Blame game

Dementia care in England is suffering from a serious case of underinvestment. Who is to blame, asks **Daniel Thomas**

It's an open secret that dementia care is underfunded in England. However, it is rare that you see those perpetuating the problem held to account. On occasion, though, justice prevails: in February Solihull council agreed to raise the fees it pays for residential care for people with dementia by 16.3%, and nursing care by 16.4% (*see page 8*).

This followed an audit by KPMG that revealed it had not recognised the true cost of care and had been overcharging the public in top up fees. With his tail between his legs, the improbably named councillor Bob Sleigh said: "The investment in care home fees means that we can reduce the financial burden on residents and their families who have to pay third party top-ups. More of the costs will now be borne by the council."

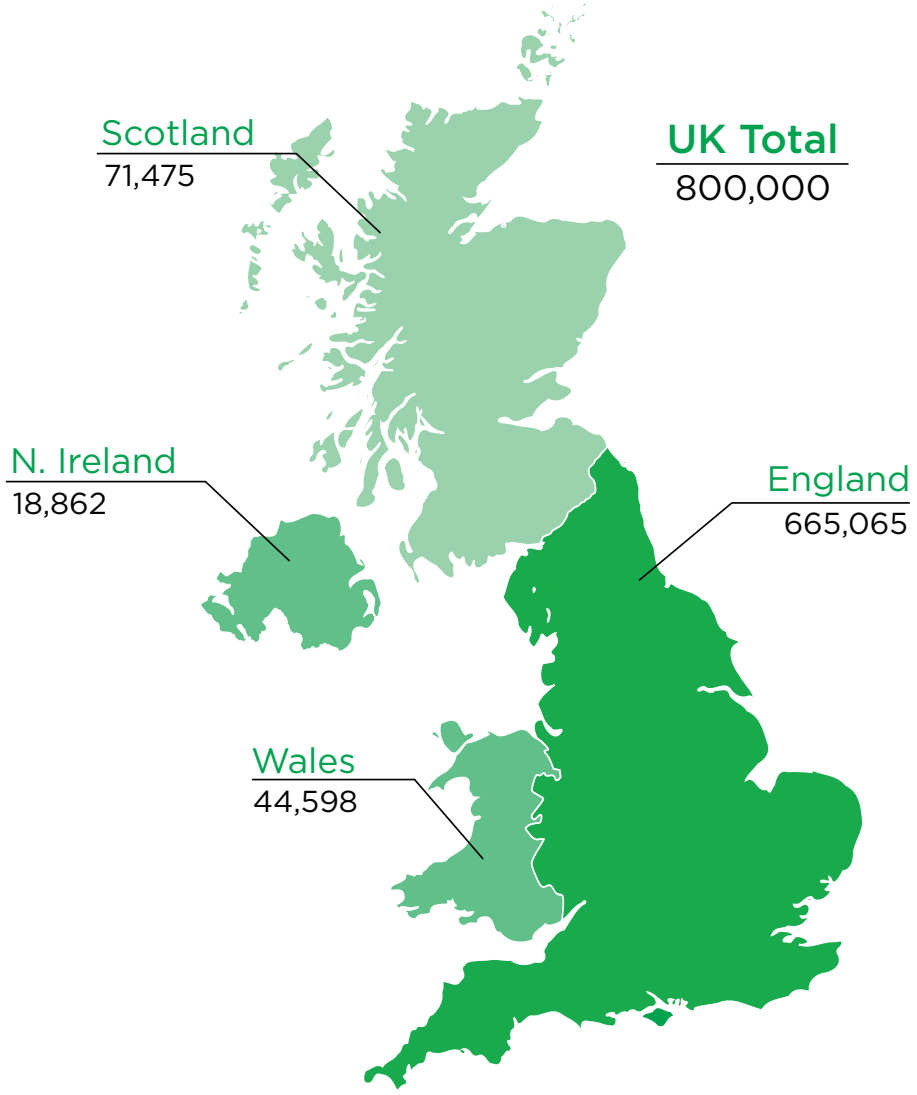
Such mea culpas are predictably rare, though, which is a worry as underfunding by local authorities (LA) has some serious implications. Providers can find it harder to reinvest in the facilities, training and staffing required to deliver high quality dementia care. Moreover, as the number at risk of dementia increases as the population ages, such problems are only going to get worse.

