC operated care homes was 1.9 (county average was 2.2). No homes received excellent or poor ratings. One home has not yet been rated.
  The average star rating for all care homes in England was 2.0 stars.
- The average CQC star rating of the 31 privately/voluntary operated nursing homes in Harrogate and Craven was 2.0. Eleven homes were rated as excellent and one poor. The county average was 1.8.
  The average star rating for all nursing homes in England was 1.9 stars.

Domiciliary Care

- The average star rating of the six private domiciliary care operators supplying 85% of hours (excluding Learning Disabilities) purchased by ACS was 2.2
- The average star rating of the six private domiciliary care operators supplying 81% of Learning Disabilities hours purchased by ACS was 2.4
- The average star rating for all categories of domiciliary care providers in North Yorkshire is 2.3 stars and for England 2.1 stars.

Hambleton and Richmondshire

Population Data

Data from Projecting Older People Population Information (www.poppi.org.uk) and Projecting Adult Needs and Service Information (www.pansi.org.uk)

- The number of people aged 65 and over in the area is forecast to increase by 19% between 2010 and 2015 and by 34% between 2010 and 2020, the highest increase in the county and significantly higher than the average forecast increase for England.
- The forecast number of people aged 65 and over as a percentage of the total population (19% in 2010, 22% in 2015 and 24% in 2020) is similar to the county average and higher than the average for England.
- The number of people aged 65 and over in the area suffering from dementia is forecast to increase between 2010 and 2015 by 18% and by 41% between 2010 and 2020, the highest increase in the county and significantly higher than the average forecast increase for England.

What is provided

Residential Care

Figures from CQC July 2009

- In Hambleton and Richmondshire there are 5 privately/voluntary owned establishments providing 232 beds (Older People and/or dementia). There are also five NYCC operated elderly peoples homes providing 174 beds. This equates to 15 residential care beds per 1000 people aged 65 and over, the lowest ratio in the county.
- There are 2 privately/voluntary owned establishments providing 12 beds for people with Learning Disabilities and one establishment providing seven beds operated by NYCC.
- There are 21 nursing homes providing 640 beds for older people in the area. This equates to 23 nursing home beds per 1000 people aged 65 and over, similar to the average for the county.

Extra Care

- In the Hambleton and Richmondshire there are currently four purpose built extra care schemes located in Stokesley, Brompton, Easingwold and Bainbridge that between them provide 158 apartments for rent.
- The schemes in Easingwold and Bainbridge each have 1 apartment that is used to provide short breaks accommodation.
- A further extra care scheme is being developed in Northallerton to provide 51 apartments and also in Richmond to provide 39 apartments for rent or purchase.

Domiciliary Care - Older People and Adults with Physical Disabilities

Based on figures for week commencing 23rd March 2009

- The total number of domiciliary care hours provided via ACS Hambleton and Richmondshire teams is typically 6540 hours per week, equivalent to 340 thousand hours per year.
- The number hours purchased from private providers is typically 2660 hours per week from 19 suppliers, equivalent to 138 thousand hours per year. 80% of the hours are purchased from six providers.
- The number of hours supplied by NYCC in-house service is typically 3880 hours per week, equivalent to 202 thousand hours per year. This is 59% of the domiciliary care hours provided via ACS in Hambleton and Richmondshire.
- During a typical week 900 people in the area received domiciliary care provided via ACS from a private provider and/or NYCC in-house services, 356 people from private providers and 584 from NYCC in-house service.

Domiciliary Care - Adults with Learning Disabilities

Based on figures for week commencing 23rd March 2009

- The number of care hours, including supported living, provided via ACS teams in Hambleton and Richmondshire for adults with Learning Disabilities is typically 9860 hours per week, equivalent to 513 thousand hours per year
- The number hours purchased from private providers is typically 9510 hours per week from 18 suppliers, equivalent to 495 thousand hours per year. 76% of the hours are purchased from four providers, 90% from six providers,
- The number of hours supplied by NYCC in-house service is typically only 340 hours per week, equivalent to nearly 18 thousand hours per year. This is 3% of the hours provided via ACS Hambleton and Richmondshire teams.
- During a typical week 151 adults with Learning Disabilities in the area received domiciliary care provided via ACS.

