Adult Social Care and Health Overview and Scrutiny Committee

16 September 2010

Agenda

A meeting of the Adult Social Care and Health Overview and Scrutiny Committee will be held at the **SHIRE HALL, WARWICK on THURSDAY 16 SEPTEMBER 2010 at 9.30 a.m.**

The agenda will be: -

1. General

(1) Apologies

(2) Members' Disclosures of Personal and Prejudicial Interests.

Members are reminded that they should disclose the existence and nature of their personal interests at the commencement of the relevant item (or as soon as the interest becomes apparent). If that interest is a prejudicial interest the Member must withdraw from the room unless one of the exceptions applies.

'Membership of a district or borough council is classed as a personal interest under the Code of Conduct. A Member does not need to declare this interest unless the Member chooses to speak on a matter relating to their membership. If the Member does not wish to speak on the matter, the Member may still vote on the matter without making a declaration'.

(3) Remit of the Adult Social Care and Health Overview and Scrutiny Committee

To review and or scrutinise the provision of public services in Warwickshire relating to adult social care services including social care to older people and people with disabilities, policies and services for safeguarding adults and any matter relating to the planning provision and operation of health services for adults and children serving Warwickshire.

(4) Minutes of the meetings of the Adult Social Care and Health Overview and Scrutiny Committee held on 14 July 2010

(5) Chair's Announcements

2. Public Question Time (Standing Order 34)

Up to 30 minutes of the meeting is available for members of the public to ask questions on any matters relevant to the business of the Corporate Services and Community Safety Overview and Scrutiny Committee.

Questioners may ask two questions and can speak for up to three minutes each.

For further information about public question time, please contact Ann Mawdsley on 01926 418079 or e-mail ***annmawdsley@warwickshire.gov.uk***.

3. Questions to the Portfolio Holders

Up to 30 minutes of the meeting is available for Members of the Committee to put questions to the Portfolio Holders (Councillor Izzi Seccombe (Adult Social Care) and Councillor Bob Stevens (Health) on any matters relevant to the Adult Social Care and Health Overview and Scrutiny Committee's remit and for the Portfolio Holders to update the Committee on relevant issues.

Health items

4. NHS White Paper

The Committee will receive an update from John Linnane, Director of Public Health, NHS Warwickshire on the consultation papers associated with the NHS White Paper, to consider implications for Warwickshire. A Briefing Note is attached.

5. Best Health for Older People in Warwickshire: Joint Director of Public Health Annual Report

This report is embargoed until 15 September 2010 and will be forwarded separately.

Report of the Joint Director of Public Health

This report aims to highlight some of the main health and social care needs of this population. It summarises the current services and priority work programmes in place to meet these needs. It will also provide a starting point for talks with our local communities and partners around our older people's need and how together we can address them.

Recommendation

It is recommended that the Overview and Scrutiny Committee consider and comment on the annual report which is attached at Appendix A.

For further information please contact Rachel Robinson, Warwickshire PCT, Tel.: 01926 493491, Ext 214.

6. Children and Adolescent Mental Health Services (CAMHS) Joint Scrutiny Review

Report of the Chair of the Joint Review Group of the former Children, Young People & Families and Health Overview and Scrutiny Committees

This report presents the report and recommendations from the Joint Scrutiny Review of the CAMHS.

Recommendation

The Committee is recommended to agree the report and recommendations of the Joint Scrutiny Review of the Children and Adolescent Mental Health Services and to forward the report and recommendations onto Cabinet for consideration.

For further information please contact Michelle McHugh, Overview and Scrutiny Manager, Tel: 01926 412144 E-mail ***michellemchugh@warwickshire.gov.uk*** or Richard Maybey, Assistant to Political Group (Labour), Tel:01926 476876 E-mail ***richardmaybey@warwickshire.gov.uk***.

