

# Commissioning News

The voice for all public sector commissioners

Issue 10 • Dec/Jan 2008

## INSIDE:

POPP pilots prove their worth

Reablement schemes boost independence

Tips for commissioning dementia services

Legal briefing on care homes

# OLDER PEOPLE – A SPECIAL ISSUE

For everyone investing in services for drugs, health, crime and social care

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PEOPLE

EXPERT ADVICE

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Learning

# INNOVATION AND CHANGE

## CREATING NEW WAYS OF WORKING

5 March 2008, 9:30 – 16:00

Manchester City Centre

Enquiries to Mark Napier on 020 7922 7823 or [mark.napier@publicinnovation.org.uk](mailto:mark.napier@publicinnovation.org.uk)

Cost £99 + VAT pp

### Facilitators:

**Mark Napier** heads CPI's innovation portfolio. Mark is passionate about introducing the energy of innovation to the public sector to enable real change and lasting outcomes for clients.

Mark has worked extensively with statutory agencies such as the Government Offices for London, South West and South East, Hertfordshire Police Constabulary and the London Probation Service to successfully introduce organisational innovation that achieves results.

**Peter Mason** BSc, RGN, RMN

Peter believes that, whilst repeating bad practice is of course wasteful, even repeating good practice will only take organisations so far. Innovation is about stretching beyond this point. High-performing organisations are proved to be the ones who innovate most effectively.

As a Harkness fellow, Peter studied at Columbia University, New York followed by Innovation Studies at the Rensselaerville Institute, New York. He is a regular advisor to Central Government on innovation.

### Aims and outcomes:

This one day workshop will introduce attendees to the concept of innovation and show why it is rapidly rising to the top of the public sector agenda.

The workshop will show you how to introduce innovation within your organisation as well as how to commission innovation. The workshop will teach you:

- what innovation really means
- the role of innovation in service delivery
- how to introduce innovation to your organisation
- how to commission innovation – enabling creativity within existing procurement systems
- how to align the system to create an innovation eco-system
- lessons from the private sector
- how innovation can help develop partnership working

### Why this seminar?

Innovation is increasingly being seen as the way in which public services can meet the pressures of increasing quality and improving outcomes for clients, within the context of budgetary restrictions and pressures on staff time. This workshop will teach you why you need to embed innovation in your organisation and give you the necessary skills to improve delivery.

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Care Services Improvement Partnership



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National Treatment Agency for Substance Misuse

**Published on behalf of**

The Centre for Public Innovation  
32-36 Loman Street  
London SE1 0EE  
Tel: 020 7922 7820  
www.publicinnovation.org.uk

The Centre for Public Innovation is a community interest company which provides training, research and consultancy services to individuals and teams in the public sector to help them embrace reform, innovation and improved working practices.

**Published by**

CJ Wellings Ltd  
Southbank House, Black Prince Road,  
London SE1 7SJ

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Printed on 9lives 55 paper which is produced with 55% recycled fibre from both pre- and post-consumer sources, together with 45% virgin ECF fibre from sustainable forests.

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**Supported by:**

The Department of Health's Care Services Improvement Partnership; Futurebuilders England; National Treatment Agency for Substance Misuse.

## Signs of hope ahead on older people's services

Welcome to this special issue of *Commissioning News*, focusing on older people. It is brought to you in association with the Care Services Improvement Partnership, to showcase best practice and offer expert advice on the commissioning of services for this growing population.

Commissioners of older people's services face significant challenges. Firstly, public perception. Two thirds of adults are frightened about the prospect of going into a care home when they're older, according to a recent poll by *The Guardian* newspaper. These fears won't be assuaged by television programmes such as *Panorama*, which this month claimed care home residents were often inappropriately medicated with anti-psychotic drugs.

Secondly, the social care regulator CSCI has made no secret of its criticism that councils are not doing

enough to advise self-funders on the range of options available to help them find the best quality providers.

Thirdly – and the real crunch for commissioners – are financial pressures, in the wake of a disappointing settlement from the comprehensive spending review.

The New Year offers promise on all these challenges. Care homes will be star-rated for the first time, a national dementia strategy will be drawn up, and a long-overdue green paper is promised to address the thorny issue of how social care should be funded in the future.

In the meantime we hope you will be inspired by the efforts of the schemes featured in this issue, and have a rejuvenating Christmas break before returning to the coalface in 2008.

**Rebecca Norris, editor, Commissioning News**

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**CSIP**

Care Services Improvement Partnership

**How CSIP can help you**

The Care Services Improvement Partnership is commissioned by the Department of Health and other agencies to help local services implement national policies. It runs a range of national and regional programmes covering all adult user groups and children.

**CSIP's Older People's Programme**

This programme started as the Health and Social Care Change Agent Team (CAT) in 2002, charged with helping health and social care communities tackle delayed transfers from hospital. Since then its remit has grown, and it now provides advice on planning and commissioning care to make sure older people get the right care and treatment in the right place and that services support people to live at home wherever possible.

**CSIP Networks and the Better Commissioning LIN**

There are five CSIP Networks: integrated care, better commissioning, telecare, housing and leadership. The Better Commissioning Learning and Improvement Network provides practical materials, workshops and seminars to encourage commissioners and providers to share good practice and keep up to date on new policy developments.

Contact: [janet.crampton@dh.gsi.gov.uk](mailto:janet.crampton@dh.gsi.gov.uk)

## NEWS IN BRIEF

**Direct payments loophole to be closed by new law**

A loophole over direct payments is set to be closed thanks to proposals in the Health and Social Care Bill published last month. Current exclusions particularly affect severely disabled children, whose direct payments to their parents stop when they turn 18. The bill proposes allowing payment to 'suitable' people on behalf of a service user who lacks capacity.

