Report title: Enhanced Care Home Model Overview

Report to: Health, Schools and Care Overview and Scrutiny

Date of meeting: 31st July 2024

Cabinet Portfolio Holder: Cabinet Member for Adult Care and Wellbeing

Report of: Hayley Ashall, Assistant Director Adult Social Care Commissioning and Prevention

Public or private: Public

Key Decision?: No

Published on the Forward Plan: No

1. Report summary

1.1 The NHS Long-Term Plan sets out a commitment to rolling out the Enhanced Health in Care Homes (EHCH) model. To deliver on this locally in 2023/24 and 2024/25 the council have an established Enhanced Care Home Model Programme which primarily focussed on engaging with stakeholders as system buy in is critical to delivering change.

1.2 The enhanced care home offer focuses on developing a variety of interventions, services and support that care homes can deliver either themselves or access from system partners to ensure that residents have the care they need to stay well.

1.3 A core aspect of this will be the feasibility of a service owned, led and delivered provision in borough to care for those living with dementia. The aspiration would be for this provision to be the centre of excellence for dementia care and help define the quality of care for other providers in borough ensuring equal opportunities in care experience.

2. Recommendations

2.1 For overview and scrutiny to review the content of the report and support the programme of work.

3. Reason for recommendation

3.1 The national Enhanced Health in Care Homes (EHCH) model sets out guidance around ensuring and driving up quality and an enhanced care offer locally for people using services. The Enhanced Care Home Model and detail within this report outlines how locally the outcomes will be achieved.

3.2 Adult Social Care like other services are faced with managing demand and where possible meeting the needs of people in borough, which is often better for the person, their carers and loved ones, importantly also helps protect the public purse. Given the unprecedented and continued need for dementia care, it makes sense to look to build the council's own provision.

4. Alternatives considered

4.1 The alternative is not to develop a system Enhanced Care Home Model to drive up quality, outcomes for individuals and equitability of services across the borough. In addition, not to meet the projected demand for services in borough therefore continuing to send people using services out of bough which is often more costly.

5. Key information

5.1 Rochdale Borough Council at the time of writing this report commission care beds from 54 residential social care services across the borough of Rochdale. 412 nursing beds from across nine homes with nursing services (total includes four dual registered care homes offering nursing and residential services). With 1152 residential beds across 45 care homes without nursing services. This is more than the total number of Northern Care Alliance hospital beds across their four-locality footprint in Greater Manchester (GM). Alongside residential and nursing bed based support the service commission 61 community based services who deliver supported or independent living, outreach to enable people to live independently or deliver care in a person's own home.

5.2 All commissioned care both in and out of borough is quality assured however; greater emphasis understandably is focussed on the care in borough where most Rochdale residents live and receive care. There are a range of inspection outcomes awarded to the care provision from the CQC mainly either requires improvement or good with a handful of outstanding provision.

5.3 Care providers are currently feeling the strain as demand continues to grow at an ever-increasing rate as a result of an ageing population, covid impacts and deconditioning in hospital and discharge pressures. The sector continues to face challenges regarding the impact of the cost of living crisis, recruitment, selection and retention, and there continues to be a shortage of good quality provision for people with a complex presentation across the sector.

5.4 The Care Quality Commission (CQC) recently remodelled their assessment process with a new single assessment framework, replacing previous numerous key lines of enquiry, instead using core quality outcomes. Both onsite inspectors and remote assessors to measure CQC's continued use of key questions including rating of safe, well led, effective, caring and responsive service delivery for people using services, assess the quality outcomes, or statements. For the first time in years, the inspection regime will also span the Local Authority. It is likely rather than one full inspection it will mean ongoing assessment and interaction from the CQC with providers, similar to the approach the Rochdale's ASC Quality Assurance Officers

(QAOs) and wider commissioning team have taken over recent years. As this is mirrored in the current quality assurance process, the QAO team is likely to adapt quickly. However, this change in inspection / assessment regime will mean further pressure and learning / development for providers and services. On top of bedside care, home visits and medical processes, staff working for care providers are often burdened with a number of time consuming administrative jobs, including updating Medication Administration Records (MAR) sheets and managing patient files. Although necessary for CQC compliance and resident safety, these tasks can cut into the limited time staff have for face-to-face care with residents. There are ongoing regular 'asks' of providers locally and nationally to provide details on capacity and core information. This is critical to market management and ensuring sustainability, although adds significant pressure on an already over-stretched provider resource. One way to maintain productivity levels, and still allow time for effective care, is to introduce digital technology. Technology Enabled Care (TEC) could be explored but will come with a financial cost.

