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Non-care and support providers may be required to pay £50 per year.

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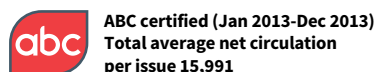
Care Management Matters is published by Care Choices Ltd who cannot be held responsible for views expressed by contributors. Care Management Matters © Care Choices Ltd 2015

ISBN: 978-1-910362-37-2

CCL REF NO: CMM 12.1



CMM magazine is officially part of the membership entitlement of:



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From the Editor

Editor, Emma Morriss explores the BBC's recent focus on the care sector.



This month we have seen social care on the BBC like never before. The week of care-related news coincided with the BBC launching its new *Care Calculator* – which Fidelma Tinneney gives an honest assessment of in *Is it just me...?* on page 7. Bringing social care to the fore of the general public is essential so I thought I'd take a look at how they approached it.

Opening the related BBC news *The Cost of Care* homepage, the stories I was presented with were:

- 'No interest' in care insurance;
- Care spend 'cut by fifth in decade';
- Care calculator launched by BBC;
- Care cuts 'leave elderly high and dry'; and
- Many elderly 'struggle' at home.

Not the most positive viewing, however there are positives to be drawn. Firstly, the headlines aren't being critical of social care as a service and the standard care and support provided to individuals. They

are finally, bringing to the general public, the issues the sector faces from funding to policy decisions and the reality of making the system fit-for-purpose.

NO CARE INSURANCE

Worryingly, the first story identifies that the care insurance products the Government was banking on to help with the implementation of the cap on care costs are not materialising. The 'enormous market' which the Government expected to open up hasn't happened with the BBC quoting Yvonne Braun of the Association of British Insurers, who said, 'The industry was ultimately responding to the "law of supply and demand". "If you wanted to sell to somebody in their 30s, 40s and 50s, or even 60s, I think you would find it very very difficult."

'She said it was more likely that other insurance products, such

as critical illness cover and life insurance, would be adapted to cover care costs.'

CUTS, CUTS, CUTS

The remaining stories focus on the reality of funding cuts to the sector, the amount of money local authorities have needed to save, the impact cuts are having on the NHS and accident and emergency departments plus the realities of everyday life for older people living at home with little or no help. The stories have been based on reports and statistics from Independent Age

and Strategic Society Centre think tank, Age UK, Health and Social Care Information Centre and Office for National Statistics.

I personally welcome this focus on the other side of social care. It's about time the national press moved away from the stories of poor care that usually dominate and take a look at the reality of the pressures in which we operate.

In the run up to the General Election, can we hope that with this level of focus from mainstream news outlets, social care can join the NHS as an election priority for the public? I really hope so.

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Is it just me...?

Fidelma Tinneney gives an honest review of the BBC's new *Cost of Care Calculator*.



This month the BBC has launched its Care Calculator. I am pleased to see the reality of the much heralded care cap is being exposed to the general public. Many will be disappointed to see how much they are likely to contribute and how long they will have to wait before the cap kicks in. It will be a surprise to many that their care fund will only increase at the 'usual price' (often hundreds of pounds less than the actual cost of local care) set by their local authority (LA), and that 'hotel costs' will be excluded.

However, the care calculator is a useful tool, if only to emphasise the woefully inadequate rates offered to provide care. After hotel costs, the calculator gives figures of between £200 and £300 per week to provide care: to have one or two people assist you to live 24-hours per day – to wash, dress, nourish, medicate, keep you well, call the doctor, deal with problems as they arise, change bedding and much more intimate attention, consuming time and

costs that have to be paid for; as well as entertain you to your own taste and ensure every part of your day and what is done with, to and for you is documented to meet the increasingly demanding 'evidence' for officials who seem to think they know better! These seem more like daily rates!

This week, two frustrated families have called our care association to ask about calculating the 12-week property disregard – it is the same process as this well-intentioned but sadly flawed approach. They are frustrated with the lack of clarity, knowledge and assistance they had received – whilst having to deal with ill and frail parents, clear out the family home, manage finances and the complex bureaucracies of the care world. This system will add to that despair.

The new system leads people to believe they will spend no more than £72,000, but in reality you are likely to quadruple this. My care calculator, based upon a Berkshire postcode

reckoned my care would cost me £128,000 (over four years and eight months).

Yet basing care fees on what LAs say they pay is pitiful. It is well-

time for assessments, accessing the specialists you need urgently, continuing healthcare funding, property disregard, and now calculating care fees...

'The care calculator is a useful tool, if only to emphasise the woefully inadequate rates offered to provide care.'

recognised that LA fees do not meet costs, and few care organisations can deliver high quality care without privately funded service users subsidising LA clients. My own calculations predict I will pay £81,000 per year inclusive of my benefits.

As a nurse, manager and care provider I find the negativity about elderly care upsetting and at times dishonest. We are largely peddled as money-grabbing, unkind, uncaring individuals. When the news is not about poor care, it is frequently misleading – the waiting

Many nursing homes in our area frequently charge £1,500 per week – and the cost is rising, as is the dependency level of service users and accordingly staffing levels. Good staff, and nurses particularly, are very hard to acquire and retain. In 22 years of elderly care, it feels an increasingly oppressive environment for service users, staff and families. Please can we have some decent honesty?

To test the BBC's Care Calculator for yourself visit: www.bbc.co.uk/news/health-30990913

APPOINTMENTS

CARE ENGLAND

Care England has announced that Avnish Goyal, Managing Director of Hallmark Care Homes, has been elected as the new Chair of Care England.

SWEETTREE

SweetTree has expanded its services to employ a dedicated Admiral Nurse. Rikki Lorenti will be offering expert advice, information and psychological support to family carers and clients living with dementia.

GLEN CARE

Glen Care has appointed qualified learning disability nurse Beverley Clancey to head up its Coulsdon-based care home with nursing service.

ADASS

Cathie Williams has been appointed Association of Directors of Adult Social Services' first ever chief officer - a post that was created following a review of the Association's management and organisation conducted by Ernst and Young.

SAHARA

Sahara Care has appointed Angela Bacon as acting manager at its Parkside Care Home. Hannah Hazelwood has also joined as the new service manager at Sahara House.

FOUR SEASONS

Alistair How has joined Four Seasons Healthcare as Chief Operating Officer. He was previously Chief Executive of Eden Futures.

SURECARE

SureCare has appointed Robert Parsons, an experienced business development manager, as part of its plans for growth.

NEWS

Adult social care crisis

The escalating cost of caring for the elderly means councils will have to divert £1.1bn from services like fixing potholes and running libraries and museums from April, new analysis shows. It comes as local authority leaders warn that a crisis in care funding will have crippling repercussions for local services as well as the NHS unless it is fixed.

Councils in England will see their core government funding cut by 8.5% in 2015/16, following the Local Government Finance Settlement. However, cuts for services the majority of people use are likely to be much bigger, new analysis from the Local Government Association reveals. This is because local authorities are having to find extra money from their shrinking budgets to meet the rising cost of caring for

the elderly and disabled.

Councils spent £14.6bn on adult social care in 2013/14. It is the biggest mandatory service councils provide and accounts for an increasing proportion of local government spending – now 35% (2014/15) compared to 30% in 2010/11. Rapidly rising demand means that even with councils protecting social care from cash cuts, the provision of care is having to be cut back to make ends meet.

Analysis carried out by the LGA, which represents councils in England, shows that in the next financial year (2015/16) councils will have to find £1.1bn from other service budgets to continue protecting adult social care spending in cash terms.

It follows a £900m hit taken by other services to help plug adult

social care funding last year.

The analysis is based on current spending patterns, which show councils have consistently been protecting spending on adult social care at a time when the elderly population continues to rise and local services have faced the biggest and most sustained cuts in funding since the war.

The LGA is warning that if the crisis in adult social care funding is not addressed, councils will have little money left for any other services by the end of the decade. Separate analysis has shown that local government funding has fallen 40% over this Parliament and almost two in three councils say they are considering stopping some services in 2015/16 as efficiency savings are fast running out.

Residents rate their care homes

The UK's largest and most authoritative survey of care home residents, *Your Care Rating*, has announced the results for its 2014 annual survey. The survey looks at the views of over 20,000 residents who take part in it from 29 different providers in more than 1,000 care homes. Each care home is awarded an Overall Performance Rating (OPR) out of 1,000. The national average score this year was 872 with scores ranging between 631 and 995.

The national average scores across the survey's four main themes were: staff and care, 871; home comforts, 852; choice and having a say, 854; and quality of life, 922. However, the high and low

scores varied considerably across the themes, for example for home comforts the scores ranged between 454 and 996.

All of this year's results for every care home surveyed are displayed in detail on *Your Care Rating's* website www.yourcarerating.org. The website also shows how homes that took part in the survey last year performed.

All of this helps families who are choosing a care home for a loved one by giving them vital information on what the residents actually think of each home.

The survey was undertaken for *Your Care Rating* by leading research company Ipsos MORI.

£30m debt facility for LNT

Omni Capital has agreed a £30m committed debt facility with LNT Care Developments Limited a wholly owned subsidiary of LNT Construction. With a term of four and half years, the new facility will enable LNT to continue to expand their development pipeline into more areas of the UK.

Omni Capital is a leading specialist provider of short and medium-term funding to the property sectors. This additional facility will complement LNT's current financial arrangements to accelerate their development growth.

Ambitious target for inappropriate placements

The Government did not meet its goal of transferring by 1st June 2014 all people with learning disabilities and challenging behaviour, for whom it was appropriate, from mental hospitals into the community. The National Audit Office (NAO) estimates that, in 2012/13, the NHS spent £557m on services for inpatients with learning

disabilities and challenging behaviour. In addition, local authorities with adult social services responsibilities spent £5.3bn, in 2013/14, on community services for adults with learning disabilities.

NHS England now has an ambition to discharge 50% of the population of 2,600 in-patients with learning

disabilities and challenging behaviour to more appropriate care settings by 31st March 2015. Some patients have already been discharged, but there is so far no timetable or ambition to reduce the inflow of inpatients with learning disabilities into mental health hospitals, or to close mental health hospitals.

CQC's fees criticised

The Care Providers Alliance (CPA) has issued a joint response to the CQC proposal on a 9% increase in its fees from April 2015. This is a proposal the CPA strongly opposes. The methodology CQC adopts to justify its current proposal is far from clear and, in many respects is neither robust nor defensible, says CPA. A weak methodology means the CQC has been unable to calculate detailed costs of regulation as differentiated by sector – this is a position the CPA find wholly unacceptable. CPA says CQC's approach is inherently inequitable, not transparent and very difficult to defend.