**PCTs must become 'world class' commissioners**

PCTs are being urged to strive for "world class commissioning" status by meeting 11 new competencies. These include prioritising investment according to local needs, service requirements, and the values of the NHS; securing procurement skills that ensure robust and viable contracts; and effectively stimulating the market to meet demand and secure outcomes. The Department of Health's director general of commissioning Mark Britnell explains the vision on page 14 of this issue.

**HIV grant rises**

Local authorities will receive an extra £17.6bn from 2008-11 to plan and care for people living with HIV/AIDS, public health minister Dawn Primarolo has announced. The funding represents a 20 per cent increase.

**CAMHS receive £31m boost**

New beds will be made available to stop young people with mental health problems being inappropriately placed in adult psychiatric wards. Care services minister Ivan Lewis has announced £31 million funding to be shared by 17 projects across England to provide 150 new or upgraded beds and enhanced community facilities for young people aged under 18.

**Private firm wins secure unit contract**

Partnerships in Care has won a three-year contract to provide 25-30 long-term medium secure beds for men in Warrington. The North West Specialised Commissioning Team said the contract would fill a gap identified by its five-year commissioning strategy.

# PCTs lose learning disability budget

By Rebecca Norris

## The NHS is to be stripped of responsibility for funding learning disability social care, the Department of Health has confirmed.

The move came after the Healthcare Commission warned that NHS-funded inpatient services were "poor...old-fashioned and institutional". It revealed that a national audit of 72 NHS providers and 17 in the independent sector, had resulted in six services being referred to councils under Protection of Vulnerable Adults protocols.

In the most serious case, involving services run by Bromley PCT, the HCC found:

- people were left sitting for long periods with little staff contact and no activities;
- toilet doors would not close;
- there were gates on bedroom doors and straps on chairs;
- corridors and doorways were not wide enough for wheelchairs to be moved easily in case of a fire ;
- three crates of patient records were found outside in an unlocked shed;
- high vacancy and sickness rates among staff;
- the PCT and local authority were unclear about their respective responsibilities.

The HCC is now monitoring the Bromley services to check improvements are made.

In response, care services minister Ivan Lewis said: "It is totally unacceptable for anyone with a learning disability to be treated in a way that compromises their human rights."

He also launched a consultation document, *Valuing people now: from progress to transformation* confirming that "PCT learning disability budgets and the associated commissioning responsibility, will transfer to local authorities."

The transfer is due to start from April 2009 but excludes general healthcare and forensic/offender services. Councils and PCTs will be expected to thrash out agreements on the budget that will be transferred.

The document also calls for commissioners to avoid placing a person in an inpatient bed unless they are receiving "an active programme of assessment or treatment prior to moving back home to their local community".

A national toolkit for fair pricing of services is due to be launched next year, it adds.

The HCC's audit was sparked by the Cornwall care scandal. Local commissioners revealed how they were dealing with the aftermath in the last issue of *Commissioning News*.

## Expansion in online tools to help commissioners

### The growing stable of free online diagnostic tools which can help commissioners assess their system's readiness for the new policy agenda will be boosted significantly from January.

They have been developed by Professor Bob Hudson, visiting professor of partnership studies at the University of Durham on behalf of the Care Services Partnership's Better Commissioning Network.

They include:

- Joint Strategic Needs Assessment – an entry-level guide to the measures that must be in place to meet the new legal duty to complete an assessment of the strategic needs of their population
- Informal Networks – an evaluation of the strength of informal local networks

within and across sectors

- Whole Systems – assessing the effectiveness of collaborative and integrative processes around the reform agenda.

The long-standing Integrated Team Monitoring and Assessment tool, and the Partnership Assessment Tool 2, which arrived in the summer, are also to be upgraded. PAT2 is currently available only "on-page" but will be fully on-line next month.

Janet Crampton, CSIP national associate for commissioning, said: "These tools provide a vital resource for local teams and managers to assess how ready they are to ensure that change delivers the greatest benefit to their communities. More tools will be added throughout 2008."

## Call to roll out dementia scheme

### A social enterprise providing a diverse range of services for people with dementia and their families, should be emulated nationally, according to a new publication.

The case study published by the Housing Learning and Improvement Network says the Dementia Care Partnership "offers an approach whose replication would be of great benefit to people with dementia and their families elsewhere in the UK". All partnership staff are committed to PEACH principles (Person-led Empowerment, Attachment, Continuity and Hope).

The project is also a DH social enterprise pathfinder.

The full case study, *Dementia Care Partnership: More than Bricks and Mortar*, is available at [www.icn.csip.org.uk/housing/index.cfm?pid=336](http://www.icn.csip.org.uk/housing/index.cfm?pid=336)



## Palliative care project wins award

**Sunderland Teaching PCT has won a top award for transforming care of end-of-life patients at one of its local services.**

St Benedict's Hospice Day Centre has reduced non-attenders by 300 per cent and halved waiting times by

introducing a referral 'decision tree'; reduced patient distress scores by 24 per cent using a new clinical distress tool; used the same tool to reduce staff and volunteers' burnout by 67 per cent; and saved an average of £5 per patient attendance.

The project was named winner of the Improvement Foundation's Guy Rotherham award at a ceremony last month. Sister Alison MaLachlan (pictured, left) and Dr Victoria Hewitt from the hospice collected the award.

## Guidance urges town planners to heed needs of ageing population

**Efforts to improve and expand extra care housing went back to basics recently with fresh guidance for planners.**

RTPI *Good Practice Note 8* encourages planners and housing officers to work with developers, providers, and commissioners from health and social care in planning to meet the extra care housing needs of an ageing population. It was published jointly by the Care Services Improvement Partnership's Housing Learning and Improvement Network, the Department of Health and the Royal Town Planning Institute in October.