Is it fair to blame local authorities entirely for this mess, though? Despite the poor pay rates, care home operators have been flocking to dementia care in a bid to boost their occupancy. But sources tell *HealthInvestor* that some are knowingly cutting corners in the care they offer as they try to satisfy the bottom line.

More importantly, the Department of Health (DH) has remained oddly silent on the issue of underpaying, despite its well-publicised campaigns to improve dementia care. The CQC has done too little to change the status quo as well.

The answer to the problem lies somewhere between these actors it seems – but is there any prospect of a solution without there being more hard cash to spend?

FIGURE 1
BREAKDOWN OF THE POPULATION WITH DEMENTIA ACROSS THE UK



Source: http://www.alzheimers.org.uk/infographic

A ticking time bomb

Dementia is often described as a time bomb. Around 670,000 people in England have a form of the condition, a number set to double in the next 30 years. Already care costs some £19 billion a year and this will increase massively, putting strain on the public purse.

While the condition is incurable, some people wrongly view it as untreatable; medicines and other interventions can in fact lessons symptoms and extend life by some seven to 12 years after diagnosis. In other words how we treat the condition matters; and yet the UK has a far from gleaming reputation in this field.

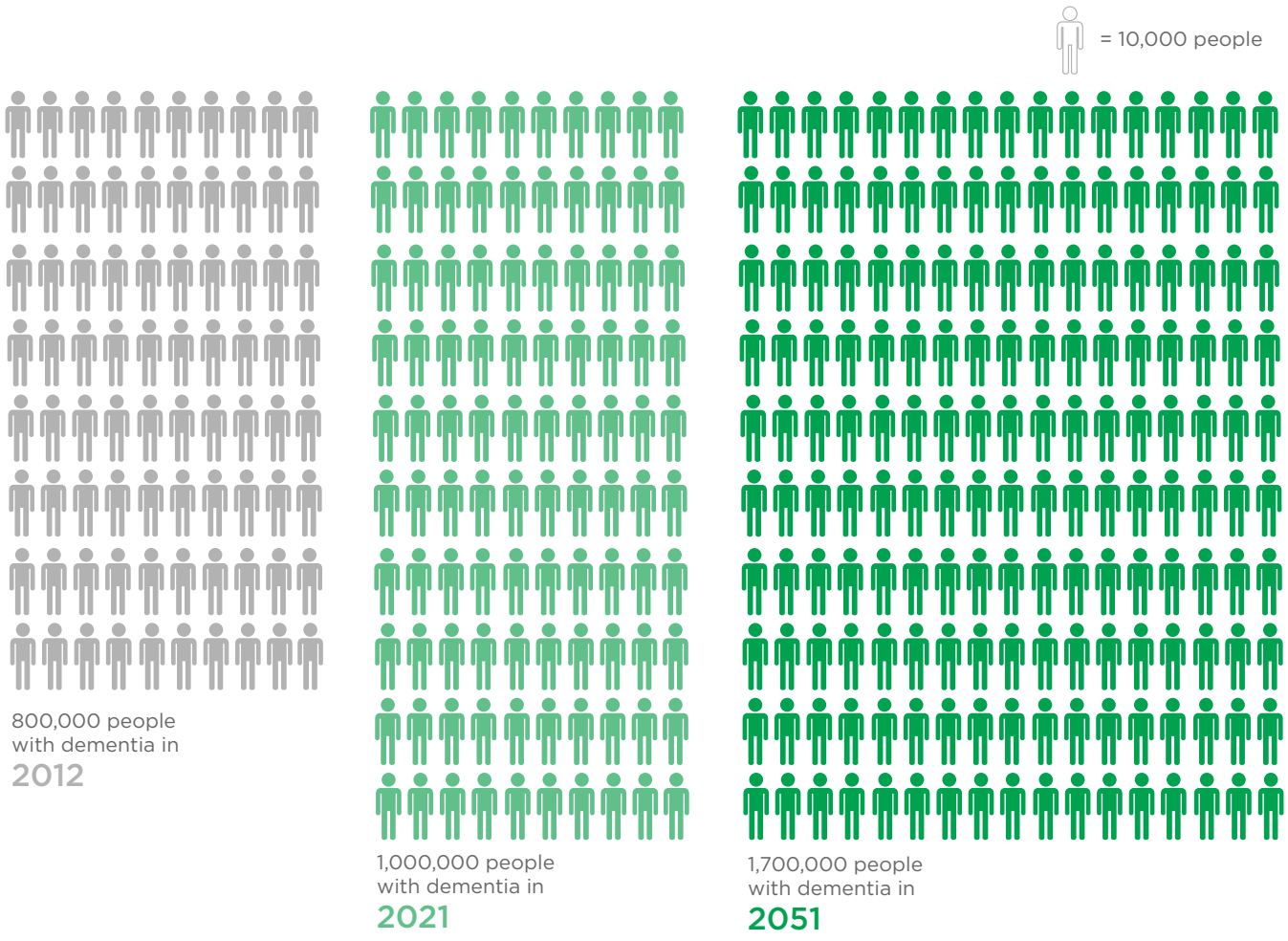
Part of the problem lies in the community and out of hospitals: too few people are diagnosed with the condition early, our communities are not sufficiently understanding of sufferers, and too few carers get the right sort of support. But care homes, which care for an estimated third of dementia sufferers, must take large portion of the blame as well.