CPA urges CQC to approach financial matters in a more considered and business-like way. It says CQC needs to move away from its casual and knee-jerk approach to setting fees to one that is intelligently based on a long-term view.

HC-One's £100m investment

HC-One has announced details of its £100m investment programme that will incorporate extensive refurbishment and upgrade schemes for its homes. This investment forms part of the organisation's on-going drive to deliver the best possible experience and kindest care to residents.

The investment programme furthers HC-One's transformation journey; commencing in April 2015 it will benefit all homes over a three year period transforming their

gardens and interiors to provide exceptional living and lifestyle environments.

Working closely with specialist health and social care interior designers, a range of interior schemes have been developed for onward consultation with residents and relatives. The interior schemes will be incorporated into all sitting and dining rooms; where possible themed rooms will be created including hair and beauty, games, reminiscence and garden rooms.

Care Home Open Day

Care Home Open Day is set to take place for the third year and will be held on 19th June 2015, promoting the themes of the Arts and Valuing Staff. Supported by a group of care providers, associations, charities and care regulators, Care Home Open Day aims to reinforce the connections care homes have with

their local communities, as well as challenging misconceptions about care settings.

Care Home Open Day has proven to be a great success with the event growing year-on-year and more care homes signing up across the UK and with several other countries celebrating on the same day.

CQC's new DoLS report

The Care Quality Commission (CQC) has published its fifth annual monitoring report on the implementation of the deprivation of liberty safeguards (DoLS).

The report examines the first five years of implementation of DoLS, during which time the numbers of applications to use DoLS rose from 7,200 (per year) in the first year to 13,000 (per year) in the year ending in March 2014. The report also shows that throughout the first five years

there have been continued regional variations in application rates, wide variations in practice and training and a persistent low number since 2011 (when this became a requirement), of providers notifying CQC of applications to use DoLS and the outcomes.

In March 2014, the Supreme Court clarified that a person lacking mental capacity to consent to the suggested arrangements is deprived of their liberty if they are both: not free

to leave and subject to continuous supervision and control. As a result, the numbers of applications for use of the DoLS has soared, from around 13,000 a year to around 55,000 in the first two quarters of 2014/15.

The report points out that this rise in applications is a good thing, since it shows willingness among providers to protect the rights of individuals, and encourage external scrutiny of their care when a vulnerable person might be deprived of their liberty.

APPOINTMENTS

CARE PROVIDER ALLIANCE

Sheila Scott OBE has been appointed Chair of the Care Provider Alliance. Sheila is Chief Executive of the National Care Association.

VOYAGE CARE

Kevin Roberts has left the post of Chief Executive at Voyage Care. Andrew Winning became Interim Chief Executive in January 2015. Previously, Andrew was Voyage's Chief Financial Officer.

HC-ONE

HC-One has made a number of senior management appointments. Bruce McLernon, John Ransford CBE and Richard Jones CBE have joined the group.

ST MONICA TRUST

St Monica Trust has appointed David Williams as its new Chief Executive. David will take up his role in April.

CLS

Sheila Wood-Townend has been appointed Head of Service at CLS Homes, having been the provider's Operations Manager for almost 12 years.

HSCIC

The Health and Social Care Information Centre (HSCIC) has appointed Andy Kinnear to its Provider Support directorate. Andy will provide advice on local delivery of integrated care.

ORDERS OF ST JOHN CARE TRUST

The Orders of St John Care Trust has completed its executive team with the appointment of a Janet Boulter as Finance Director.

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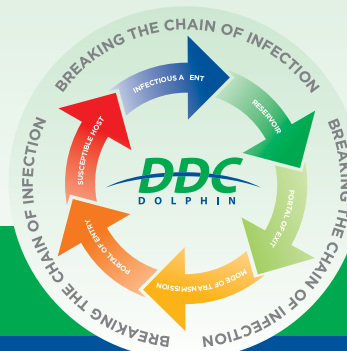
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NMC publishes revised Code

The NMC has published the revised Code for nurse and midwives, which will come into effect on 31st March 2015. The Code contains the professional standards that nurses and midwives must uphold. They are the standards shown

every day by good nurses and midwives and the Code should be seen as a way of reinforcing their professionalism. The Code will be a focus for professional reflection during revalidation, which will be introduced in December 2015.

Hazlewoods 2014 year review

Hazlewoods and its specialist health and care advisory and due diligence teams had an exceptionally busy year in 2014. In the year they advised on 43 completed transactions valued at £185m.

The social care sector continued to attract interest from private equity investors, and this was accompanied by greater availability of bank debt. An interesting point was how the bank debt markets changed during the course of the year. They found that debt was generally easier to access and the terms were 'softer'. It will be interesting to see if this continues into 2015, with the cautiousness over the recovery seeming to return.

Although trading conditions continue to be challenging many operators are cautiously optimistic. It does however depend upon

what sub sector of social care and what geography people operate within, and clearly the quality of the business. The team was able to advise a number of clients either in their acquisition strategies, or to successfully exit their businesses, and the pipeline going into 2015 is very positive.

A selection of the team's 2014 transactions include: Acquisition advisory services provided to Acorn Care and Education; Financial due diligence on behalf of August Equity on its acquisition of a number of businesses for its portfolio companies; Financial due diligence on behalf of Sovereign Capital for a number of its investee companies; Advising on the disposal, tax planning and exit of businesses in supported living, domiciliary care; residential learning disability, elderly residential and nursing and foster care.

Social care manifesto

Care England has launched its manifesto, which provides a future government with a roadmap to an outcomes-based health and social care framework.

In a difficult financial climate, it is important that all parts of the system are treated fairly and work together in the interests of the people who use services, and this manifesto is written with that goal in mind.

Social Care Commitment

A new website has been launched to support the Social Care Commitment and includes changes that have been made as a direct result of employer feedback. The new website will make it even easier for people to embed the Commitment as it comes with new guidance, and some excellent case studies, showing how different organisations have used the Commitment.

Integrated health and social care

The programme to promote innovative ways of joining up health and social care has been extended to 11 new areas. The aim is to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

The new integrated care pioneer areas are Airedale, Wharfedale and Craven; Fylde Coast; Camden; Greater Manchester; Nottingham (City); Nottinghamshire; Sheffield; South Somerset; Vale of York; Wakefield; and West Norfolk.

The first annual report for the Integrated Care Pioneers Programme sets out the experiences of the first 14 areas to take part in the programme. It provides examples of best practice to help other areas to develop innovative ways of joining up their health and social care services. These pioneers have shown that, by working together to prevent people becoming ill, they can reduce hospital admissions, reduce the amount of care people need, and save money.

For examples of how social care can work alongside health see Debbie Sorkin's article on page 27.

New Care Act support to help councils cut social care bureaucracy

A new web tool is available to help councils reduce unnecessary bureaucracy and simplify their social care systems so people experience better support.

The *Personal Budgets Minimum Process Framework* helps councils through common social care practice by suggesting simpler ways to meet people's needs.

Developed by Think Local Act Personal, the Framework lists what councils must do to meet their Care Act responsibilities, while also addressing many of the process problems reported by people who use services, carers

and families through various forums, including the *National Personal Budget Surveys*.

It covers ways to improve people's first contact with the council, their assessment, resource allocation and hospital discharge; as well as 'managing the money' (including direct payments), providing brokerage, developing care plans, and undertaking monitoring and reviews. The *Personal Budgets Minimum Process Framework* has been designed for people who work in councils to 'dip in and out' based on what issue they might be

focusing on.

Website users can see what the legal requirements for personal budgets are, the common problems encountered with particular processes and ideas for possible solutions based on case studies from councils across England. The Framework will change and grow over the coming months - people can comment on the processes, add their own suggestions and submit case examples they know about, particularly as people set their sights on the Care Act 2014 coming into force from April.

Bespoke care

Manorcourt Homecare, the homecare services division of Healthcare Homes, has launched a new bespoke, private care service called (My Way), which enables individuals to choose the level of care and support that they want to receive in their own homes. The fully tailored service lets individuals select the level of service required, from regular morning, lunchtime and evening visits, respite care, through to 24-hour care.

The new ((My Way)) private care service has been designed to support those people across Watton, Swaffham and Thetford who wish to organise their own home-based care, to suit their individual circumstances.

New funds for joint working

The Government has found new funds to encourage more joint-working between councils and the NHS.

In a bid to ease the pressure on the NHS during the current cold snap, the Department for Communities and Local Government (DCLG) and Department of Health (DH) have released an extra £37m for councils to get people home from hospital quicker and stop them from being admitted in the first place.

The DCLG has also provided £12m to help join up health and social care services.

OSJCT launches Your Vote Counts

The Orders of St John Care Trust (OSJCT) has launched its *Your Vote Counts* initiative across its 69 care homes. The launch sets out to proactively encourage residents to vote during the election, as many of the key issues concerning the way older people are treated and cared for have a direct impact on their lives. OSJCT will also identify Voting Champions in each of its care homes, all of whom will receive training from the National Development Team for Inclusion.

Sheffcare annual report

The annual report of Sheffield not-for-profit organisation Sheffcare has highlighted the excellent levels of care being offered in all areas of its services. Sheffcare is a registered charity that was established in 1993 and now operates 11 residential care homes across the city.

In addition to its residential services – including some of the

region's most outstanding facilities for people living with dementia – Sheffcare also operates a home care service, offering people support in their own homes. All Sheffcare services have received excellent Care Quality Commission reviews over the past 12 months, while user surveys have shown almost 100 per cent satisfaction with levels of service.

First Elizabeth Care course

Jeremy Hunt, MP for South West Surrey and Secretary of State for Health and Anne Milton, MP for Guildford and former Health Minister, celebrated the success of the first Elizabeth Care course by awarding certificates to the nurses and carers who've completed the initial module.

Elizabeth Care is the first work-based, practical course in the care of older people. This university-accredited course creates opportunities for developing a career for health and social care

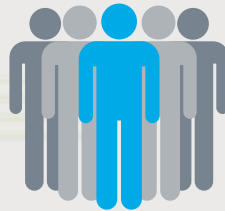
practitioners and is designed around what older people want and need and will build confidence in health and social care provision and for the wider public.

Jeremy Hunt, MP said, 'I was delighted to visit Birtley House Nursing Home and take part in the presentations to students involved in the Surrey-based Elizabeth Care project... This programme is a really important initiative and I look forward to seeing it develop further in the future.'

TLAP's Care Act resources

The Care Act 2014 has significant implications for people who use services and their carers because for the first time it puts them in control of their care and support. It also

makes clear what kind of care they should expect. The Think Local Act Personal partnership has developed resources to improve awareness of the new duties and responsibilities.