Jeremy Porteus, national CSIP programme lead, said: "Demographic change carries with it implications for a range of services. Government policy has consistently emphasised that housing, health and social care must work closer together. Ensuring planners are aware, for example, that they need to consider and discuss issues such as

the availability of GP services when examining planning applications for extra care schemes can only be helpful."

In their foreword for the document, Baroness Andrews and Ivan Lewis, parliamentary under-secretary of state at the Department for Communities and Local Government and Department of Health respectively, said the document is "a valuable step in preparing for the improvements that the forthcoming national housing strategy for older people will rightfully bring".

Jenny Crawford, RTPI head of research, said: "We are in new territory, looking beyond short-term fixes which tuck away older people in the belief that a roof over their head, sometimes with a one-size-fits-all warden service is sufficient. Consensus shows we need strong planning guidance for the co-ordination of public and private response to the housing, health and community implications of demographic change."

### NEWS IN BRIEF

#### Targets set for providers of offender management

Providers of offender management services must comply with a new set of national standards published by the National Offender Management Service. The standards set specific time limits on actions such as assigning offender supervisors or managers, carrying out assessments, and completing reports. The standards should be met "in all but exceptional individual circumstances". See [www.noms.homeoffice.gov.uk](http://www.noms.homeoffice.gov.uk).

#### PBC making limited headway

Practice-based commissioning is making limited progress, according to an Audit Commission report. PBC allows GPs to manage indicative prescribing and secondary care budgets but practices are being hampered by a lack of timely and accurate data from providers on patient activity. Some PCTs are reluctant to relinquish control to practices, while concerns have been raised about potential conflict of interest in GPs who both commission and provide new services. See [www.audit.gov.uk](http://www.audit.gov.uk) for more details.

#### Consultation launched on offender health

Cross-government consultation plans have been launched to improve health and social care for all people in contact with the criminal justice system. They include plans to register all such people with a GP and improve screening, assessment and treatment of hepatitis C, TB, and alcohol problems. *Improving health, supporting justice*, is out until 4 March.

#### Roadmap encourages consistent commissioning

A website has been launched to help all commissioners in the north west region share practice and gain new skills. The goal of [www.northwestroadmap.org.uk](http://www.northwestroadmap.org.uk) is to support the most effective, efficient and consistent commissioning of adult health and wellbeing services across councils and PCTs. The site also offers an action learning set.

# Treading a new path



“The population is certainly older and the cost and quality of social care are real issues for Herefordshire.”

On 10 December Chris Bull started work in the first post of its kind. He has been appointed joint chief executive of Herefordshire Council and Herefordshire PCT under plans to create a single ‘public service trust’ through a merger of local government and health functions (see box). Mr Bull joins from Southwark Council, where he was deputy chief executive. *Commissioning News* quizzed Mr Bull just before his departure from London.

**Commissioning News:** What attracted you to the Herefordshire post?

**Chris Bull:** Two things – firstly and self-evidently, the job itself. I think it’s an incredibly exciting job, and a fantastic opportunity to think about public services and how we can get better outcomes for people by joining things up. Secondly, it’s Herefordshire the place, I think it’s really beautiful and I’m quite excited to be going there.

**CN:** How will you manage the differences between inner-city Southwark and rural Herefordshire?

**CB:** They’re clearly different places. The population is certainly older and the cost and quality of social care are real issues for Herefordshire. But interestingly, the really big challenges are common across all public services – achieving efficiency, understanding how services impact in terms of outcomes for people, and managing resources. The important task for me is to make sure the solutions we reach in Herefordshire make sense in Herefordshire – you can’t just take and implant solutions from London.

**CN:** How do you feel about working in the national spotlight given the pioneering model in Herefordshire?

**CB:** Of course it’s right that people are going to be interested in how this job progresses and how I do, and it’s important to contribute to a national debate and to make sure that we both

learn from others and offer learning to others. But my focus is going to be on doing what's right for Herefordshire.

**CN:** What do you consider to be your biggest achievement in Southwark?

**CB:** The work I did in bringing together health and social care in Southwark is probably my biggest achievement. I previously held the joint post of director of social services and chief executive of Southwark PCT [managing budgets totalling £520m] and I think the level of service integration we achieved is something which we can be proud of. Just as one example, as I look out of my window now, I can see a brand new child development centre, in a building built by the PCT through LIFT [the NHS public-private investment scheme for primary and community care facilities]. It's a single building offering an integrated service delivered by various health and social care professionals for children with learning disabilities.

**CN:** Commissioning currently has a high profile, particularly with the DH's world class commissioning plans. Do you believe commissioning is an art or a science?

**CB:** Commissioning never stands still and will continue to develop along a continuum. Fundamentally, it's about understanding need, resource levels and the best practice in meeting needs within resources, and it's about partnership between commissioners and providers. It's not just about procurement and purchasing – although that's part of it – it is about squaring that circle of needs, resources and best practice.

**CN:** How well do you think commissioning is being carried out?

**CB:** I think we can always do better, but I also think that there is no end point to this. We're always trying to get better at understanding needs and what interventions really do improve outcomes. I don't think we should beat ourselves up over whether we've been good or not – it's a developing process.

**CN:** What's your view on contestability of public services?

**CB:** I think it's a useful tool. I think we've got past the point where we start from the assumption that everything has to be provided directly, but equally we shouldn't assume that other forms of provision are intrinsically better. I think that contestability offers an opportunity to test out value, to explore alternative ways of doing things and to improve the commissioning process. If a consequence of that is that some services end up being provided by alternative providers, well I don't have a problem with that.

**CN:** How much of a challenge do you face in bringing together health – where you get for example, autonomously working GPs – and social care cultures?