Annual Expenditure

Residential Care

Total expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private providers on residential care for people it partly or fully funds is approximately £3.4 million. Spending on temporary residential care is £196 thousand.
- Forecast spending by ACS with private providers on Nursing Homes for people it partly or fully funds is approximately £1.4 million.
- Forecast spending on NYCC operated residential care homes is approximately £2.8 million

Domiciliary Care

Expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private/voluntary organisations on domiciliary care for older people or adults with physical disabilities is forecast to be £1.8 million
- Spending on domiciliary care for people with learning disabilities is forecast to be £2.1 million
- Forecast cost of ACS in-house domiciliary care service is £2.8 million

Direct Payments

2009/10 expenditure by ACS as forecast at the end of June 2009

- Forecast spending on direct payments to people wishing to organise their own care is £1.1 million

Quality

Care Quality Commission ratings July/August 2009

Residential Care

- The average Care Quality Commission (CQC) star rating of the 7 privately/voluntary operated care homes in Hambleton and Richmondshire was 1.9 (county average was 2.3). One homes were rated as excellent (3 stars), no homes were rated as poor (0 stars). The county average star rating was 2.3.
  The average star rating of the 6 NYCC operated care homes was 2.3 (county average was 2.2). Three homes received excellent ratings, no homes received a poor rating.
  The average star rating for all care homes in England was 2.0 stars.
- The average CQC star rating of the 18 privately/voluntary operated nursing homes in the Hambleton and Richmondshire area was 1.6. One homes were rated as excellent and one poor. Three homes had not yet been rated. The county average was 1.8.
  The average star rating for all nursing homes in England was 1.9 stars.

Domiciliary Care

- The average star rating of the six private domiciliary care operators supplying 80% of hours (excluding Learning Disabilities) purchased by ACS was 2.2
- The average star rating of the six private domiciliary care operators supplying 90% of Learning Disabilities hours purchased by ACS was 2.8

The average star rating for all categories of domiciliary care providers in North Yorkshire is 2.3 stars and for England 2.1 stars.

Scarborough and Ryedale

Population Data

Data from Projecting Older People Population Information (www.poppi.org.uk) and Projecting Adult Needs and Service Information (www.pansi.org.uk)

- The number of people aged 65 and over in the area is forecast to increase by 15% between 2010 and 2015 and by 27% between 2010 and 2020, lower than average for the county but higher than average for England.
- The forecast number of people aged 65 and over as a percentage of the total population (23% in 2010, 25% in 2015 and 26% in 2020) is the highest in the county and significantly higher than the average for England.
- The number of people aged 65 and over in the area suffering from dementia is forecast to increase between 2010 and 2015 by 13% and by 28% between 2010 and 2020. Although lower percentage increases than the rest of the county, they are larger than the average for England.

What is provided

Residential Care

Figures from CQC July 2009

- In Scarborough and Ryedale there are 43 privately/voluntary owned establishments providing 1002 beds (Older People and/or dementia). There are also has seven NYCC operated elderly peoples homes providing 262 beds. This equates to 34 residential care beds per 1000 people aged 65 and over, the highest ratio in the county.
  There are also a further seven specialist establishments providing beds for people with mental health problems, sensory impairment, etc.
- There are 20 privately/voluntary owned establishments providing 214 beds for people with Learning Disabilities and one establishment providing seven beds operated by NYCC.
- There are 15 nursing homes providing 536 beds in the area. This equates to 14 nursing home beds per 1000 people aged 65 and over, the lowest ratio in the county.