A recent Alzheimer's Society survey of sufferers, their families and carers found adherence to standards in homes was "patchy", and that staff wanted more training. While 68% thought that quality of care for sufferers was good in homes, only 41% thought quality of life was good.

There is a catch here, of course. To fix all of this costs money, not enough of which appears to be forthcoming. Local authorities who fund or part fund more than half of all residential care, do pay an enhancement to reflect the higher acuity of dementia. But that typically stands at an average £30 extra a week – not enough in areas like the North, where there are fewer self-funding residents to cross subsidise those on lower LA pay rates.

The corollary is that LAs can have unrealistically high expectations of providers. "They want the moon on a stick," says the head of one medium sized care home. "You're looking at fees

FIGURE 2
THE NUMBER OF PEOPLE IN THE UK WITH DEMENTIA WILL DOUBLE IN THE NEXT 40 YEARS



Source: http://www.alzheimers.org.uk/infographic

of about £500 a week for nursing care at the bottom end, £650 at top, and it's just very, very difficult to do everything you need to treat advanced dementia within that fee regime."

She believes that £800 is in fact the real cost of good care; to put that in context Solihull will raise its maximum fee for dementia nursing care to £661 per week. LAs need to spend more, then, but in a climate of local authority spending cuts the chances of that are slim. (According to another source, a local authority he knows of even took away its dementia enhancement, claiming there was no specialist requirement).

It's not surprising then that the quality of care at some homes has suffered. This most obviously manifests itself in facilities: experts tend to agree that good care homes should be new builds, tailored for those with cognitive decline. For instance, it's preferable that facilities are built to a circular design so that residents can wander freely and never come to a dead end, which may upset them. But the cost of such facilities means they are comparatively rare.

Space can be an issue too: mixing dementia care residents with standard elderly care residents is thought to be a bad idea for both parties, and yet it goes on. "Providers hang on to all the residents they can get in my area because they don't want to lose them," says one source.

You can still provide a great dementia care service in suboptimal premises; as long as your staff are up to scratch, that is. Firstly that means training them well, as dementia sufferers can be highly challenging patients with a wide range of needs. But that is expensive too: in some areas of the country extra cash is provided for training, but in others it's a case of too little or none at all. "Good training doesn't mean up-skilling one nurse in a home," says Dr Joe Taylor, engagement manager at the consultancy Candesic. "It requires making sure everybody from the carers through to the cleaner has an appropriate level of training."