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Second annual Learning Disability Census

The second annual *Learning Disability Census* was initiated in response to events at Winterbourne View Hospital and the details are published by the Health and Social Care Information Centre (HSCIC). The census considers inpatients with learning disabilities, autistic spectrum disorder and/or behaviour that challenges, giving information about their characteristics and their experiences of care in NHS and independent facilities in England.

The HSCIC finds that more than half of inpatients who were included in the 2013 Learning Disability Census were still in specialist units one year later (1,830 of the 3,250 inpatients counted in

2013). On 30th September 2014, 3,230 individuals met the criteria of the census, compared to 3,250 who were included in the 2013 headcount.

The most recent census provides information on why individuals were inpatients on the day of the census, showing 2,545 patients (79 per cent) were considered not ready for discharge. The most common reason reported by providers (for 1,365 individuals or 42% of inpatients) was a continuing need for inpatient care due to mental illness. The second most cited reason was that inpatients were receiving a continuing behavioural treatment programme (695 or 21%) and

third that the individual's current behaviour was assessed as too risky for the Ministry of Justice to agree any reduction in security level (485 or 15%).

The *Learning Disability Census Report, England, 2014* also found:

- The use of antipsychotic medication has increased.
- The number of patients who experienced one or more incident (self-harm, accident, physical assault, restraint or seclusion) dropped slightly.
- The median average length of stay was 547 days for the 2014 census, compared to 542 in 2013.
- The median average distance from home in 2014 was 34.4km, compared to 34.5km in 2013.

Excel's SLASL success in Reading

Excel Support Service has been successfully entered onto the Reading Borough Council Supported Living Accreditation

Select List (SLASL). This is a considerable achievement for Excel as it is one of only 12 supported living providers within Reading

that were chosen by the council to be entered onto the list, following a rigorous and lengthy selection process.

POLL

Can social care save the NHS?

Yes

No

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February's results

Are you ready for the forthcoming Care Act changes?

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Yes - 47%

Source: www.caremanagementmatters.co.uk
Figures correct at time of print.



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IN FOCUS

The Department of Health's consultation on implementing the cap on care costs

WHAT'S THE STORY?

This latest consultation from the Department of Health asks for views on changes to the way care and support is funded, through the introduction of a cap on care costs. It also seeks views on proposals for a new system of appeals.

These reforms are part of the Care Act 2014 and are due to come into effect in April 2016. The guidance and regulations associated with the Act set out how it will work in practice. It is the Government's response to the recommendations made by the Commission chaired by Sir Andrew Dilnot.

WHY IS THIS IMPORTANT?

The Care Act brings together adult care and support law into a single clear statute and sets out the core legal duties and powers that underpin the care and support system.

The Act, which is being implementing in April 2015, also contains regulation-making powers which allow the Government to make secondary legislation (regulations) that provide more detail on how the system operates.

The regulations set out the detail of how reforms should be implemented. The cap on care costs is set within the legislation at £72,000.

WHY ARE CHANGES BEING MADE?

A major requirement of the Care Act is the reform of the way people pay for care and support.

The current system is considered outdated and unfair and doesn't provide people with the protection and support they deserve. Care and support has never been free. The current system for paying is based on laws written over 65 years ago, developed at a time when few people lived into their 70s, and fewer needed care and support.

WHAT WILL IT MEAN FOR CARE PROVIDERS?

One of the most significant changes heralded by the Care Act is the right for people to receive an assessment. Care providers fear that the combinations of assessment, national eligibility and the involvement of local authorities could result in further pressure being put on the rates paid for care services.

The changes to legislation and statutory guidance is complex and the cap on care costs need to be seen in the wider context of reform of the care system.

The consultation will be open until 30th March 2015 it is available at www.gov.uk/government/consultations/care-act-2014-cap-on-care-costs-and-appeals

Disposal of development land

Carterwood acted on behalf of Leonard Cheshire Disability in the disposal of a parcel of land fronting Banbury Road in Adderbury, Oxfordshire to Gracewell Healthcare, backed by Patron Capital. Carterwood were able to identify that the land posed an excellent potential development opportunity due to the under-provision of elderly care bed spaces within the catchment area and a strong wealth profile that would support a care home aimed at the private fee paying market.

After the deal was agreed, Carterwood was commissioned to prepare both a needs assessment and a sequential test in support of the planning application. Extensive discussions were undertaken with the adult social care team to determine how Carterwood could best present the case for the proposed scheme. Planning permission was granted with officer recommendation for approval on the site for a 60-bedroom care home, despite being located in open countryside.

Sale of specialist dementia home

GVA's Health team has announced the sale of Willinbrook Healthcare Ltd. The business operates Willowbrook, a high quality purpose-built care home on the outskirts of Birmingham which provides both residential and nursing care services to residents with dementia and complex care needs. The 45 bed dementia home was sold off an asking price of £7m.

The shareholders instructed GVA to identify a suitable purchaser for the business by approaching, on a confidential basis, a highly focused and select list of parties. James Sandry from GVA's London office negotiated the transaction and commented, 'The team at GVA

forged a strong relationship with the directors of the business over a number of years prior to being appointed. We have, therefore, had an opportunity to watch the business evolve over time into a very sustainable and robust performer.'

'The directors maintained an investment programme which meant the home was maintained to a very high standard both in terms of the fabric of the property and the staffing group. It therefore came as no surprise when there were a number of highly motivated parties seeking to acquire the business which is testimony to the high regard in which the home was held by the referring authorities.'

HC-One acquires Meridian

HC-One has acquired Meridian Healthcare's 30 home portfolio, which will ensure the continued provision of the very best care in Greater Manchester, Merseyside, West Yorkshire, North Lincolnshire, Cheshire and Derbyshire.

Meridian is a highly-respected regional provider with a long and successful track record. With shared values and a passion for providing the kindest care in the best environments, Meridian and HC-One are natural partners. The company will continue to trade as the Meridian brand and there will be no changes at the homes or with the management team. HC-One is committed to continuing

Meridian's exemplary record.

Over the last 15 years Meridian Healthcare has grown to be an outstanding provider with a record for excellence. Meridian now operates across 30 locations, with over 1,500 registered beds, over 1,200 dedicated staff, and has an admirable record of service delivery and staff development.

Through this acquisition by HC-One's parent company, Meridian will have the benefit of HC-One's sector-leading financial strength and depth of support services, ensuring that all residents at Meridian homes continue to receive the highest quality care through a range of specialist services.



Care delivery goes mobile

Advanced Health & Care have launched mobile working solutions designed specifically to support care workers gain access to data and record care provided **at the point of care**.



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SCIE's Prevention Library

Investing early in prevention in adult social care can reduce or delay the need for costly crisis intervention or care services – and support people's independence and wellbeing for longer. The new *Prevention Library*, developed by SCIE, aims to help inform commissioners and service providers to find information and examples of emerging research and practice in the provision of prevention services across England.

The resource, which has been commissioned by the Department of Health includes examples of current services, access to related resources and an introductory film highlighting the challenges of investing in prevention in a way that meets local needs. SCIE is continuing to develop the *Prevention Library* and is keen to feature more service examples, reflecting the broad spectrum of prevention provision.

New data set released

The first report from the *Mental Health and Learning Disabilities Data Set* (MHLDDS) has been released by the Health and Social Care Information Centre (HSCIC). The scope of the MHLDDS was expanded from September 2014 to ensure that information about people in contact with LD services is recorded.

The report makes available the most recent MHLDS monthly report and presents a wide

range of information about care delivered to users of NHS-funded secondary mental health and learning disabilities services for adults in England. Data is presented by local authority level, clinical commissioning group (CCG), provider and CCG/provider combinations.

The report also includes a special feature, *Monthly MHLDS Reports – A special feature on the distance to treatment for people in hospital*.

Target acquires Swaffham home

Target Healthcare REIT has acquired a purpose-built care home in Swaffham, Norfolk for approximately £4.5m including acquisition costs.

The home, Icen House, is a modern two storey property with 74 bedrooms arranged around a central courtyard, each with full en-suite bathrooms.

The property has been acquired

from Zest Investment Group, and leased to Norfolk Care Homes Limited on an existing 30 year lease with circa 23 years remaining. Icen House was sold by Bespoke Care who acted for the vendors and approached a select number of parties with regards to this 'off market' opportunity. The sale was concluded within a few months.

New Chelsea nursing home

Meeson Williams Phillips has obtained permission for a Chelsea residential care home to convert its day centre into nursing-led accommodation for elderly people. Owned by the Royal Borough of Kensington and Chelsea and managed by Care UK under a lease arrangement and service contract, Ellesmere House residential care home in Fulham Road will now implement its plans to create accommodation for elderly residents who require round-the-clock nursing care. The Council has

already announced plans to relocate the day centre from Ellesmere House to elsewhere in the Borough as part of a review of healthcare provision.

The planning permission also secured alterations to the nursing home including changes to the elevations to maximise views from the new rooms over internal landscaped courtyards and gardens and the creation of a retail or restaurant unit at the front of the building. Ellesmere House is a purpose-built residential care home which opened in 2008.



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Oakland Care

DC Care has completed the sale of Oakland Care Ltd (In Administration). Oakland Nursing Home is registered for 27 and is located in Whitby, North Yorkshire. The new buyer is an existing regional operator, who saw the potential in the business and is looking forward to integrating it into their existing portfolio.

Society redevelops Paddock Wood

The Abbeyfield Kent Society has completed building work on its supported home in Paddock Wood, adding en-suites to all rooms and two new self-contained apartments alongside the home.

Margaret Fisher House, which sits in Old Kent Road in Paddock Wood, has had all 10

rooms refurbished. Two entirely self-contained semi-detached one-bedroom apartments have also been constructed, each have a wet room and open plan living area including a kitchen, diner and lounge.

The new apartments have been created to provide independent

living for over 55s and bespoke fixtures and fittings ensure the home is suitable for people with disabilities.

Staff are also on hand to check on residents daily and the Society's domiciliary care provider, Caring Companions, can provide domiciliary care, if required.

Care Your Way acquisition

Carterwood has successfully acquired a second domiciliary care provider based in Surrey on behalf of Care Your Way Limited. Local Care Group, a provider of homecare and support services since 2005, was owned by Graham Jones and set up with the ethos to move away from the time-based service provided by many local providers to a system based on need and clients' aspirations.

Garry Fitton, Finance Director at Care Your Way commented on the acquisition, 'We were delighted with the approach Carterwood took to

acquire Local Care Group. The ethos Graham Jones had built the company around suited the values at Care Your Way very well. It also fitted in with our own future acquisition and growth strategy.'

Carterwood's Tom Hartley, who was responsible for the acquisition, commented, 'While we have a bespoke nature to all our transactions, this being our second acquisition for Care Your Way meant that we understood right away how Care Your Way operate and what their requirements were.'