5.5 Delivering quality care is and remains paramount for all providers, although is increasingly difficult to achieve when the workforce, leadership and management capacity is pulled in a number of directions. To ensure and aid this work locally, a number of things have been implemented, including bolstering the quality assurance function and wider training and development. The introduction of a dedicated Care Market Training Coordinator brings a new level of support to providers by effectively sourcing training and development opportunities. A review and refresh of the outcomes framework, quality checklists and process has been undertaken and working with providers to improve. Regular provider engagement to hear from providers, address challenges and barriers but also share core leaning / good practice.

5.6 Workforce challenges are likely the most significant and apparent challenge for providers, with further impacts and considerations highlighted below.

- **Care provision pay rates** – these are often lower than other sectors. For instance, retail industry pays more per hour, and it could be argued the work is not as intensive or demanding. Historically, the NHS has paid their non-qualified staff more than social care providers, and is potentially perceived as a 'better' career path. This substantial competition for care providers leads to difficulty in attracting and then retaining staff.

- **Workforce retention** -once the right staff have been recruited, an ongoing challenge for providers can be retaining valuable employees. As above, care workers may be attracted by other industries or move to another care home or care provider when terms and conditions appear favourable. Skills for Care research shows that circa 67% of recruitment in the social care industry is from other roles within the sector. This means that employers who are able to foster high levels of employee satisfaction could benefit from improved retention levels among staff who have a strong passion for providing outstanding levels of care.

- **Workforce burnout** – providers have fed back that care workers are 'burnt out' having worked longer hours, increased number of shifts and dealt with heightened pressure that has gone beyond the pandemic. Staff shortages result in further pressure on existing workforce. Research shows that a high proportion of carers will also be impacted by the cost of living crisis, again possibly leading to further stress to the workforce. This can lead to a sense of disenchantment in current role, increased absence through sickness as well as the possibility of staff becoming so disenfranchised they leave the industry altogether.

- **Workforce sickness** – providers have reported higher levels of unexpected absence and sickness. This was impacted by the pandemic, seasonal flu and sickness type bugs, meaning staff have to take time off. Some care workers cannot afford to be off and will attend work when unwell passing illness to colleagues and risking the health of the people they support. .

- **Cost of agency staff** – it is not uncommon for providers to utilise agency staff when their own workforce is depleted. Unfortunately, the pool of candidates on the agency books is also shrinking, and means the cost of agency staff is been driven to almost unaffordable levels.

- **Quality workforce** – it takes time to build a quality workforce, including time to release staffing to undertake training and development. Providers want to invest in their staff; however, this is often an impossible balance of prioritising delivery of services against releasing resource for training.

5.7 There are a number of activities underway to help support care providers face the challenges head on, and in turn, support the shaping and sustainability of the market place. As described the QAO provision has been expanded enabling the service to widen the scope of work also increase regular monitoring for all providers and working towards community based adult care settings receiving as much focus as the residential care sector. This continues to enable the team to build rapport and relationships with all commissioned providers, as well as their workforce. Which in turn aids identifying issues and concerns at the earliest opportunity and, in many cases, working with the provider to prevent escalation. QAOs work closely with providers to ensure a range of key performance indicators are met, including but not limited to, ensuring business plans are clear, processes are robust and business continuity arrangements are regularly reviewed.

5.8 Developing the quality assurance framework and contract monitoring process, collaborating with health partners to consider all intelligence and input to the process, will enable clear outcomes and expectations, aligned to the revised CQC assessment regime. ASC commissioning is developing a suite of market position statements and commissioning intentions, these will help describe and define what the current and future market place, provision and capacity looks like. It will also provide providers clear direction of need and future demand. This will help drive up quality of provision as well as help providers

to determine what level of staffing is required to ensure outcomes and care demands are met.

5.9 A number of workshops and meetings have taken place to understand better the challenges and opportunities facing care sector provision and support functions available. From those functions, it became very clear there is a shared aspiration by care providers to drive up quality of care, also shared by professionals, services and colleagues who work in and around that same care provision. Alongside this, there is strong support from ASC and commissioners, therefore, it was agreed that an 'Enhanced Care Home Model' should be developed for Rochdale council helping to define what best practice for care provision in borough should look like, and where collaboratively systems and services could come together to make that model a reality. This paper will outline the work to date as well as planned next steps for the Enhanced Care Home Model.

6. Enhanced Care Home Model

6.1 The NHS Long-Term Plan sets out a commitment to rolling out the EHCH model. To deliver on this locally in 2023/24 and 2024/25 the council have an established Enhanced Care Home Model programme which primarily focussed on engaging with stakeholders as system buy in is critical to delivering change. The enhanced care home offer focusses on developing a variety of interventions / services and support care homes can either deliver themselves or access from system partners ensuring residents have the care they need to stay well. A core aspect of this will be the feasibility of a service owned, led and delivered provision in borough to care for those living with dementia. The aspiration would be provision of a centre of excellence for dementia care, and help define the quality of care for other providers in borough ensuring equal opportunities in care experience.