**CB:** I think that we should emphasise the things we have in common across health and local government: a commitment to public service, and a belief in wanting to achieve improvements, better services and outcomes for local people. Those are common across the piece and we need to build on those. It's important not to feed myths as well – when I talk to GPs, they care passionately about standards of social care because it's GPs, amongst other professionals, who work with users of social care on a day-to-day basis. They have a role in helping improve standards of social care.

We shouldn't set this up as a conflict. Nor is it about either sector lecturing the other. It's about us building positively on a forward-looking agenda.

## Herefordshire's road towards a single public service trust

**Early 2006:** The government's plans to halve the number of PCTs across England act as an impetus in Herefordshire to debate the future of public services. Herefordshire PCT escapes a merger with other PCTs on the condition that it works with Herefordshire Council on a more integrated approach to public services.

**October 2006:** Plans for a single public service trust (PST) in Herefordshire enter the public domain when they are presented to the hierarchies of the council and PCT.

**12 June-31 July 2007:** Residents consulted on the plans, which boast a vision to deliver seamless and more efficient services through joint management of a £300m budget (equating to about 70 per cent of each organisation's revenue). More than half (57 per cent) of the 221 responses are in favour of a PST, 41 per cent against.

**August 2007:** The council's health scrutiny committee welcomes the plans. It notes the compatibility of IT systems, recommends a joint accommodation strategy, but views the timetable as optimistic and over ambitious, and regrets the lack of wider engagement during the public consultation.

**September 2007:** The council and PCT effectively give the PST a green light by agreeing to recruit a joint chief executive and other senior managers. They also adopt two other core principles: both parties are equal, and they will build trust through openness and honesty and recognition of cultural differences.

The organisations have been told there is no legal impediment to creating the joint chief executive post, but they must address concerns expressed by the Audit Commission over how they will handle any conflict of interests between the PCT and council or differences of opinion in the chief executive's performance. The organisations could find the Local Government and Public Health Involvement Act, passed in October, helpful, as it sets out requirements on close working and dispute resolutions.

Until any changes in legislation, the planned PST will have no legal status, rather, joint working arrangements will be enacted under flexibilities allowed under section 75 of the NHS Act 2006.

**December 2007:** Chris Bull starts as joint chief executive of Herefordshire Council and Herefordshire PCT. An interim single director of human resources, Gi Cheesman, has also been appointed and there are plans to recruit a single director of public health and single director of integrated commissioning.

**January 2008:** An interim public service trust board is due to be set up.

**September 2008:** PST arrangements due to be formalised. Its first priorities will be the commissioning of children's services, adult services, public health, and corporate and shared services, under a phased approach.

See [www.publicservicetrust.info](http://www.publicservicetrust.info) for more information.

# A reabling approach

**Reablement packages are turning traditional domiciliary care on its head by encouraging older people to carry out many daily tasks themselves. Rebecca Norris reports**



Charles Moulds is just one of the thousands of older people Leicestershire County Council has helped regain confidence and independence through its in-house Homecare Assessment and Reablement Team (HART).

Weeks out of hospital after a collapse, he describes how the team's care staff are encouraging him to carry out some tasks himself. "I've washed my hands, washed my face, washed my stomach and my thighs and what-not."

"It's brilliant", he says, of the alternative approach to traditional domiciliary care, "because you can sit and rot in a chair if you let yourself go."

Mr Moulds features in a short video on the council's website describing the difference that HART has made. His positive experience is backed by hard data, including an independent evaluation of Leicestershire's reablement pilot, carried out by De Montfort University, which showed reablement reduced ongoing care hours required by 28%, compared with a control group. A national report published last month by the Department of Health's Care Services Efficiency Delivery Programme was also enthusiastic about the potential of reablement to keep people in their homes longer, support them through rehabilitation, reduce future reliance on homecare and promote a greater sense of wellbeing (see box).

Leicestershire's HART is the largest and longest running scheme of its kind. Jane Dabrowska, the council's service manager for Melton and Market Harborough older and disabled people's service, says the idea originally came from talks with home care assistants.

"They were saying 'I've only got half an hour to do this [help with daily living tasks] but the only way I can do it in that time, is to do it for them'. What that does is makes people more dependent because not

only do they lose any skills they may have had as part of doing that task themselves, but also they're dependent on the relationship they build up with that [care] provider.

"So we set up a pilot in 1999," explains Ms Dabrowska. "We said to service users, 'we'll spend up to six weeks with you and help you to help yourself as much as you can and we'll also try to help you regain skills that you may have lost before.'"

It was a step into the unknown, with nobody quite sure how much longer care workers would need to spend with the service users to help them do this. "What we found was that on average, people needed a lot less formal support – not more. In fact, by taking this approach, their dignity was maintained because they felt they were directing what was going on."

If care staff assess that people still need ongoing domiciliary support once the reablement package ends, then the service user will be passed onto the independent sector, which provides normal home care services in the county. "But we don't do it on the basis that we stop on Sundays and they start on Mondays – there's a proper handover, usually from two days up to a week. Incidentally, we've improved the quality of the independent sector service. They get a very up-to-date and accurate care plan and all the information they need to provide good quality care."

Ms Dabrowska reels off a range of other benefits. "From the information we supplied to the CSED study, it was worked out that, if somebody has ongoing needs after 26 weeks, from then on, we're making savings on what would've happened if they'd had traditional home care.

"It's also meant that while we haven't reduced the volume of domiciliary care we commission, neither have we had to increase our eligibility criteria. Many

**“While we haven’t reduced the volume of domiciliary care we commission, neither have we had to increase our eligibility criteria. Many authorities are now on a high or critical FACS threshold, but we’re still on moderate.”**

authorities are now on a high or critical FACS threshold, but we’re still on moderate.

“We’ve also seen a steady reduction in residential admissions, which we believe is partly down to the fact we can maintain people at home for longer.”