Albion Ventures exits Oakland Care Centre

Albion Ventures, one of the largest independent venture capital investors in the UK, has announced the successful sale of its investment in Oakland Care Centre. The initial investment of £4.35m was made between November 2010 and October 2011 and was followed by £0.85m in April 2014. The company has traded at mature levels for the past two years and delivered excellent profits. As a result of the

sale, Albion Ventures has achieved 25% internal rate of return over a period of four years.

Oakland Care Centre provides residential care for up to 46 residents in a purpose-built care home in Chingford. The home incorporates the latest thinking in the provision of elderly care and employs highly trained staff under the supervision of an experienced care management team.

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3. Insight led education

This year Care Management Matters will be curating the seminar content based on a year's worth of industry research. The programme features over 20 FREE educational sessions with leading care industry thought-leaders and experts including speakers from Dorset Clinical Commissioning Group (CCG), CQC and the National Care Forum.

The programme tackles key business challenges and opportunities within care including sessions focused on "Funding strategies and guidance on alternative sources of

funding", "The future of adult social care regulation" and "Recruitment and retention".

This year's programme will deliver solutions to your key challenges as well as insight into developments and predicated regulatory changes which are likely to affect you.

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Care Show Bournemouth features a stream of content for healthcare professionals facing challenges around dementia whilst caring for older people. Attend these sessions to discover strategies to help improve dementia care, listen to research results that will help streamline operations and listen to inspirational dementia care case studies by leading industry commentators.

This year will feature a great programme including key topics such as:

- Best practice in Dementia friendly design
- Rural international Dementia care: Challenges, opportunities
- Evaluating support for end of life care in Dementia
- Enhancing social care services for people with dementia

By attending one or more of our Dementia seminar sessions you will gain valuable insight but more importantly will be able pose questions to the experts based on the unique requirements of your business.

5. The Big Political Debate

On the 25th March at 3pm MP's will discuss their proposed plans in "The Big Political Debate - The Political Parties Share Their Vision for Care hosted by National Care Association". The session will be chaired by Nadra Ahmed OBE and gives you the opportunity to be heard and pose your questions to our panel.

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A wooden mannequin arm is shown reaching upwards, with the hand pointing towards the top of the frame. The arm is made of light-colored wood and has a jointed structure. The background is a solid blue color. The text is positioned in the upper left corner of the image.

CMM is offering readers the opportunity to put their questions to senior decision-makers. Is there something affecting your business that you'd like an answer to? Are you facing specific pressures you'd like to know how to tackle? Send your questions to CMM.

COMMISSIONERS AND THE **CARE ACT**



Q With the Care Act looming, what are commissioners' thoughts on the changes, how are they looking to tackle them and is there enough money to see them through?

A David Pearson, President, Association of Directors of Adult Social Services responds.

With the Care Act rapidly approaching its Phase One of implementation, it will probably be regarded as one of the most fundamental parliamentary contributions to our sector since the post WW2 legislation, consolidating as it does that family of statutes which give teeth to our aspirations towards well-being, integration and personalisation. It can and will make care and support fit for the 21st Century.

It has also given rise to a host of activities related to grounding it fully and securely within the statutory framework which make up our collective practice with adults of all ages with disabilities or illnesses requiring care and support to meet needs and achieve personal outcomes.

Witness, for example, the intense work being carried out by Public Health England, the Department of Health and other bodies on a sophisticated communications strategy designed to raise the awareness of users and carers at the same time as local authorities are preparing to meet the additional demands that they are anticipating. There is evidence of considerable training investment being directed towards the new legislation. Anticipated demand has led to enhanced recruitment of social work staff. New obligations to work with the NHS have required intensive discussion and joint training – all of which come at a price.

MEETING THE COST

No, we haven't finally reached agreement on the overall costs of implementation. But rising to the challenge of taking on new responsibilities and meeting growing demands at a time of maximum financial austerity will have its cost. Part of meeting that cost will, of course, inevitably be drawn from users of the system themselves.

It's fantastic that we are all living longer – a real tribute to decades of scientific and medical advance. But it is worth briefly rehearsing as well what additional demographic demands adult social care is facing, as well as what pressures the austerity of the past five years has brought. The figures do not make happy reading! Although local authorities have protected social care budgets as far as has been possible, funding to adult social services has been reduced by a further 1.9 per cent, or £266 million, in 2014/15 to £13.68 billion. This will be the third year of continuing cash reductions and the fifth year of real terms reductions in spending.

Yes, we have had the help of some money in the Better



➤ Care Fund for 2015/16 and this is very welcome. As has been the £25 million new money distributed recently for the sole purpose of alleviating the crisis in the NHS' accident and emergency services. But the continuing scale of reductions in funding to local government presaged by last year's Autumn Statement continues to be a cause for extreme concern.

We have experienced a 12 per cent cut in real terms at a time when – irrespective of the pressures the Care Act will bring – demand for our skills and services has increased by 14 per cent. Inevitably this has led to fewer people receiving support, with councils over the last four years making savings to their adult social care budgets totalling £3.53 billion. Some 150,000 people who might have qualified under previous eligibility criteria now no longer receive services.

The Association of Directors of Adult Social Services' budget survey for 2014/15 showed a 5.8 per cent reduction in the

Councils and providers need to work closely together locally to negotiate and agree the price paid for care based upon local circumstances.

numbers of eligible adults receiving services during the previous year. The biggest decrease was directed towards older people supported in community settings which reduced by 7.9 per cent compared to a 4.7 per cent reduction in the number of older people in residential care.

QUALITY SERVICES

Transparency, accessibility and simplification are the Care Act buzzwords and well-suited to grappling with the complexities of 'how, what and when' social care is paid for. Unlike the bigger £100 billion-plus NHS, social care is not a 'free at the point of access' service. It is rationed. Councils have to apply means and needs eligibility tests to allocate these precious resources, with most people having to fund all or some of their own care and support with the council contributing the rest.

With increasing numbers of people living longer with multiple complex health conditions, there is a competitive market of providers to meet this growing demand. We have a competitive market, and it will be the job of councils to ensure that it is high quality, sustainable and one which is diverse.

At the same time, councils are equally concerned with money and high quality, focusing on making the most efficient use of scarce public resources to keep pace with demand of the most

vulnerable in our local communities and commissioning for better outcomes.

This difference could be significant and there is a general acknowledgement of a potential cross-subsidy existing, where it could be assumed that private funders paying high fees are in turn underwriting the lower fees paid by councils or individuals. However, this is not immediately evident, as fees paid are normally confidential between the individual and the provider/commissioner.

APPROPRIATE PRICE FOR CARE

This difference also opens up a debate about what is the appropriate price of care. Councils and providers need to work closely together locally to negotiate and agree the price paid for care based upon local circumstances. These discussions are often informed by the use of financial models, such as the Association of Directors of Adult Social Services *Price of Care* tool, but do not cover fees paid by self-funders.

The new duties in the Care Act for councils to arrange care on the request of individuals is very likely to expose these differences. While this duty promotes greater transparency about the cost of care, a number of commentators have also expressed reservations about what this could mean for the sustainability of the market.

There are a number of scenarios for what might transpire: the biggest concern of care providers is that with greater exposure of costs, the market will drive the price paid down to the lowest common denominator. From a consumer point of view this must be welcomed, but providers argue that this could undermine profitability and market diversity. On the other hand, commissioners have commented that this exposure of price paid for care could drive prices upwards, with providers challenging lower rates being paid.

Either way, there is fundamental need to ensure the system is properly funded and that there is access to a rich diversity high quality of services and support. These questions will be at the heart of the current consultation on the Care Act Phase Two duties to be introduced in April 2016, and the Association of Directors of Adult Social Services welcomes the opportunity to contribute to these important decisions.

CMM

David Pearson is President of the Association of Directors of Adult Social Services.

What are your thoughts on the Care Act? Do you feel commissioners are ready for the changes? Do you think it's possible implement the Act with the amount of money currently in the system? Join the debate at

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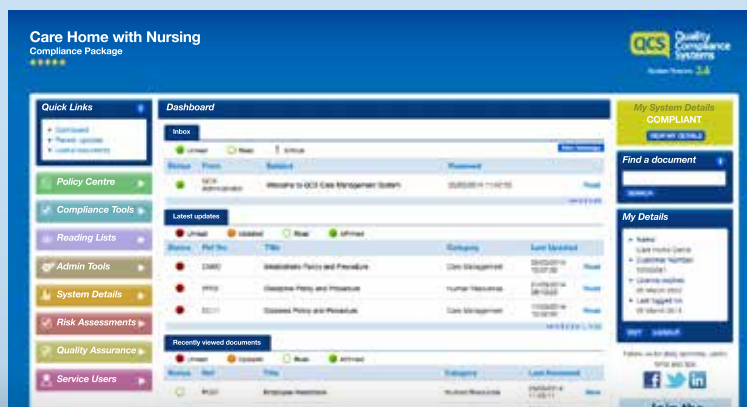
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DANSHELL – SHAPING THE FUTURE

Danshell has had a period of consolidation since it acquired the Castlebeck portfolio in September 2013. As it comes out the other side, it is shaping its services and the company whilst pushing forward innovation in learning disability provision.

The Danshell Group was founded in 2010 by Efi Herskovitz, who had successfully built up and sold on Forest Healthcare. Danshell was founded following the acquisition of Oakview Estates which provided treatment and care for young people detained under the Mental Health Act. From this starting point, the Group expanded rapidly acquiring specialist hospitals and residential services across England and Scotland.

Its growth culminated in the acquisition of 20 services formerly operated by Castlebeck. The acquisition was completed in September 2013; the services had been in administration since March of that year when Castlebeck appointed administrators. Following the abuse of clients at Castlebeck's Winterbourne View, Castlebeck had worked to rebuild trust, confidence and quality care in its services. However, Winterbourne View's closure and the closure of two other services impacted on Castlebeck to the point that it was unable to continue trading.

In the period since these acquisitions, Danshell has worked to consolidate the services and ensure its standards were implemented across the portfolio. Chief Executive, Efi Herskovitz and the executive team introduced a new leadership structure; a refreshed Quality Strategy, robust clinical governance and enhanced policies and procedures.

DISPOSAL

Following on from this consolidation the company has now disposed of its acquired brain injury (ABI) and

neurological division, developed bespoke services and re-registered two of its hospital services.

In December 2014, Danshell sold its ABI and neurological division to independent secure and step-down mental health provider, Partnerships in Care. The division comprised 50 beds across three sites – Warwick Lodge, Croxton Lodge and The Dalby Unit. All three facilities had been part of the Castlebeck portfolio acquired in 2013.