More worrying still are staffing levels. Best practice would have it that all sufferers do activities seven days a week, but that of course requires extra manpower, increasing a provider's overheads. As such many just don't hire the staff needed. Understandably, only 44% of respondents in the Alzheimer's Society survey felt that opportunities for activities in care homes were good.

FIGURE 3
SOME OF THE COST OF DEMENTIA IS HIDDEN BY THE WORK DONE BY FAMILY CARERS SUPPORTING PEOPLE AT HOME

Source: http://www.alzheimers.org.uk/infographic

Chicken/egg

Clearly local leaders must take much of the blame here. However, most accept that LAs are in between a rock and hard place as they struggle with huge cuts to their formula grants from Whitehall over the course of this parliament.

Furthermore, some note that firms may just not be deploying their finances that wisely: "Not all investment has parity of outcome for the experience of people in the home," says Taylor. "The colour of the wallpaper in the lobby may make a difference to visitors but doesn't make a blind bit of difference to residents. But having a contrasting colour loo seat and floor, or having your photo on your door really does."

Others go much further than this, though, alleging that some providers may in fact be knowingly cutting corners. And driving that risk is something of a paradox: while it may seem counterintuitive given the low rates of LA pay, dementia care is in fact becoming increasingly popular among providers as a way of increasing occupancy.

As readers of this magazine will know, care home occupancy has been under pressure for some time: average rates in the UK slipped from 87.8% to 87.2% in 2012 according to Knight Frank, although they were much lower in the South West and North East. Given the high fixed costs of most care homes, outfits struggle when they don't fill beds, especially if they're smaller operators. As most of the profit they make comes from the last 10% of rooms they fill, occupancy

of any lower than 85% can be hazardous to the bottom line.

Filling your rooms offers an obvious way out – and with two thirds of residents in care homes already thought to be dementia sufferers, many are keen to nurture this market. Registering your purported capacity to deliver dementia care with the Care Quality Commission (CQC) is said to be relatively easy, too. "There is definitely a perception that dementia care is a way forward because there's a bigger market growing in that area without a solution," says one care home head.

The upshot is that poor providers slip through the net. Mansfield Advisors, a consultancy, says that local authority commissioners it has surveyed complain of a 'considerable shortage' of good dementia care beds in the UK. Using dementia care as a shortcut to better occupancy is clearly counterintuitive, then, and needs to be discouraged. After all, the sort of investment needed in staff and buildings for good care offsets any 'quick wins' to be had in the space.

The pre-eminent model of care home operation in the UK will make changing the status quo hard, though. The easy answer to improving dementia care is to invest more in your staff and training upfront, even if it means a running lower ebitda margin, say of 25%. The argument for this is that, by improving your reputation among commissioners and the public, you will ultimately raise your level of occupancy.

But the high costs involved in running asset heavy care homes often preclude taking short term risk onto the balance sheet, as providers strain for higher margins of 30%-35% to maintain growth. "I think the corporate aspiration for such margins is the wrong model for dementia care," says one source despondently. "Your other costs are rising, like the minimum wage and utility bills, and so the only thing you can squeeze are your hours of service provision."