Initially HART only took those who had a recognised potential for reablement; now the majority of people assessed as needing home care are referred first to the team, unless there is an evidence-based reason why this would not be suitable.

The occupational therapist who began on the team is no longer there as well. “After six months, she said ‘you don’t need me anymore,’” explains Ms Dabrowska. “The other team members observed her and realised that a lot of the equipment and aids for daily living are very basic pieces of kit. We trained the staff to assess for and order themselves, a defined range of aids and equipment. Anything more complex is referred on a fast-track to the occupational therapists in our ordinary adults commissioning team. The point about reablement is that you need to do it at the time you need to do it, not wait two or three months.”

Ms Dabrowska has four key lessons to share with councils who are planning to introduce reablement schemes.

“The first thing is to get the commissioners [Leicestershire’s preferred term for social care assessors or care managers] on board and understand why it’s of benefit to service users. My job as the champion at the time was to go around all the commissioning teams explaining what this scheme was all about, because some

commissioners obviously felt threatened that this was about checking up on their assessments. When really, it was about continuing their assessments and changing the outcomes in response to the changing abilities of the service users.

“The second thing is to get your staff groups on board. Starting from scratch, you’d want to draw up a spec, and interview and recruit a whole new staff group – but that’s not the real world – you have the staff you’ve got. So you’ve got to get your staff to understand this is not a threat to them; in actual fact, it gives them more responsibility to do what they wanted to do along and just confirms their skills in regard to providing domiciliary care.

“Thirdly, it takes a lot longer to transform it than you first think. Our action plan was 12 months – but it took us four and a half years.

“Fourthly, I would add how crucial it is that the original commissioner explains to the service user what the service is about. Many people contact us at a point of crisis and what they want is someone to come and do things for them and make the crisis go away. It’s very important that it’s explained to them at that stage that the team, although short-term, will work with them and if they still have needs after that, those needs will be met. They shouldn’t be concerned they’ll be reabled and then left.”

David Sprason, Leicestershire County Council’s cabinet member for adult social care, says HART is now an “essential service” which helps many residents remain in their own homes. “We are extremely proud of our care teams who carry out this and other invaluable work.”

### National findings and lessons from a study of four council reablement schemes

- Between 53 and 68% of people in three schemes, and 94% in the other, left reablement requiring no immediate homecare package
- Between 36% and 48% in three schemes, and 87% in the other, continued to require no care package two years after reablement

#### Ensure any move to mainstream homecare doesn’t undo reablement

There is a risk service users will revert to having things done for them as independent sector providers may not foster independence or have any financial incentive to adjust care packages downwards. Solutions include more flexible contracts; better handover; training council staff in outcomes-based commissioning; and giving free training to independent sector staff.

#### Various factors influence service users’ willingness to take part

Family, friends and carers can significantly affect service users’ attitude to managing risk, while isolated service users may want reablement purely for social contact. Reablement care staff are crucial for fostering a “can do” attitude in service users and helping carers accept that it is okay to use telecare at times in place of visits.

#### Ensure referrals to reablement teams are high quality and responded to quickly

Responding quickly to referrals can be difficult where reablement managers are both managing staff and undertaking assessments, and/or where assessors are not available at the weekend to deal with situations such as a Friday discharge from hospital. Steps need to be taken to avoid poor quality referrals – such as people who need convalescence before they can fully benefit from reablement, or those told to take it because it was “free for six weeks”, without explaining what would be required.

#### Reablement is also a means to signpost to other types of support

The schemes also used reablement to signpost older people to voluntary organisations, government agencies, or even the local mobile hairdresser, and to encourage new activities such as using the internet.

#### Ensure a lack of capacity doesn’t delay ongoing care

In three of the four sites, difficulties and delays when clients were referred on from reablement had led to ‘blocking’ of places, or even a gap between reablement and their on-going package of care.

#### Be flexible about the duration of reablement

Most packages are for six weeks but some staff felt some service users might need more time for the impact to be sustained in the longer term.

The full report can be found at:  
[www.csed.csp.org.uk/silo/files/longit-study-bc.pdf](http://www.csed.csp.org.uk/silo/files/longit-study-bc.pdf)

## HOW POPP PILOTS ARE PROVING THEIR WORTH



**Nearly 30 pilot areas across the country are transforming the care of older people in their communities. Rebecca Norris finds out how they're doing it in the London Borough of Camden.**

Gary Roebuck / Alamy

“It’s not a pot of gold – it’s a resource, it’s time-limited, but it’s exciting and a great opportunity for older people’s services.” That’s the verdict of Camden commissioner Angela Neblett on the £1.5m Partnerships for Older People Projects (POPP) grant awarded to her area.

Camden is one of 29 POPP pilot sites, which together have received £60m from the Department of Health to test out 245 projects to improve care of older people.

For every £1 spent on POPP, £1 is potentially saved on hospital bed-days, according to an interim evaluation of the pilots published in October by the University of Hertfordshire (see box).

Ms Neblett, who is head of strategy and commissioning for mental health and substance misuse in a joint role across the London Borough of Camden and Camden PCT, says POPP is different to opportunistic funding commissioners have received in the past.

“There has never before been that emphasis from the word go that this is going to be evaluated, it’s all about outcomes, and if it doesn’t make a difference and you can’t show it’s right for mainstreaming, it won’t happen,” she says.

Camden’s POPP involves a range of schemes run under the banner, ‘Community Interventions for Older People with Mental Health Needs’ (see box). Locally there are an estimated 1,400 older people with dementia while more than 3,000 people experience depression or anxiety. Many are socially isolated or do not access mainstream services until a crisis hits.