Andrew Murray, Chief Operating Officer at Danshell told CMM, 'Part of the company's strategic planning was to focus on the key service user group of learning disability and Autism. Partnerships in Care was ideal to take on the ABI/Neurological division because of its extensive experience in ABI. This ensured the safety of both the patient group and the staff team.'

INNOVATION

The company has also looked to innovate and push forward its service offering. In September 2014, it opened its first fully-bespoke service, Hope House in Hartlepool, followed by Thors Park in Colchester and Yew Trees in Frinton-on-Sea. Each service has been commissioned directly to meet the needs of individual service users whose needs were greater than conventional services could offer.

Andrew continued, 'Danshell was responding to service user and commissioner needs. We identified there were service users with more complex needs requiring extensive levels of support for whom it can be difficult to find a sustainable placement within a community setting. At Danshell the bespoke

services are within a safety net of a wider service, giving access to a multi-disciplinary team, activity bases and a wider group of staff.'

At the time Debra Moore, Group Clinical and Nursing Director at Danshell who was heavily involved in formulating the bespoke services, said, 'By designing the service to fit the person, rather than trying to fit the person into a more generic care setting, triggers for behaviour that challenges can be reduced. As a result the individual feels valued and listened to and their quality of life is greatly enhanced.'

RE-CONFIGURING

Most recently, in January 2015, the company refocused two of its services from hospital to care home with nursing to reflect the changing needs of service users and commissioners. Following consultations with service users, families and commissioners, the former hospitals, Hollyhurst in Darlington and Oaklands in Hexham, now offer a person-centred robust package of residential care with nursing to support service users towards more independent lives.

Andrew Murray added, 'We want to offer an environment that promotes independence and delivers person-centred care for service users, together with developing care pathways for people with complex needs including learning disabilities and complex physical health issues. It is all about maximising independence for service users. Nobody was detained in the hospitals and the new registration enabled us to meet specific needs and offer a care pathway back into the community.'

POLICY CONTEXT

There is ongoing determination to move policy towards supporting individuals in the community. In November 2014, the *Winterbourne View - Time for Change* report on the future of services for people with learning disabilities was launched by Sir Stephen Bubb, Chief Executive of the Association of Chief Executives of Voluntary Organisations. In his foreword to the report, Sir Stephen said he was tasked with considering, 'how we might implement a new national framework, locally delivered, to achieve the growth of community provision needed to move people out of inappropriate institutional care.'

'Only by a big expansion of such community provision can we achieve a move from institution to community.' This includes a 'mandatory national commissioning framework that delivers the expansion, pooled budgets and a focus on the individual's needs not the system boundaries.'

CMM

OVER TO THE EXPERTS...

Policy is increasingly driving change to learning disability services. Danshell is shaping its organisation to meet the needs of commissioners, service users and policy. Is this a step in the right direction for service innovation? Is this where the market should be heading? As a large organisation, is this ability to adapt, change and build bespoke services limited to those providers with large financial backing?

A STEP IN THE RIGHT DIRECTION

Danshell's re-shaping is a step in the right direction for service innovation. As a result of the Bubb Report, re-shaping is essential. For providers with hospitals, changes are coming.

There will be many patients who aren't ready to move into community settings and where specialist hospitals have a role to play in their care pathway. However, there is significant traction in identifying those patients ready to move and setting dates. The deliverability of local services to meet those needs is crucial including suitable accommodation and skilled staff.

For those able to move into community settings, this is where the market should be heading. Relatives frequently say their loved ones are too far away so they don't see them often. Being able to see family and friends regularly, because they are close by, can make a huge difference to people's quality of life.

Is there a difference between the capabilities of large and small

providers to emulate service re-shaping? Commissioning is driven by local needs and the ability of commissioners to pay. However, there is more commissioner focus on price rather than quality although patients' quality of life must be consulted upon. The ability to provide quality of life, at an affordable price may favour larger providers with economies of scale, who may be able to deliver a full care pathway and cover the costs of gradual transitions between services.

Danshell is re-shaping and others will too. Providers able to respond and develop innovative solutions via engagement with service users and commissioners will lead the way. However, one word of caution is affordability. With quality of life seemingly less of a priority than cost, local commissioners may still be attracted to lower cost out of area placements despite best endeavours locally.



Roger Harcourt Partner, Shakespeares

TIME TO END INSTITUTIONAL CARE

In the words of the late Professor Jim Mansell, 'The real solution... is to stop using these places altogether.' (2012). We have known for some 30 years that the best way to support people with learning disabilities and behaviours that are labelled as 'challenging' is individually in the community.

Where an individual is able to live in the right setting, with the right amount and type of highly-skilled and consistent support, the positive life outcomes for them and their families have proven this to be the case.

Andrew Murray, Chief Operating Officer at Danshell is correct when he says that, 'It can be difficult to find a sustainable placement within a community setting', but his solution to build more specialist hospitals - in the cases of Thors Park and Yew Trees - or change the status of others - such as Hollyhurst with 23 beds - to 'care homes with nursing' is simply perpetuating the problem.

This is not a correct interpretation of current policy, or where we should be focusing our efforts.

The places described in this article are simply different forms of institutions and are heavily based on a medical model. They continue to be bought by commissioners because they have little or no true community-based options available.

If the NHS funding allocated to these inappropriate services were invested instead in very carefully planned individual community-based solutions, we could actually start to end the practice of 'placing' people in Assessment and Treatment Units.

The right thing for large providers with private investors is to use their money to develop community-based support solutions; but I guess that the model, while being the right thing for people with learning disabilities, just might not pay off for shareholders.



Lucy Hurst-Brown Chief Executive, Brandon Trust

THE RIGHT THING TO DO

Moving from hospitals to residential care is the right thing to do. Care homes are based in the heart of the community; smaller than hospitals but big enough to provide the high staffing levels, tiered management/leadership and expertise that is required to support those previously in hospitals. It's more accessible to families and commissioners who see the whole service and get a feel of the culture. It's homely and person-centred.

This is where the market should be heading. We support people who've been rejected by other providers. We have been able to support them successfully in our residential services, due to our robust infrastructure.

Many of the people we support would've been sectioned under the Mental Health Act if they had not had residential placements available to them. Under a section they've no option but to be put in a hospital placement.

I believe it was Jim Mansell who said

that if people were correctly supported in the community then they shouldn't be sectioned. I agree and this is what we've been able to achieve.

Opening specialist residential care services isn't cheap and we wouldn't be able to do this without our investors' commitment and backing. To accommodate the people we support requires a heavy investment in the physical environment. This must be carefully planned around the specific needs of the individuals and maintained to a high standard, which is costly. It's difficult to see how smaller providers can achieve this, given the current financial climate and the difficulties of securing investment. That's not to say that it's impossible. However the benefits of being part of a large organisation isn't just finance; it's different departments and functions that are crucial but are more difficult for smaller providers to achieve.



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TAKING THE INITIATIVE

driving integration

DEBBIE SORKIN REPORTS ON HOW RESIDENTIAL AND HOME CARE PROVIDERS ARE PLAYING A PROACTIVE ROLE IN WORKING WITH HEALTH SERVICES, TO IMPROVE THE WELLBEING AND QUALITY OF LIFE OF THE PEOPLE THEY SUPPORT.

Have you heard that clucking sound recently? It's the sound of chickens coming home to roost. If you cut local authority social care budgets (to the tune of over £3.5 billion over the last four years according to the Association of Directors of Adult Social Services), at the same time as you let GPs skip weekend care and neglect other pre-emptive services like NHS 111, and you couple this with rising demand, then pressure builds up elsewhere in the system.

The pressure has been seen most acutely over the past few months in accident and emergency (A&E), with visits in England increasing by more than 400,000 so far this financial year, and waiting time performance slumping to its lowest level in a decade.

As Simon Stevens, Chief Executive of NHS England, and his partners have acknowledged in the Five Year Forward View, this way of working is simply unsustainable. Hence the plan over the next five years is to place much more emphasis on prevention, so that people are supported in the community, health and care services are much more integrated and there is less strain on acute services.

Social care providers are reporting that getting NHS Trusts to see what they can do to support the integration agenda, and to work in partnership, has been a frustrating experience, with >

➤ offers of help falling on deaf ears. It doesn't need to be like this, and there is mounting evidence of the way in which providers across the private and not-for-profit sectors around the country are taking the lead in driving these new models of care.

PROVIDERS DRIVING INTEGRATION

At a basic level, providers are quite simply going in and sorting out issues that are leading to delayed hospital discharge. Langton Care, a small provider working with older people in Devon, is a good example. In one case, a service user had been in hospital recovering from a hip operation, and there appeared to be conflicting information as to why their transfer to residential care was taking so long. With the family's permission, the Managing Director of Langton Care, Christina Sell, went to the hospital and resolved four separate – and as it turned out, easily resolved – issues that were preventing the service user from leaving.

The first issue stated was that the person could not be moved because of constipation: Christina explained that they could manage this in the home. The second issue given was that the person needed a particular kind of bed – again, one was already available in the home, but no-one in the Trust had thought to ask. Thirdly, there was a delay because medication had not been sent up from the Pharmacy, so Christina went to the Pharmacy to collect it. Lastly, there was no available transport, so Christina arranged for this and the patient was discharged to Langton Care the following day. The Discharge Sister was apparently amazed at how quickly they could react to each and every problem presented.

In Christina's view, 'On many occasions, as responsible providers and as people with a working knowledge of how the NHS and social care systems work, we have been able to cut through red tape, reduce lost bed days in hospital and provide the service user and their families with a service which they had chosen for themselves.'

Similarly, in Shropshire, Coverage Care, a not-for-profit organisation with residential and day services for older people, works closely with the NHS, either through clinical

commissioning groups (CCGs) or more directly, in terms of clinical support for individuals, with acute, community and mental health trusts.

Coverage Care works with its local acute trust with referrals from 'trusted assessors'. The aim here is to discharge to assess and move through the re-ablement process to enable a planned return home without an unnecessary long-term admission to a care home. Both Telford and Shropshire have witnessed a significant reduction in permanent admissions to care homes this year as a result of this and other initiatives. As David Coull, Chief Executive of Coverage Care, said, 'The reality is that all social care is local, and the better health services are managed locally, in partnership with the same local social care services.'

PREVENTING ADMISSIONS

This isn't just about proper care of people leaving hospital. Providers have been working for many years to prevent hospital admissions in the first place. For example, Coverage Care has used this approach for more than five years, especially for people with dementia, working with a local consultant psychiatrist who spends an agreed amount of time, with his team, in Coverage Care's 75-bed nursing home.