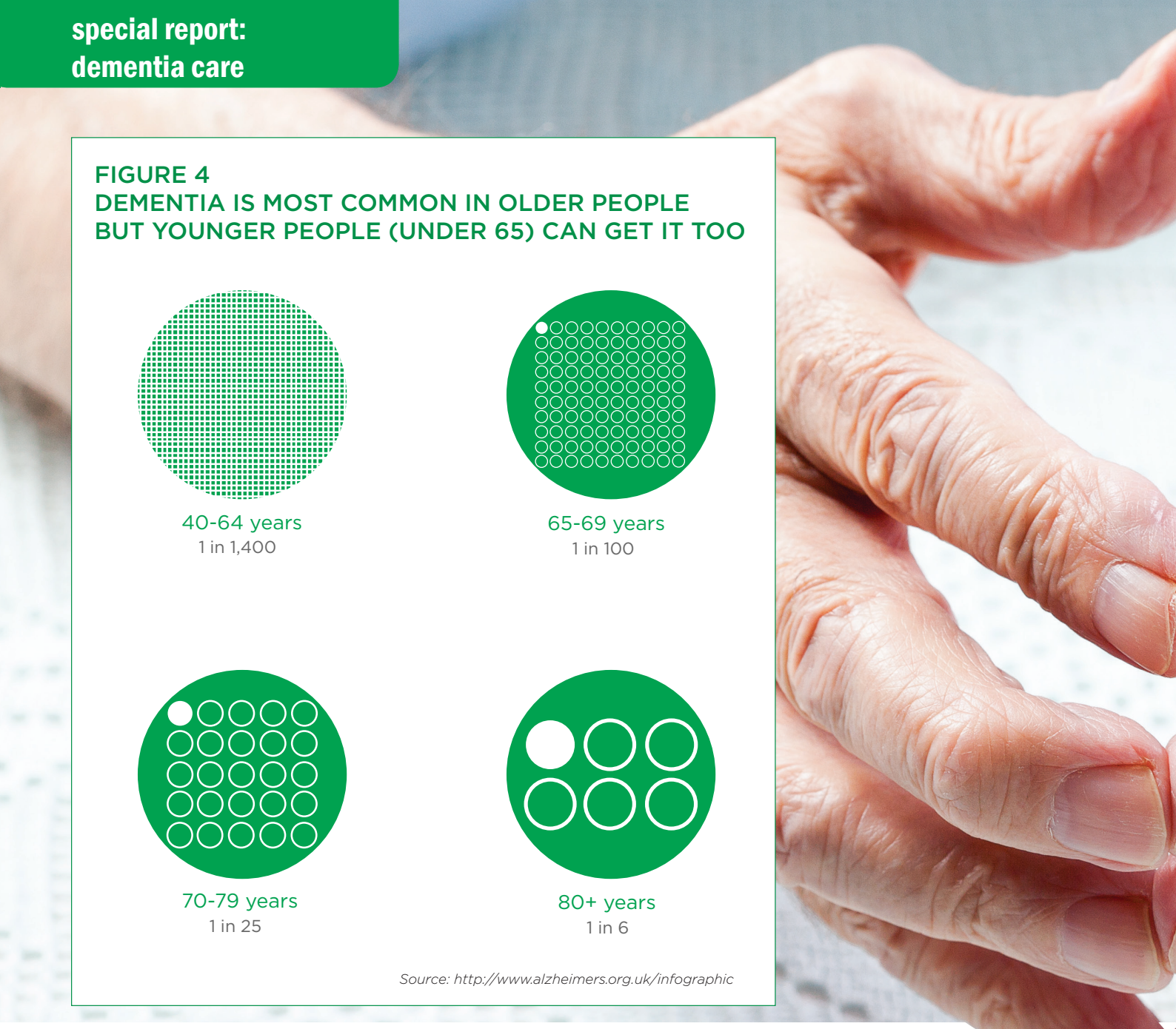


FIGURE 4
DEMENTIA IS MOST COMMON IN OLDER PEOPLE BUT YOUNGER PEOPLE (UNDER 65) CAN GET IT TOO

40-64 years
1 in 1,400

65-69 years
1 in 100

70-79 years
1 in 25

80+ years
1 in 6

Source: http://www.alzheimers.org.uk/infographic

Blame it on the man

So what is the government doing about all this? In March 2012, David Cameron launched the Prime Minister's challenge on dementia, which focuses on improving early diagnosis, building dementia-friendly communities, and improving health and social care services. But while the DH has been willing to increase funding for research (David Cameron has claimed we could see a cure within 12 years) and improve a limited number of care facilities, its support for care homes overall has been flimsy.