6.2 As outlined above the care home sector is a key component of the care market across the borough, providing a 'stepped up' approach to how the council meet individuals needs that live in the community and at the same time ensures flow from mental health and acute hospital inpatient care. Care homes provide a home for a number of adults across the borough. Therefore, it is essential the quality of care provided, the environment, professional competence and skills, knowledge and expertise of staff are at an excellent standard. This standard of care can only be achieved through collaborative working between health, social care, voluntary, community, faith and social enterprise (VCFSE) sector and care home partners.

6.3 An Enhanced Care Home Model looks to move away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Care should be coordinated and consistent, with interventions offered as early as possible to meet the needs of individuals, improve outcomes and promote independence for people living in care homes.

6.4 There is a recognition across the local system that the current picture feels chaotic and uncoordinated, with a variation in skills, quality and approach. Meaning whilst the overall quality of care provided is good across the borough, the individual experience of living in a care home can vary. The focus is to develop new ways of working and explore new models of care delivery within our care home market to drive up the quality of care homes in the borough.

6.5 To support the development of an Enhanced Care Home Model, a series of system workshops have taken place to explore areas of best practice, identify barriers and challenges as well as develop key priorities to support in shaping the unified vision for enhanced care.

6.6 Key system partners included in the work to date are ASC (operations, quality assurance and commissioning), Rochdale Local Care Organisation, Primary Care, Heywood Middleton and Rochdale Integrated Care Board, Northern Care Alliance, Pennine Care Foundation Trust, Care Home Matrons and provider representatives. The partners helped identify what a model should include, along with highlighting barriers, challenges and core actions.

6.7 There was a shared view the Enhanced Care Home Model should build good practice locally, as well as taking learning from other areas of excellence including, but not limited to:

- Person centred, good quality care across the borough, which would be reflected in CQC assessment outcomes and quality monitoring.
- Neighbourhood approach to care delivery (with an inward and outward reach).
- Equability of offer despite location, condition or need.
- Equability of offer and support from wrap around services to all care homes.
- Training and development offer for care home staff to ensure shared learning, best practice and outcomes.
- Care home staff perceived as equal across the market and including by other health care professionals.
- Shared provider learning including when things go wrong, good practice and meaningful support of one another.
- System learning including willingness to hold the mirror up even when things outcomes have not been expected or not gone well.
- Clear expectations including from people delivering service, supporting services and those accessing services.
- Promotion of the wider offer ensuring those in the sector are aware of and feel able to access the benefits of the offer.

- Wider and inclusive offer of TEC.

6.8 The Enhanced Care Home Model vision is ***'****To drive up the quality of our care homes across the borough, ensuring consistently enhanced care, empowering individuals to achieve what matters most to them, enabling people to live well and age well in their home'.*

6.9 A suite of underpinning principles have been developed including:

a) Personalised care

- Centring the needs of the person through '*what is important to you'* conversations, ensuring the person has choice and is actively involved in shared decision-making, including about end of life care.
- Supporting people to talk about what matters most to them; encouraging and enabling them to take as much responsibility as they can for managing their own care, health and wellbeing.
- Supporting carers and a person's loved ones, recognising their needs as well as those of the person receiving care, and acknowledging them all as experts in their own care and lives.

b) Co-production, engagement and collaboration

- Acknowledging the value and expertise of the care home sector for all they do, including the significant level of healthcare delivered by social care staff, who work alongside the NHS as equal partners.
- Equal partnership between health and social care: the NHS working with local government, the community, acute trusts, voluntary, community and social enterprise (VCSE) and independent care homes sectors to co-design and co-deliver the model of care.
- Adopting a whole-system approach, breaking down the organisational barriers between health, social care and the VCSE sectors.
- The workforce committing to collaboration, mutual respect and improving the experience and outcomes of care home residents, and investing time for this.

c) Quality

- Using research, innovation and evidence-based practices to drive and sustain improvements.
- Ensuring the views of people living in care homes and those close to them inform service development and quality improvement.
- Quality improvement is driven by truly collaborative teams responding to local need and intelligence as well as national priorities.

d) Leadership

- Strong, collaborative leadership at local, regional and national levels between health and care, and a shared vision for better care across the multidisciplinary team (MDT), led by the care home clinical lead/ Registered Manager.
- Recognising cultural differences between organisations and sectors, and the different types of commissioner and provider, whilst ensuring shared vision and aims, despite differences in ways of working.

e) Digital

- Digital technology is a key enabler for all the conditions critical for the success of the EHCH model, underpinning improved information sharing between health and care teams and the enhanced quality, safety and personalisation in the care people receive.