At the same time, they work with a modern matron who completes a weekly visit for any resident at the home who is unwell, spends time with the residents and prescribes antibiotics and other drugs as needed. Both projects have worked well and have been supported through the local CCG.

Likewise, Nightingale, which provides residential care for older Jewish people in South London, has been funded through its CCG for medical services to be provided on-site, rather than having to pay for GPs to come in, as had historically been the case.

A nearby practice provides a doctor who attends five days a week, a senior nurse practitioner, and a practice manager, who handles the administration. The CCG also funds on-site pharmacy services, which sit alongside audiology, dental services and occupational therapy. All residents are seen in the



privacy of their own rooms. The outcomes have included lower rates of hospital admission and much faster hospital discharges. There is a huge advantage for the home through having the ability to ask a GP to attend multi-disciplinary team meetings for all their residents.

Leon Smith oversaw the introduction of these services as Chief Executive of Nightingale. In his current role as Executive Vice-President, he notes that as well as being much better for residents, 'we are saving local hospital and community services a significant amount of money, and the overall service is a good example of how integrated health and social care can work.'

It's true that Nightingale has a large number of beds, and is based in a relatively wealthy part of the country. But working in areas of deprivation and in challenged health economies, or being a smaller provider, needn't preclude you from working in similar ways.

Community Integrated Care, for example, is working with Salford Royal Hospitals and University Hospitals of South Manchester on two Intermediate Care schemes, and with Mersey Care Mental Health Trust on a new service designed to ease bed blockages.

The Royal Masonic Benevolent Institution (RMBI), in its homes in Leicester, works closely with local GPs to get advanced agreed plans of care in place to help prevent hospital admissions. In Porthcawl, the RMBI is piloting a scheme with the NHS in Wales to help reduce unnecessary hospital admissions out of hours, as this is often when people are sent to A&E by covering GPs. They will connect directly with a central hospital, where a consultant will see the person via video link and have access to their observations. They will then be able to decide whether they do, in fact, need hospital treatment or whether they can remain in the home with appropriate care.

Finally, Marches Care, a residential care and specialist nursing provider in a predominantly rural area, works closely with local CCGs and trusted assessors, and has agreed protocols in place for shared assessments, to reduce any potential delays in admission.

PRACTICAL STEPS

All this is at odds with the commonly reported story of social care being a 'major cause' of A&E problems. It deserves to be more widely reported, and more widely promoted by the social care sector. If you'd like to do this, if you'd like to build better links with your local health economy, or if you're having problems, there are things you can do:

1. Engage with your local CCG(s), NHS Trusts and other system-wide groups – and just persevere until you find an ally.
2. If you're a smaller provider, think about building alliances and partnerships with others in a similar position, so that, for example, you might share on-site medical services.
3. Concentrate on building relationships: getting things done often depends more on relationships, trust and commitment, and less on formal structures.
4. Work with your local care association if they are involved in discussions around integrated services.
5. Social care has long been a source of innovation and community links – don't be nervous about bringing your ideas to the table and promoting them locally.
6. Local promotion also means going to your local Health and Wellbeing Boards, council leads, MPs and local media.
7. Think about developing your staff teams to work across systems and sectors. Collaborative skills are becoming more and more essential.
8. See yourselves as part of the collective leadership of the system in your area, as well as leaders in your own services and organisations.

At the Leadership Centre, we want to help to change the narrative around the role that social care is playing in integration, and the positive effect that good providers can have. If you have your own examples that you'd like to contribute, or if you'd like to find out more about what other providers are doing, please get in touch.

The more positive stories we can tell, the better.

CMM

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For further examples of integration in practice, to submit your own or to join the debate, visit www.caremanagementmatters.co.uk

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PETE CALVELEY

Pete Calveley is Chief Executive Officer of Barchester Healthcare.

REFLECTIONS ON THE LAST DECADE

Over the last decade, Barchester has grown significantly and now runs more than 200 homes, as well as seven hospitals, and employs 17,000 staff. Despite difficulties that have affected the sector in the last decade and public funding constraints, Barchester has been able to find ways to continue its business growth. Looking back, I think Barchester has demonstrated that it is an organisation focused on quality of care and shows that a company can develop successfully by sticking to its core principles.

My own career has undergone a fascinating transition in the last decade. I was a GP and working in commissioning in a Primary Care Trust as Medical Director and Chair of the Executive Committee ten years ago and I am now working as Chief Executive Officer at Barchester Healthcare, a role I took up in June 2014. This transition from working in commissioning to working in the private sector has been a thoroughly enjoyable and stimulating experience.

PROJECTIONS FOR THE NEXT DECADE

The future of the sector looks to be hugely promising. Significant progression will be driven by the integrated commissioning and care agenda, which strives for a closer relationship between health and care services.

Care providers have the opportunity to play a key part in the integrated

solution and the changes should enable the independent care sector to actively participate in a much more holistic service to any given community.

Barchester is ideally placed, with its skill set and facilities, to support this agenda while at the same time further developing its own business model and growth. As a company, Barchester is a forward-looking organisation and we are keen to contribute and work on tailored care solutions where we have the expertise to do so.

INSIGHT

It's my firm belief that quality should always come first when running a business and this is at the forefront of my mind as I lead Barchester forward. The quality of service provided and the quality of your team are vital. Get those elements right all the time and your company will generate an excellent reputation, which will help you become the provider of choice, which will in turn lead to commercial success.

INFLUENCES

My father has been one of the biggest influences in my life. He was a professional engineer who later made the transition into management and became the Managing Director of Ferranti, the electrical engineering and equipment firm. Although it was a different sector to the one I went into, seeing my father successfully make this transition in his career showed me that

it could be done – and done well!

LESSONS

When I worked within the NHS management structure I went on a leadership course. It was a particularly memorable learning experience for me as the training sessions occurred a few times a year and were led by world-class leaders who shared some great advice. One word of advice that comes to mind is the importance of listening in meetings. People come to meetings with a purpose so it's essential that you listen carefully to everything others have to say.

These courses also exercised your lateral thinking and problem-solving abilities through scenario-based challenges. For example, you were asked, if you were planning emergency services what would you do if A&E was shut down and there were no ambulances? It's always useful to practise thinking in new and innovative ways and this was an enjoyable and challenging way to do that.

ADVICE

I'd advise others to listen to people who are trying to make a contribution. Try to get the best out of the people you are working with and make sure they feel engaged with what you are trying to achieve. When leading a team, it's essential to have your team's full support and that you clearly articulate your strategic aims.

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A person is walking a tightrope over a rocky mountain peak. The person is silhouetted against a sunset sky. The tightrope is a thin line extending from the peak towards the right. The mountain is rugged and rocky, with a peak in the foreground. The background shows a valley with rolling hills under a soft, orange and pink sky.

Special measures for adult social care

As part of its new regulatory regime, late in 2014, the Care Quality Commission (CQC) issued its first consultation on how a special measures regime may work in the independent sector. The consultation set out CQC's 'special measures' proposals for adult social care. Carlton Sadler explores concerns and potentially unlawful proposals contained within the consultation document.

Although the special measures document is only a consultation, it is concerning that the proposals within it are in some respects unclear and potentially unlawful.

WHAT DOES A SPECIAL MEASURES REGIME MEAN?

Although CQC is keen to use the term special measures across all sectors, it acknowledges the practical effect of such measures will be very different from its use for NHS trusts and foundation trusts. For adult social care (and, no doubt for the independent healthcare sector too), being placed into special measures is basically a case of being given a 'last chance to improve' prior to closure of the service.

So what does CQC's latest consultation say about



➤ how special measures will work for adult social care?

ENTRY POINT OF SPECIAL MEASURES

CQC states that services will enter into special measures in one of two ways:

- Immediately, if, on one of CQC's new comprehensive inspections, the service has an overall 'Inadequate' rating. This will occur if the service receives an 'Inadequate' rating for two or more of the five key questions - Is the service: Safe? Effective? Caring? Responsive? Well-led?
- After six months of continuing to have an 'Inadequate' rating for one of the five key questions – CQC states that it 'will carry out a focused inspection after six months. If the provider still has an 'Inadequate' rating for any key question following this focused inspection, they will be placed into special measures.'

This second limb raises two important questions. Firstly, there seems to be a lack of clarity in CQC's thinking around the timing of these follow-up, focused, inspections which could result in entry into special measures: the special measures consultation indicates that the focused inspection would have to be at least six months after the comprehensive inspection which resulted in an 'Inadequate' rating on one of the five key questions.

However, CQC's provider handbooks for adult social care services state that focused inspections will normally be carried out 'within three months of the date the provider said they would no longer be in breach of the relevant legal requirement.' Obviously, on that basis, the focused inspection may not necessarily be more than six months after the initial comprehensive inspection at which the 'Inadequate' rating was given.

Secondly, CQC's consultation states that special measures will be triggered if the provider 'still has an inadequate rating for any key question'. Although CQC focused inspections do not look at all five key questions, it appears they can look at more than one. As such, it would appear (although it is not altogether clear) that a rating of 'Inadequate' against any of the five key questions at the time of the follow-up focused inspection will result in special measures, even if it was a different question which was rated as 'Inadequate' at the previous comprehensive inspection.

There is, therefore, a lack of clarity in the consultation as to what will trigger entry into special measures under this second limb.

DURING SPECIAL MEASURES

The theory behind special measures is to give providers a clear timeframe in which to improve the quality of their services. CQC states that 'the process will enable the provider to implement a

credible improvement plan within a fixed time period and avoid enforcement action by CQC.' However, again, CQC's proposals are not altogether clear as the consultation goes on to state 'when a service is placed into special measures we may also take other enforcement action against the provider'.

As a general principle, however, it seems that the special measures process is meant to give providers a 'last chance to improve' before CQC takes action to close poor services. During this time, the provider will need to implement a credible improvement plan. In addition, the CQC consultation states that it will 'signpost providers to potential improvement agency support (where they exist)'. It is unclear, however, precisely what forms of 'improvement agency support' CQC is referring to. In particular, who might these agencies be; what authority over a provider will they have; and what responsibilities will they have in terms of reporting lines to the provider, or to CQC?

REVIEW OF SPECIAL MEASURES

CQC's proposals state that, after a service has been placed into special measures, a further comprehensive inspection will be carried out within six months. This is the review stage and, at that stage, CQC states that there are three possible options:

- If sufficient improvements have been made so that the service no longer has any 'Inadequate' rating against any key question, the service will come out of special measures.
- At the other extreme, if there is insufficient improvement, CQC states that it will proceed to the end point of special measures, i.e. closure of the service.
- As a middle ground, if there has been some, but not enough, improvement, services may be given a further six months to improve before yet another comprehensive inspection is carried out and a decision made whether to take the service out of special measures or proceed to closure.