The projects aim to identify earlier, ill-health or isolation; provide more support to people in their own homes; help people with functional mental health needs remain in the community; and reduce unnecessary stays in hospital.

Ms Neblett says of all the projects, the memory service in particular has proven to be “very effective” by offering early

diagnosis of dementia within people’s homes as well as treatment and signposting to other services.

She adds that the additional resources put into extra care sheltered accommodation are also paying off. “We gave some pump-primed training which meant they [staff] were happier to take people with mental health problems than they had been previously. What you find is that staff have very entrenched ideas about risk, capacity and capability to manage certain challenges. The training has enabled them to think, ‘we can take this person because we’ve got the skills and training to help us do that’. So it’s about opening doors to access.”

There are also signs that the more ‘upstream’ services are having an impact.

Ms Neblett says: “Talking Therapies, developed with Age Concern, provides counselling for older people at the lower end of need. It’s about prevention and engaging with people so that they don’t end up further up the pathway, but it’s also about specifically targeting older people from BME communities.

“We’re finding with our older people’s services, they [BME older people] are just not going, until things have deteriorated to a point where families are unable to cope. The service is really making a difference – in terms of the numbers coming in, the engagement and opportunities for signposting.”

POPP has also created some unexpected spin-offs, Ms Neblett explains.

“It’s forced us to look at how our older people’s services are configured. It’s provided a real opportunity to say ‘maybe the memory service shouldn’t be appended to one part of the borough; we need to look at access across the piece’. It’s built some real momentum and engagement among senior managers about reconfiguring teams, both to improve efficiency and moving

towards a model that incorporates a memory service.

“We’re also looking at remodelling the clinical time so that it reflects the changes in continuing care provision and integration of our day hospital care.

“It’s brought about those broader synergies, co-operation, and a spirit of ‘what else can we do that maximises the difference this is making’. That’s been a spin-off that wasn’t planned in.”

Other added-value benefits include “better engagement with the voluntary sector, and other parts of the care trust organisation that are delivering services in mental health for older people, who weren’t around the table before”.

However Ms Neblett says evaluating the success of the projects is challenging.

“When we’re dealing with secondary care services it’s very easy to ask them to report numbers of people, throughput, and x number of freed-up beds, for example, if you’re able to move people into extra care sheltered accommodation. When you’re trying to evaluate the input and the outcomes of someone engaging in exercise at home or having talking therapies for the first time, that takes time.”

Ms Neblett relates a story passed on by Age Concern, about an older woman who had come in for counselling. “She was isolated and in a marriage she wasn’t happy in, and had wanted to study and never had an opportunity. For her, it [the counselling] was an opportunity to talk about and put herself centre stage for the first time. It helped give her thoughts about how she could network and use education opportunities in the community colleges.

“It was heartening to hear. It’s not giving you that firm data that says she won’t be relying on health and social care services [in the future]. But it’s about enabling people.

“We’ve moved in terms of adult mental health services to talking about recovery and real outcomes and people moving forward – we now need to use that same positive language when we’re talking about older people’s services.”

She adds: “It’s very difficult to say, this has made a transformational change across the piece and this is the pound that is saved. I think it’s softer and more subtle than that and it

takes a much longer time to evidence some of those things.

“That’s been one of the drawbacks of the POPP funding, that it is only over two years. To do a randomised control trial takes [many more] years and rightly so, to know if what you’re doing makes a difference and is cost-effective. We’re trying to evaluate something in a very, very short time and decide as partners whether to invest our energies and resources in mainstreaming this – it’s very difficult to do in a short period of time.”

Ms Neblett says her key message to other councils considering POPP-style projects is to “engage with stakeholders at the earliest opportunity, and always think, ‘what difference will it make?’

“If you don’t believe it’s going to make that much of a difference, then that’s not the direction of travel for your partnership.

“All services should have that emphasis on outcome/evaluations – prove it, show it. Our projects have to report monthly, which is an enormous discipline, so I would say to other councils, warn your organisations this is not a pot of gold that is coming your way, it’s going to take work to maintain.”

Ms Neblett also recommends creating the role of mental health care of older people (MENCOP) commissioner, as she did in Camden. That post-holder – Suzanne Barcz – is also the POPP project lead. “The great advantage is that exclusively, mental health care of older people is her domain. In other councils this work tends to be merged with other things – such as mainstream older people, or older people and learning disabilities, or integrated with adult services.

“By her having the POPP portfolio, there are clear synergies. When we’re talking about mainstreaming these services, and the impact on commissioning – well she’s the commissioner, she’s able to inform discussion and debate from a very strong discussion.

“You need to know who’s going to be your organisational storyteller for these services.”

Researchers evaluating the POPP pilots have cautioned that the encouraging interim results were based only on the first six months and may be subject to change. A final report is due out in October 2008.

## The projects running in Camden

### Voluntary sector:

- A local social enterprise scheme, Alternative Care (Help at Home) is providing practical and social support to vulnerable older people to enable them to remain independent in their own homes
- An expansion of Age Concern’s Talking Therapies initiative is targeting people with anxiety, depression, and the early stages of dementia
- Networkers is an organisation that trains older people who have direct or indirect experience of mental ill health as volunteers
- An information and training course is targeted at carers.

### Public services:

- Exercise programmes in people’s own homes aim to increase mobility and confidence to enable those people to then access exercise activities in community venues
- Care workers receive specialist home care training to enable them to work safely and sensitively with people with dementia, with the support of assistive technology
- An enhanced community mental health team service, which now operates seven days a week
- A community based memory service provides early assessment of dementia at home with access to a full range of investigations and appropriate follow-up
- Designated places for people with functional mental illness are available in extra care sheltered housing.