The first oversight has been quality assurance. Critics say the CQC's evaluation of care homes has in the past been too infrequent (thanks in large part to a cut in the number of inspectors) and vague in terms of outcomes. More importantly, rather than highlighting and spreading best practice, it has acted more as a safety net: identifying failure and ensuring basic compliance.

CQC is in the midst of overhauling the way it inspects care homes, and dementia care is likely to benefit to some degree. On the cards is a generally tougher line on poor providers and a 'star ratings' system, giving the public clearer information about the quality of operators. But for Taylor the overhaul is still too focused on failure: "It's clear the current CQC evaluation overhaul is aimed at identifying as early as possible those homes which are performing poorly. What I'm arguing for is that the CQC looks at the other end of the market, to those doing incredibly well, and holding those up as examples for the rest."

Charged as they are with safeguarding care quality too, local authorities have tried to fill the breach. While the CQC is expected to visit homes at least once a year, some LAs visit as many as four times, often carrying out two day-long inspections. They are also increasingly writing their own quality standards into provider contracts, and even raising fees for the best providers.

This strategy could encourage transition in the market, but it comes with caveats. For one, it is questionable whether commissioners who hold the purse strings should also be assessing quality.

It also doesn't answer the fundamental

Dementia in brief

1. The current system of funding of social care means that many people with dementia and their families face significant care costs, sometimes running into hundreds of thousands of pounds.

2. Around 670,000 people in England have dementia and this number is expected to double in the next 30 years.

3. Dementia costs £19 billion a year, more than the costs of cancer, heart disease or stroke.

4. An estimated 25% of hospital beds are occupied by people with dementia.

5. People with dementia also stay in hospital for longer, are more likely to be re-admitted and more likely to die than patients admitted for the same reason.

6. An estimated third of people with dementia live in residential care with two thirds living at home. Approximately two thirds of care home residents are believed to have dementia.

7. Dementia is progressive and the condition is currently incurable.

8. Around 60% of people with dementia have Alzheimer's disease, around 20% have vascular disease and many have a mixture of the two. There are other less common forms of dementia.

question of how to channel more LA investment into maintaining standards in care homes in the first place. On that thornier (and far more expensive) issue, the DH has been conspicuously silent. In a 65-page report on dementia, published in November, it bemoans the variable quality of care in homes across the country, as well as the lack of training. However it makes no mention of underinvestment by local authorities, despite high profile calls to action on the matter from the Alzheimer's Society.

The DH told *HealthInvestor* it was aware of the problem, but it would take none of the blame: care providers needed to focus less on their bottom lines, LAs less on securing care for lower prices. The solutions it proposes are mainly focused on reinforcing commissioning standards, while plans to increase overall funding raise as many questions as they answer. For example, the DH wants to tackle the high cost of dementia care for the public, which under our current means-tested system can stretch into the hundreds of thousands of pounds. The new Care Bill looks to address this by capping the amount anyone pays towards care at £72,000 from 2016 – but what it saves the consumer may well end up costing local authorities (which may in turn end up affecting the consumer).

It leaves a lot riding on another government initiative, to increase integration between local authority-backed and NHS services. Efforts to pool budgets will mean more NHS money ends up being spent on social care, increasing the total amount of expenditure in this area. But how much funding will be made available in future and what it will be spent on is unclear.

Furthermore, integration is primarily designed to allow more NHS patients to be treated in the community as opposed to in hospital, so funding per dementia suffer in care homes may not rise by that much at all.

For now, then, dementia care's most deep-seated problem is set to continue. Some sufferers will continue to miss out on the care they need, while paying far too much for the privilege.

The exposure of those behind the problem will help to a certain degree: Solihull's move to rectify its faults is definitely a sign that things can change. But while the English Community Care Association called it a "significant move", it rather bleakly expects that few other councils will rush to mirror such good deeds.

More importantly, blaming one side or the other won't solve the basic problem: we need to invest more in dementia care in care homes, but few are willing to pay. ■