However, in this 'middle ground' scenario, it appears to be envisaged that, even though it will schedule a further comprehensive inspection, it will still initiate the legal process of closure by issuing a Notice of Proposal to cancel registration. The flow diagram within the consultation makes it clear that, in such a situation, CQC would not make a decision on whether to adopt that proposal, i.e. would not serve a formal Notice of Decision to cancel registration, until the outcome of the further comprehensive review inspection was known. It appears, therefore, that in this 'middle ground' scenario, CQC would be serving a Notice of Proposal to cancel registration in a situation where that proposal is dependent on the findings of the next comprehensive inspection. Obviously, at the time the Notice of Proposal is issued, neither CQC nor the provider would know the outcome of the forthcoming inspection and this would seriously impact upon the provider's statutory right to make ➤

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➤ representations against the cancellation proposal. It is questionable, therefore, whether initiating enforcement, by serving a Notice of Proposal on such a contingent basis, would be a lawful step for CQC to take.

END POINT OF SPECIAL MEASURES

It is clear that the proposed end point of special measures, for services which do not make sufficient improvements, is for CQC to close the service. However, even here, the language CQC uses in its consultation proposal is unclear and unhelpful. CQC talks about the end point of special measures being 'cancellation' of registration. However, for providers operating from more than one site, it is presumed that CQC will take action by removing the relevant location from the provider's registration(s), rather than cancelling the registration(s) altogether. Again, however, the lack of clarity in the CQC consultation upon this is unhelpful.

LIAISON WITH COMMISSIONERS

There is a further lack of clarity in CQC's proposals with regard to the timing of its liaison with commissioners about any services placed into special measures. In the introduction to the consultation, CQC talks about engaging closely with commissioners, to enable continuity planning for services, 'where, following the start of special measures, cancellation of registration is considered'. This would suggest that such engagement with commissioners will only take place where CQC has not noted sufficient improvement at the review

stage of special measures. However, at page three of the consultation, CQC states 'when a service is placed into special measures we would liaise with the local authority and the clinical commissioning group so that they can begin planning for service continuity.'

There is clearly a concern that such liaison between CQC and commissioners could jeopardise further placements at the service and, therefore, render struggling services even less viable. There is also a real risk that CQC and commissioners will pre-judge the outcome for expedience rather than give the provider a genuine chance to improve. It is, therefore, imperative that CQC is clear as to precisely when such engagement with commissioners will take place and as to what commissioners are told about the status and impact of the special measures regime on the service. The lack of clarity in the consultation document regarding these matters does little to provide reassurance as to how and when such issues will be discussed with commissioners as and when the regime goes live.

CLARITY AND FAIRNESS

As set out, there are real concerns regarding the lack of clarity and, in some cases, the lawfulness of the proposals within CQC's special measures regime for adult social care. By the time you are reading this the consultation will have closed and we will need to see how CQC responds to that process in order to inject more clarity and fairness. The CQC expects to publish final special measures policy for adult social care in March 2015.

CMM

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To read CQC's proposals for special measures in adult social care visit www.caremanagementmatters.co.uk



BUILDING FROM THE BOTTOM UP

Guy Dewsbury explores the benefits of building person-centred service delivery from the bottom up, the importance of equipping and valuing staff to have more control, accountability and to deliver the services everyone wants within current constraints.



Building efficient and quality care services from the top down can be tough. Staff work at the service delivery end and are a company's most important asset. They can be the key to ensuring that service users receive good quality, person-centred care, whilst organisations increase their efficiencies. However this can be a step-change and it's not always easy to build services from the bottom up.

BENEFITS OF A BOTTOM UP APPROACH

Rethinking how people are cared for is an increasing concern. Traditionally, health and social care are managed from a top down approach as advocated by the Care Quality Commission, employing strong management

techniques. The Care Quality Commission's *State of Health Care and Adult Social Care in England 2013/14* report highlighted that, 'Strong, effective leadership at all levels is vital. We have found in our more rigorous inspections that "well-led" drives up quality and safety.... Good leadership is vital' in which 'Leaders at all levels should develop a culture of support, openness and learning.' The drive for a person-centred approach to care is central to common visions, as is the reduction on spending and other economic drivers which mean producing more output for less and with less.

If the person-centred approach is to benefit everyone, then it is required to be responsive to the ebb and flow of people's needs which change regularly. Top down management techniques can make it more difficult to be person-centred as all changes require higher approval. This >



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➤ approach can be sluggish and can lead to extra health costs in the long-run to correct something that could have been prevented.

Frontline staff are the people that know about those who are cared for. The day-to-day management of the people in their care results in the frontline staff being the first people to be aware of small changes to someone's condition. The accuracy of the report to senior staff could be the determining factor of whether the person receives further additional support.

The question for providers is how they allow care staff the ability to care and have control over the care process without diminishing the management role. The bottom up approach allows for flexibility to delivering care needs within an organisation.

EQUIPPING STAFF WITH MORE CONTROL

Delivering care relies on care staff following each person's care plan. Care plans should be regularly updated to reflect the current situation of the people in their care. Often though, in reality, care plans can be outdated. This can be due to many factors. One method of ensuring care plans are up-to-date is through the use of technology. Electronic care plans can be based directly on the observations and experienced assessments of frontline staff. This means that as a person's needs change the care plan can be modified accordingly. Here, the frontline staff are, in many ways, the best people to manage day-to-day care.

The current state of mobile working or working with technology provides work stations where staff can access care data and update notes on the people in their care. These stations can be mobile but are often static in offices. Therefore, care staff must retain key information until they can get to a work station to upload it. The difficulty with this is that care staff are always busy and will often have numerous other things to do before they sit down and update records. In this time, valuable information could be lost and the new needs of a person might not be updated.

A further issue is that the care plan directs the care the person receives. If it is outdated, the frontline staff could be providing inappropriate care to a person with negative consequences. A system that provides real time care records which can be updated on the go by frontline staff is a possible new strategy that could be deployed. The solution is required to be easy to use by all staff and have a quick method of data entry and feature all the care plans. Laptops and iPads could be used to transfer this information but

these are bulky. A possible resolution for this is the mobile smartphone.

ACCOUNTABILITY AND SERVICE DELIVERY

When frontline staff are working they are accountable for all they do, including reporting change. They require a method to evidence what they have accomplished with the people in their care and what requires modification. Having the ability to note down changes whilst in situ means that information is recorded immediately and can be accessed by managers and other health or social care professionals.

Managers also need to know where their staff are and what they are doing, this is a relevant in large care settings as it is in home care and community-based support. Having a smartphone-based programme, in real time, allows the managers to be kept up-to-date on all their staff. The software could also help with reports and handovers ensuring the most up-to-date information on each person being cared for is available to the frontline staff coming on shift.

The use of a system like this relies on a new management style in which frontline staff are valued more and have a greater influence over the care pathway. As a result managers are provided with clear, current, accurate information on all the people in their care. This locates the frontline staff and the person being cared for at the top of the pyramid and the higher echelon lower down. Effectively it inverts the current care pathway, but potentially achieves a better quality of care, as frontline staff are not required to spend time updating records in an office because they are updated on the go.

MANAGING CHANGE

Managing change is never easy, and staff need to be valued and empowered in any change situation. The Care Quality Commission suggests that social care providers should, 'Recognise and value excellence in all staff, especially those in professional or leadership positions. By recognising the contribution of, for example, registered nurses in nursing homes and excellent registered managers in any service, supportive systems can start to attract, and critically retain,

excellent staff in these positions. Stability and professionalism will help to improve care.'

Whilst these values are excellent, they could be extended to explore the role of other frontline staff and the use of these staff in the maintaining health and care of people. This might appear daunting to providers as this means moving responsibility of real-time reporting and changes to care planning from the top to the bottom takes a high degree of trust. Through placing responsibility on the people in the frontline, the management are demonstrating their respect for the staff. It also ensures all staff are correctly trained to perform these duties.

Risk mitigation is a management concern with a bottom up approach and clear monitoring is essential to ensure any changes are authorised, highlighted by the system, followed up with case conferences, face-to-face or telephone conversations with the person to ensure they are in their best interests at all time. The core value of allowing people in the frontline to make alterations is that it saves time and money as well as adds a level of respect to the staff undertaking these duties.

The Care Quality Commission also says that, 'Leaders at all levels should develop a culture of support, openness and learning. Welcome feedback on the service you provide and treat it as a free source of intelligence that can help you improve... Offer support to staff who are trying to do the right thing in often difficult and stressful environments, and enable them with the skills and the emotional support to do the job with compassion.'

The first steps include ensuring you have the correct systems in place.

TECHNOLOGY CAN HELP

Taking a bottom up approach to care in which frontline staff have the ability to modify care in situ is daunting to many but can be a step closer to making care person-centred. The correct technology can facilitate this change and enhance the care of people and ensure staff are better appreciated for the skills they demonstrate. Empowering frontline staff with technology can mean more appropriate, timely care and a more resilient workforce who are happier as their worth is valued.

CMM

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To read about mobile care monitoring in practice and to access CQC's *The state of health care and adult social care in England 2013/14* report visit www.caremanagementmatters.co.uk

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- Independent care providers; and
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- Rehabilitation centres.

PRODUCTS

- Nursecall systems;
- Staff safety systems;
- Dementia systems; and
- Disabled toilet alarms.

COMPANY PROFILE

Intercall Launches the Touch Series. As market leaders in the design and development of nurse call systems, Intercall is committed to learning, adapting and improving the level of care and security within the care sector. The new Touch series has been developed in consultation with the sector, using experience and learning from previous systems.

Building on the technology of Series 600 and 700, one of the Touch Series key features includes

the use of Radio Frequency Identification (RFID). Intercall is leading the industry with the use of RFID to identify staff and their actions. This data can be logged and accessed by managers, giving them an insight into staffing levels and average call response times. Using this intelligence, managers are able to set staff performance indicators and ensure that staff receive the support they need at all times.

The launch of the Touch Series follows a period of extensive research and design development. The result is a family of products that look as good as they work.

Simon Hardy, Managing Director of Intercall said, 'We've listened to customer feedback and developed a range of products that can be both hard-wired or use web-based technologies. We believe the Touch Series reflects the needs of modern health care providers and it is future-proofed for the 21st Century. We're excited about the new Touch series and can't wait to hear what our customers think of the new range.'



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All of Agora's titles offer practical solutions plus forms, templates, sample policies and checklists which can be implemented immediately. We seek writers, ideally who have successfully managed elderly care

services to provide practical, actionable tips and advice on how to improve care quality within care homes, palliative care services, dementia services and domiciliary care services.