## Early findings from the national evaluation

- Most projects are aimed at all older people, followed by those at risk of hospital admission; those with mental health problems, carers and ethnic groups
- 83% of projects are new, the rest are extensions of existing schemes
- 32% are led by voluntary or private organisations, the rest by the public sector
- Two-thirds of older people using a POPP service are aged over 75
- 35% of POPP staff are older people as volunteers
- 92% of projects involved older people in the design of the programme
- 77% of projects are involving older people in the evaluation of POPP
- For every £1 spent on POPP, £1 could be saved on hospital bed-days, but extracting this saving from secondary care contracts is a challenge
- 66% of projects will be mainstreamed when the grant ends
- A key start-up challenge was defining respective responsibilities between partner agencies
- A key success has been the better integration of older people’s needs into wider strategic agendas



### Legal briefing

## Are private care homes subject to public rules?

*Independent care providers are affected by two recent developments over how public sector activity is legally defined, writes legal expert Mark Johnson of TPPLaw.*

### Protection of Human Rights

In June, the House of Lords gave an important judgement, in *YL v Birmingham City Council*, on whether the Human Rights Act should apply to care homes operated by independent providers on behalf of local authorities.

The private care home in question gave a resident 28 days notice to quit following a dispute with the resident's relatives. This raised questions about whether the care home was subject to section 6 (3) (b) of the Human Rights Act, which states that anyone who performs "functions of a public nature" is required by law to comply with the European Convention of Human Rights when carrying out those "public activities". Article 8 of the convention states the right to respect for private and family life and home – which the care home could have been breaching by asking the resident to leave.

Opinion amongst many lawyers was that the courts would eventually rule that all care homes are functional public authorities, because of the close involvement of government in ensuring the welfare of residents, the involvement of public funding and regulation by CSCI. The expansionist view was: what is the Human Rights Act for, unless it is to protect vulnerable people like care home residents?

However, the House of Lords did not agree. The majority of the judges (3-2) took the view that the relationship between the resident and the care home operator was essentially a private contractual relationship. Put simply, if you are paid for allowing someone to live in your property, that is private in nature. The fact that some of the funding comes from public sources or that it is arranged by a public authority does not change that.

I can think of several situations where,



Dennis MacDonald / Alamy

however distressing it may have been for the individual at the time, the welfare of the majority of residents was undoubtedly served by removing a disruptive or seriously disturbed resident who just could not continue to live in that setting. Providers would surely have been constrained in their freedom of action had the court found that this resident had a public law right to remain in the home for life.

Age Concern reacted angrily to the judgement and called for the government to take "immediate steps to legislate" to extend human rights protection to all people in independent care homes. So while the courts have settled the matter for now, it may not be the end of the story if politicians choose to change the law.

### Access to information

Since January 2005, the Freedom of Information Act has obliged over 100,000 public authorities – such as government departments, local authorities, and NHS bodies – to disclose information they hold upon request, unless there are compelling reasons not to do so. It has been used by journalists, commercial competitors and aggrieved citizens alike to garner evidence and hold the organs of the state to account.

But buried within section 5 of the act is a power for the secretary of state for justice, by making an order, to extend the reach of the act to (a), those who appear to the secretary of state to exercise functions of a public nature; or (b), those who are providing, under a contract with a public authority, any service whose provision is a function of that authority.

The government is now consulting on whether to activate this power. It believes there is a case for extending the duties to independent service providers because many of them now receive large amounts

of taxpayers' money to carry out public functions and they should be subject to the same scrutiny as public bodies.

Various options are being considered: to allow organisations to self-regulate by adopting their own code of practice; to build information access clauses into contracts between commissioners and providers (which often happens already in practice); to go for a 'big bang' order covering all providers; or finally, introduce progressive coverage of different types of organisation. You have until 1 February 2008 to make your views known via [www.justice.gov.uk](http://www.justice.gov.uk).

The practical effects of this power would be significant. Public bodies had to recruit information officers who spent months preparing catalogues of documents held, and still incur an estimated £35m each year in administration costs responding to information requests within the 20-day time limit.

Is it really appropriate to introduce this additional bureaucratic burden onto the private and voluntary sectors, which risks stifling the nascent and exciting possibilities of third sector involvement in public services? Can it not be addressed more simply by the commissioner taking the necessary contractual rights to request this information in the contract?

It seems a cautious and proportionate approach is what is needed: striking an appropriate balance between the rights of the individual, the interests of society as a whole and the appropriate use of scarce resources and funding.

**The author is managing director of specialist public services law firm TPPLaw. He can be contacted on [mark@tpplaw.co.uk](mailto:mark@tpplaw.co.uk) or 020 7620 0888.**

# How to plan a local dementia strategy

Commissioners shouldn't wait for the new national dementia strategy before developing local plans, writes **Ruth Eley**.



The announcement by care services minister Ivan Lewis that a national dementia strategy will be developed over the next year or so is very welcome news. For too long people with dementia and their carers have had to put up with what is available – which, often for historical reasons, is of poor quality and usually commissioned without clear specifications and with little reference to outcomes – rather than what is needed.

Services are often commissioned by PCTs or local authorities in isolation from each other. A local, jointly agreed strategy for dementia is still a rarity and without this commissioning remains a shot in the dark. There are notable exceptions, of course, and both the national dementia strategy and the NHS review by health minister Lord Darzi will be gathering examples of effective commissioning and service models.

We should not have to wait for the national strategy to be published, however. We already know what works from previous reports such as *Dementia UK*, published by the Alzheimer's Society; *Improving services and support for people with dementia*, by the National Audit Office; and the joint NICE/SCIE dementia guideline.