Extra Care

- In Scarborough and Ryedale there are four purpose built extra care schemes located in Castleton, Malton and two in Scarborough that between them provide 172 apartments for rent or purchase (Plaxton Court only).
- The guest suite at the scheme in Malton is used to provide accommodation for short breaks in accordance with an agreed protocol.

Domiciliary Care - Older People and Adults with Physical Disabilities

Based on figures for week commencing 23rd March 2009

- The total number of domiciliary care hours provided via ACS Scarborough and Ryedale teams is typically 8550 hours per week, equivalent to 445 thousand hours per year.
- The number hours purchased from private providers is typically 5990 hours per week from 28 suppliers, equivalent to 312 thousand hours per year. 53% of the hours are purchased from five providers, 84% from twelve providers.
- The number of hours supplied by NYCC in-house service is typically 2560 hours per week, equivalent to 133 thousand hours per year. This is 30% of the domiciliary care hours provided via ACS in Scarborough and Ryedale.
- During a typical week 1003 people in the area received domiciliary care provided via ACS from a private provider and/or NYCC in-house services, 613 people from private providers and 431 from NYCC in-house service.

Domiciliary Care - Adults with Learning Disabilities

Based on figures for week commencing 23rd March 2009

- The number of care hours, including supported living, provided via ACS teams in Scarborough and Ryedale for adults with Learning Disabilities is typically 8210 hours per week, equivalent to 427 thousand hours per year
- The number hours purchased from private providers is typically 7870 hours per week from 29 suppliers, equivalent to 406 thousand hours per year. 75% of the hours are purchased from three providers, 90% from six providers.
- The number of hours supplied by NYCC in-house service is typically only 340 hours per week, equivalent to nearly 18 thousand hours per year. This is 4% of the hours provided via ACS Scarborough and Ryedale teams.
- During a typical week 165 adults with Learning Disabilities in the area received domiciliary care provided via ACS.

Annual Expenditure

Residential Care

Total expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private providers on residential care for people it partly or fully funds is approximately £8.1 million. Spending on temporary residential care is £284 thousand.
- Forecast spending by ACS with private providers on Nursing Homes for people it partly or fully funds is approximately £3.5 million.
- Forecast spending on NYCC operated residential care homes is approximately £3.5 million

Domiciliary Care

Expenditure for 2009/10 by ACS as forecast at the end of June 2009

- Forecast spending by ACS with private/voluntary organisations on domiciliary care for older people or people with physical disabilities is forecast to be £4.2 million
- Spending on domiciliary care for people with learning disabilities is forecast to be £2.5 million
- Forecast cost of ACS in-house domiciliary care service is £2.6 million

Direct Payments

2009/10 expenditure by ACS as forecast at the end of June 2009

- Forecast spending on direct payments to people wishing to organise their own care is £1.2 million

Quality

Care Quality Commission ratings July/August 2009

Residential Care

- The average Care Quality Commission (CQC) star rating of the 70 privately/voluntary operated care homes in Scarborough and Ryedale was 2.2 (county average was 2.3). Two homes were rated as poor (0 stars) and 21 as excellent (3 stars). Three homes had not yet been rated. The county average star rating was 2.3.
  The average star rating of the 8 NYCC operated care homes was 2.3 (county average was 2.2). Three homes received excellent ratings, no homes received a poor rating.
  The average star rating for all care homes in England was 2.0 stars.
- The average CQC star rating of the 15 privately/voluntary operated nursing homes in Scarborough and Ryedale was 1.7, one homes were rated as excellent. The county average was 1.8.
  The average star rating for all nursing homes in England was 1.9 stars.

Domiciliary Care

- The average star rating of the ten private domiciliary care operators supplying 78% of hours (excluding Learning Disabilities) purchased by ACS was 2.0
- The average star rating of the six private domiciliary care operators supplying 90% of Learning Disabilities hours purchased by ACS was 2.7

The average star rating for all categories of domiciliary care providers in North Yorkshire is 2.3 stars and for England 2.1 stars.