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- NHS wards.

PRODUCTS

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- Automatic staff monitoring;
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- Enterprise resource planning;
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- Frail elderly;
- Supported living;
- Learning disability homes; and
- Mental health.

PRODUCTS

- Evidence of care;
- Mobile care monitoring; and
- Integrated care planning.

COMPANY PROFILE

Care staff use Mobile Care Monitoring to evidence care for service users. It is an intuitive and easy to use application that works on lightweight, robust devices, which gives staff all the information they need to care for service users and allows them to quickly evidence the care that they deliver.

The system has been specifically designed to give carers more time to spend with service users. As daily records are written with a few taps on the device, the entire shift can be spent delivering care. The app uses pictures to guide people through each care note that they enter, making it very easy to use for non IT literate staff. As carers evidence care, all the charts and reports are automatically updated, without anyone having to fill in any additional paperwork. With less paperwork to complete, care staff are under less pressure and service users receive a better quality of care.

Every carer can see what others are doing during their shift. Flags are shown to indicate if important

actions are overdue or about to be missed, ensuring important care interventions are not missed. As care is evidenced as it is delivered, all carers are able to see exactly what happened before they came on shift. Mobile Care Monitoring helps staff support each other by making everyone aware if an individual has not received their planned care, or if they are unhappy. The monitoring system displays everything that can be seen on the care delivery devices to managers.

Setting up the system requires inputting a few pieces of information for staff and service users. Service users are placed into any number of totally flexible communities, onto which is overlaid comprehensive staff-based security, ensuring people can only see the individuals they should. Every staff member has a secure log-in, so no-one can impersonate anyone else and it's easy to see who has delivered care.



CARE SHOW BOURNEMOUTH



25/26 March, Bournemouth International Centre, Bournemouth

The Care Show returns to the Bournemouth International Centre (BIC) on 25th and 26th March for another packed event, a one-stop forum for those involved in the social care. For the first time CMM is putting together the seminar content in the theatres. Based on the Care Show's research into the information needs of the sector, *You talked, we listened*, the CMM-led programme will cover all aspects of owning and operating a social care business.

CMM SEMINAR THEATRE

This year's programme will deliver solutions to the sector's key challenges as well as insight into developments and regulatory changes which are likely to affect providers. Speakers and presentations include:

- Alison Murray, Head of Inspection (South Coast) at the Care Quality Commission will discuss the changes to regulation, the new quality ratings and other regulatory considerations.
- John Lucas, Partner at Hazlewoods Corporate Finance will give attendees an insight into funding strategies and alternative sources of funding.
- Recruitment and retention is an ongoing issue for the sector and Neil Eastwood, founder of Sticky People will share his expertise on the subject of finding more, and better, frontline candidates.
- Sandie Sims, Joint Dementia Quality Lead Care Homes at Dorset Clinical Commissioning Group will discuss best practice for dementia care in the community – how care providers can integrate better with the community.

POLITICAL DEBATE

New for *Care Show Bournemouth 2015*, local MPs will discuss their proposed plans in *The Big Political Debate - The Political Parties Share Their Vision for Care*. The Big Political Debate will give delegates the opportunity to be heard by posing questions to the panel.

With a General Election in May it is the ideal time for providers to interact with politicians and try to raise social care's standing in the election campaign of the main political parties. The debate takes place at March 25th and care providers as well as visitors are invited to not only attend, but also actively participate and contribute to the shared vision for care that organisers are championing.

EXHIBITION

In addition, *Care Show Bournemouth 2015* will also give attendees the opportunity to source new or alternative products from over 150 suppliers. Filling both halls at the Care Show Bournemouth, participants featuring innovative products for care include: Intercall – profiling a new and advanced care home monitoring software, Advanced Health & Care, Aidcall, Care England, Care Quality Commission, Clydesdale and Yorkshire Banks, Person Centred Software, Skills for Care and many more.

For full details on who is exhibiting, products on show and all visitor attractions, plus to register to attend, visit the Care Show's website

www.careshow.co.uk/bournemouth



'This is my first visit to the show and aside from viewing lots of interesting products – I've also found the education sessions very, very useful and been able to absorb a number of messages from them, including financial/capital allowances best practice. I'll be back again tomorrow for another full and beneficial day!'

John Timbs, Managing Director, Lodge Care Group UK



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WHAT'S ON?

Event: Care Showcase 2015 – Challenges and Opportunities of Working Together
Date/Location: 18th March, Brighton
Contact: Lisa Mack, Event Coordinator, Tel: 07779 584397

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Media Partner

Event: Sheltered Housing Conference
Date/Location: 20th March, London
Contact: Capita Conferences, Tel: 0870 400 1020

Event: Care Show Bournemouth
Date/Location: 25th/26th March, Bournemouth
Contact: The Care Show,
Web: www.careshow.co.uk/bournemouth

CMM
Media Partner

Event: Improving Dementia Care
Date/Location: 26th March, London
Contact: Capita Conferences, Tel: 0870 400 1020

Event: The Gold Standards Framework Centre 'Celebrating Best Practice' Conference and Awards Ceremony
Date/Location: 27th March, London
Contact: Gold Standards Framework Central Team,
Tel: 01743 291892

Event: Care and Support West Spring Conference
Date/Location: 30th April 2015, Bristol
Contact: Care and Support West, www.careandsupportwest.co.uk

Event: NICE Annual Conference
Date/Location: 12th/13th May, Birmingham
Contact: NICE, Tel: 0845 056 8339

Event: All Together Now! Breaking the Boundaries of Care
Date/Location: 29th May, London
Contact: Care England and Royal College of Nursing,
Tel: 0207 492 4840

Event: Health+Care 2015
Date/Location: 24th/25th June, London
Contact: CloserStill Media, Tel: 0207 348 5261

CMM EVENTS

Event: 3rd Sector Care Awards
Date/Location: December, London
Contact: Care Choices, Tel: 01223 207770

Please mention CMM when booking your place.

CMM's regional care conferences will return in 2015.

Visit the events page at www.caremanagementmatters.co.uk to keep updated on developments.

STRAIGHT TALK

Martin Green explores
the accident and
emergency crisis and its
repeating patterns.



Once again this year we have been beset by headlines about the accident and emergency (A&E) crisis in our acute hospitals. Every year we have the same repeating story of A&E departments unable to cope with demand and waiting time targets not being hit.

This year was particularly interesting because the pressures were supposed to be worse than they had ever been before, and yet we are not in the grip of a severely cold winter, we have not seen an unusually high level of flu, but we are still mired in the problem.

It is my view that some of this derives from the way in which the system separates out the funding of health and social care and has not recognised the realities of the 21st century; where much of the population are older and living with multiple conditions. The health service is built on a 20th century model of diagnose, intervene, and cure, this model is no longer fit-for-purpose, and we have to think

differently about how we ensure people live well with their long-term conditions.

Long-term care is largely the preserve of the social care system, and yet the Government has protected NHS funding at a time when we have seen dramatic cuts in social care budgets. It is also interesting to see the way in which the bad behaviour of the NHS is constantly rewarded by more money being put into the system. Rather than looking for the cause, the Government rewards the NHS for having a crisis.

The Secretary of State announced that he was putting an extra £750 million into the NHS, but there was no clarity about how this money should be used to solve the problem, and in many cases, acute hospitals just opened more beds, and expanded, rather than solved the problem.

Social care is the answer to our problems in health. Every year we have been going to the Department of Health (DH) and the NHS, telling them that we have the solutions to their problems, asking them to engage with us and hoping that they will see the logic of using services that can offer better outcomes to patients, and more value to the taxpayers. Every year we hear the same platitudes, but we do not have any different approach to forward planning. This year the DH has finally engaged with us, now we are in the midst of the crisis, but if they had talked to us when we wanted to talk to them, 10 months ago, there probably would not have been a crisis.

I am a firm believer that there is a need for culture change in the NHS. Every reorganisation costs the taxpayer millions and results in new structures, reconfigured offices, endless amounts of money being spent on infrastructure, but here is the problem, they just recycle the same people and move them from one desk to another, and having done that, they fail to understand why they still have a problem.

The question I want to ask is, why, if these people are so good, were they incapable of finding a solution to the

problems of the interface between health and social care years ago. It is ludicrous to think that just by giving a new job title, a new job description and a new office, people will suddenly be capable of coming up with a new solution. The NHS is in serious need of fresh thinking and people who are prepared to challenge its power elites and put citizens at the centre of the service.

A good example of the way in which power elites are not being challenged, is the fact that one of the reasons why there is pressure on the acute sector is because GP services are so difficult to access. At any point when the Government wants to get a GP to do anything, the default response is to pay them more. This certainly does not happen with the rest of the private sector that works in health and social care, and governments are very eager to try to force more and more out of their contracts with social care providers, but they fall shy of addressing the problems in GP services. GPs are private contractors to the NHS and it is time that the Government started to require them to deliver a 24/7 service.

I am always mildly amused when people talk about 'out of hours' health services because illness does not fall into a 9 to 5 pattern, health emergencies happen around-the-clock and we should have a system that is geared up to that. If you can have 24-hour services in other sectors, I think we have a right to expect it from health and social care, particularly because as taxpayers we are putting over £120bn a year into the system.

I am sure many will see this as a heresy, criticising the NHS, the sacred cow of our system. I am absolutely committed to a high quality health service, but it must be fit-for-purpose and fit-for-the-future and that requires us all to understand that we must work differently. The NHS must change its culture and share its resources with social care, it is only by changing culture, and the way we work together that the NHS will serve us in the future, as well as it has served us in the past.

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Do you agree with Martin? Join the debate at www.caremanagementmatters.co.uk

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*Pricing shown is ex VAT, for the Sky in-room package. Customers will be billed monthly and installation costs apply. **Over 65s Sky TV viewing statistics based on Sky IQ data, April 2014. †Sky Box only free where Sky installs your equipment. Charge of £50 per box (plus VAT) if Sky does not install your equipment. Installation of equipment is not included, please call for more information. Free box offers not available if you have previously had such offers. 12 month minimum term for Sky TV and WiFi. Both in room and lounge packages available. Channels available dependant on chosen package and scheduling may be subject to change. Some content/channels unavailable in communal areas. As at the date of print, channels not available in communal areas are: Ailbhi, G.O.L.D., Watch, Star Gold, Star Life OK and Star Plus. #WiFi availability subject to location. WiFi pricing subject to survey. Set up fee applies. †Free £500 voucher for Oomph! is available as part of the Sky Lounge package. Further terms apply. See voucher for details. Calls cost 5.1p per minute (plus 15.97p connection fee) for BT customers. Calls from other providers may vary. Correct as at 11 December 2014.

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