One of the three key themes of the strategy will be early diagnosis and intervention. We already know, for example, that:

- Early diagnosis helps people plan for their futures while they are still able to do so;
- Early diagnosis means that further help and advice can be offered at a time when people can most benefit from it;
- Support networks can be built up and maintained, thus helping to prevent further deterioration and reliance on more intensive services;
- Preventing crises occurring through early diagnosis and intervention reduces the

unnecessary use of acute hospital beds; and

- Making a diagnosis at a time of crisis (such as an emergency hospital admission) or when the disease is more advanced is likely to lead to an assumption that residential care is the only realistic option.

The other two themes in the strategy improving awareness and improving the quality of dementia care.

So what does this mean for commissioners? The starting point has to be a joint local commissioning strategy for dementia. If there is not one already in place, start the discussions now about how you and your partners are going to agree such a strategy by next autumn so that you will be ready to influence the local process for determining priorities for 2009-10.

Here are some ingredients:

1. **Use your local joint strategic needs assessment to help you understand the needs** of your community and the specific needs of people with dementia. Do you know their age profile and ethnicity?
2. **Identify some outcomes for people with dementia** that you want to achieve through commissioning. These should be clear and measurable, and help you determine what services need to be in place to achieve them. An example could be: 'People will receive a diagnosis of dementia face to face; this will be entered in the medical record and followed up with written confirmation.'
3. **Be clear about how much money is currently being spent on dementia** in your locality, across the whole health and social care system. The resources currently spent on specialist mental health services such as memory assessment services, community mental health teams for older people and EMI registered care homes should be fairly

straightforward. However, you will also need to include mainstream services such as general residential care homes (nationally, two-thirds of places are occupied by people with dementia) and people supported to live intensively at home (we know that 20 per cent of people over the age of 80 have dementia).

4. **At the very least, agree with your partners three priorities** for commissioning services together over the next three years.
5. **Talk to your local providers sooner rather than later.** The independent and voluntary sectors know what they can deliver and although this may mean some uncomfortable discussions about fee levels – for home-based care as well as long-term residential care – investing now in some clearly defined services (such as imaginative emergency respite services or home care) should reap benefits in the longer term.
6. **Review how you engage with people with dementia** and their carers. Do you have an ongoing involvement strategy or do you rely on "one off" consultation exercises for specific topics? How do you get feedback on what works and what needs to be improved?
7. **Commission training for the workforce jointly** with your partners. Staff working in mainstream services as well as specialist teams need to know how to care well for people with dementia.

These measures will not change the world overnight for people with dementia, but they will put you on the right track.

**Ruth Eley is CSIP's national programme lead for older and disabled people and is a member of the Department of Health working group for the national dementia strategy. She can be contacted on [ruth.eley@dh.gsi.gov.uk](mailto:ruth.eley@dh.gsi.gov.uk)**



## Your shout

**The Department of Health's vision for world class commissioning, launched this month, is set to dramatically transform the way we commission health and care services in this country. It will deliver better health and well-being for all, better care for all, and better value for all.**

We have called the programme world class for a very simple reason – the people in this country aspire to and deserve a world class health service – and this cannot be delivered without a world class approach to commissioning.

The nature of demography, lifestyles and disease are changing, requiring a new focus on long-term conditions, lifestyle consumption and an ageing population. By delivering a more strategic, long-term and outcome focused approach to commissioning, we will ensure the NHS can meet these challenges and continues to set the benchmark for health and care services around the world.

Although pockets of excellent commissioning already exist within the NHS, we need to ensure a systematic, world class approach. Commissioners will need to demonstrate excellence in leadership, engagement, knowledge management and strategy development. Commissioners will also need outstanding negotiating, contracting, financial and performance management skills. However, world class commissioning is not an end in itself. In order to be successful, commissioners need to demonstrate better health outcomes for

**“Commissioners will need to demonstrate excellence in leadership, engagement, knowledge management and strategy development. They will also need outstanding negotiating, contracting, financial and performance management skills.”**



## PCTs must be world class

their local population; adding life to years and years to life.

PCTs will lead the work to turn the world class commissioning vision into a reality. To succeed, they will need to work in close partnership with patients, the public, local authorities, clinicians and providers. Indeed, partnership sits at the very heart of world class commissioning.

Our vision has implications for joint commissioning. It is essential that PCTs and local authorities work closely to decide in which areas joint work will deliver the greatest impact, and the level of ‘jointness’ required, as this will vary from service to service. For example, when looking at a hospital discharge service, close working and service integration will be essential to get the best for the service user and both organisations. Workforce development is another area for integrated thinking and action.

Building close partnerships with local government has additional benefits for PCTs, by cutting across into areas such as transport, housing, leisure, education, and safe communities, all of which have an impact on population health and wellbeing, particularly when considering prevention and promotion.

Finally, there are considerable benefits to be gained from working together on areas such as assistive technologies.

The launch of the vision and competencies is only the start of our journey and we have a lot of hard work ahead. However, I am in no doubt that we are going to succeed. What

has impressed me most so far, has been the level of enthusiasm and engagement demonstrated by our NHS partners.

The next phase of the programme is development of a national assurance system to oversee commissioning performance. This will be locally managed by strategic health authorities and there will be local flexibility to set priorities and stretch targets. The system is being built and tested with the help of 24 PCTs in the north west, before being rolled out later in 2008.

A support and development framework will also be launched next year to make it easier for commissioners to share services and good practice, develop internal resources, and buy in external expertise.

With the NHS back in financial balance, we are now in a stronger position than ever to directly impact the health and wellbeing of the population by commissioning services in new and innovative ways. The next stage review, being undertaken by minister and surgeon Lord Darzi, signals a vision for the NHS that is fair, personalised, effective and safe. World class commissioning will be one of the most important vehicles for delivering this vision. Through world class commissioning we will drive unprecedented improvements in patient outcomes and ensure the NHS remains one of the most progressive and high performing health systems in the world.

**Mark Britnell is director general of commissioning and system management at the Department of Health.**



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