6.10 From the workshops, and work to date, nine key work streams have been identified, these will be picked up by the Head of Service for Commissioning, Living and Ageing Well who directly, or via their team, drive forward some of the work outlined below. A detailed project plan will be developed outing work underway in each of the nine areas, and activities planned with responsible lead(s):

1. Enhanced primary and community care
2. Falls prevention and reactive response to falls
3. Mental health, learning disability - complex and challenging presentation
4. Dementia Care
5. IT, Technology, TEC and Information Governance
6. High quality palliative and End of Life (EoL)care
7. Quality and provider fees
8. Blended Roles
9. Co-ordination of wrap around support and where possible a single point of access

6.11 In the meantime, it was identified the most potential would come from development of Local Authority led and delivered care home provision, where the care quality would be set by the Local Authority. With clear models of best quality care and support enabling other providers to develop their care provision in line with the local authority's ambition to deliver outstanding care. There are differing options for the Local Authority to lead and operate a provision including tender of care delivery or direct award via NHS frameworks. Whichever model of delivery chosen, this would clearly fit with an Enhanced Care Home Model vision, principles and ethos. The core will focus

on the feasibility study of a specialist dementia service in borough, designed to be the centre of excellence in delivering dementia care. The work will also bring service leads together to develop and deliver a variety of initiatives to improve the offer for residents in care homes, ensuring consistency and equitability across the market.

7. Feasibility study for an in borough dementia service

7.1 GM currently has 30,027 people over the age of 65 living with dementia. This is estimated to rise to 36,190 by 2030 and 28,215 of those are estimated will be living with severe dementia. There are currently 808 people under the age of 65 with a dementia diagnosis living in GM. This figure could be considerably more due to the challenges people face in receiving a diagnosis under the age of 65. The annual costs of dementia care in GM is £1265m and is expected to rise to £1985m by 2030.

7.2 ASC commissioning have seen an increase in demand for dementia nursing and dementia residential placements for people who have complex needs and distressed behaviours. Due to the growing need for complex dementia care, for both nursing and residential placements, and the limited number of beds available, people are being placed out of borough and away from families and friends at a higher cost.

7.3 In the borough there are 55 nursing beds for complex dementia needs at present with an additional in borough provider looking to open a 22 bedded dementia nursing provision in August 2024 (‘Reconnect’). This new provision will support medium to high complex behaviours and needs, with standard packages costing the council C£2139.12 per week, with Funded Nursing Care as additional health cost. Despite new provision and an increase the bed base of 75 complex dementia nursing, commissioners do not feel satisfied that this will be suitable to meet the growing demand over the coming years.

7.4 Demand remains high and will continue to increase, data from the GM frontrunner programme suggests as many as one in four patients in hospital across GM have dementia and this is set to double before 2030.

7.5 Therefore the ASC commissioning service in conjunction with strategic housing and assets team and planning services are currently reviewing existing council assets and land to ascertain if there is potential to develop a dementia-centric scheme. This work will include a detailed options appraisal of care models, provision and support offered.

7.6 The service would provide state of the art design, technology and care, developing best practice models that could be shared with other care provision in the borough. This type of service would be the first of its kind locally, regionally and possibly nationally. It will link in with existing services such as Oasis unit, the Willows and the developing Reconnect unit as well as with support services who are involved in the Enhanced Care Home Model work. The scheme will offer outreach and in reach services, so people living in the community with dementia and their loved ones can gain support, access

the facilities, develop a familiarity with the service, grow much needed friendships and connections, and also receive diagnosis relevant information, advice, guidance and signposting. Appendix 1 highlights this in diagrammatic form.

7. Finance

7.1 A capital investment bid is being developed to request a capital budget to either buy, develop and build a scheme on either council or non-council land or develop an existing building. A cost benefit analysis is being undertaken to demonstrate the level of investment required and outline the projected plan to be able to repay that investment. Also describing the income generation opportunity beyond the point of repaying the investment.

8. Legal

8.1 Legal services will be consulted as the feasibility work develops and relevant advice sought.

9. Human resource

9.1 Human resource services will be consulted as the feasibility work develops and relevant advice sought.

10. Sustainability impact

10.1 A sustainability impact is being undertaken as part of the feasibility work.

11.0 Other considerations (corporate priorities, risks)

11.1 The Enhanced Care Home Model fits with the statutory duties, national and local guidance, the corporate, ASC and health strategies and priorities.

11.2 A risk register is being developed as part of the feasibility work, with each options carrying various risks. However, any risk to scheme development will be outweighed by the risk of demand for dementia services increasing and an inability to meet those needs in borough, causing residents to go out of borough to receive care and at a greater cost to the public purse.

Background Papers: None

Contact: Hayley Ashall, Assistant Director Adult Social Care Commissioning and Prevention (Hayley.ashall@rochdale.gov.uk)