Adult Social Care items

7. Review of Support for Carers

Report of the Chair of the Member Panel

In September 2009 the Overview and Scrutiny Board commissioned a review of support for carers in Warwickshire. A panel was formed comprising members from the (then) Adult and Community Services Overview and Scrutiny Committee. Appended to this briefing covering report is the panel's main report which contains its findings, conclusions and recommendations.

Recommendation

That the committee agrees the recommendations of the panel and passes them to Cabinet for consideration.

For further information please contact Paul Williams, Overview and Scrutiny Officer, Tel: 01926 418196 E-mail ***paulwilliams@warwickshire.gov.uk***.

Joint Health and Adult Social Care items

8. Progress Report on Implementation of Recommendations from Review of Falls Prevention in Warwickshire

Report of the Strategic Director of the Customers Workforce and Governance Directorate

In April 2008, the Health Overview and Scrutiny Committee and the Adult and Community Services Overview and Scrutiny Committee resolved to establish a joint panel to look into the topic of falls prevention and make recommendations which would lead to improvements in the services provided across Warwickshire. This is a progress report on the implementation of the recommendations suggested by both committees.

Recommendation

The Committee to:
Consider and deliberate the progress being made with the implementation of the recommendations from the review of falls prevention in Warwickshire.

For further information please contact Alwin McGibbon, Overview and Scrutiny Officer, Tel: 01926 412075 E-mail ***alwinmcgibbon@warwickshire.gov.uk*** or Michelle McHugh, Overview and Scrutiny Manager, Tel: 01926 412144 E-mail ***michellemchugh@warwickshire.gov.uk***.

9. Work Programme and proposed Task and Finish Groups

Report of the Chair of the Adult Social Care and Health Overview and Scrutiny Committee

This report contains the Work Programme for the Adult Social Care and Health Overview and Scrutiny Committee and review outlines for the proposed Task and Finish Groups suggested by the Committee at its meeting on 14 July 2010.

Recommendation

The Committee is recommended to agree:

i) the work programme, to be reviewed and reprioritise as appropriate throughout the course of the year

ii) the draft review outlines for the proposed Task and Finish Groups (Low Level Prevention Services and Delayed Discharges and Reablement Services) and forward them on to the Overview and Scrutiny Board for consideration.

For further information please contact Michelle McHugh, Overview and Scrutiny Manager, Tel: 01926 412144 E-mail ***michellemchugh@warwickshire.gov.uk***.

Forward Plan

For information:

Cabinet – 14 October 2010
Director of Public Health Annual Report

10. Any Other Items

which the Chair decides are urgent.

JIM GRAHAM
Chief Executive

Adult Social Care and Health Overview and Scrutiny Committee Membership

Councillors Martyn Ashford, Penny Bould, Les Caborn (Chair), Jose Compton, Richard Dodd, Kate Rolfe (S), Dave Shilton (Vice Chair), Sid Tooth(S), Angela Warner and Claire Watson.

District and Borough Councillors (5-voting on health matters) One Member from each district/borough in Warwickshire. Each must be a member of an Overview and Scrutiny Committee of their authority:

BRIEFING NOTE ON WHITE PAPER – EQUITY AND EXCELLENCE: LIBERATING THE NHS

1. On 12 July 2010 the new Coalition Government launched a white paper on the future structure of the NHS. The White Paper reaffirmed the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based clinical need, not the ability to pay.

2. The White Paper sets out a long term vision for the NHS and outlines a number of reforms principally:

    - More patient choice and control
    - More local authority oversight – Health and Wellbeing Boards
    - Creation of a consumer champion – Health Watch England
    - A greater focus on quality outcomes
    - Devolution of responsibility for commissioning services to GPs, working in consortia.
    - Establishment of an independent NHS Commissioning Board
    - ALL NHS Trusts to become Foundation Trusts

3. With regard to resources, the Government committed year on year to real term spending increases on the health service. In addition, the White Paper promised to:

    - Release £20 billion of efficiency savings by 2014
    - Reduce management costs by more than 45%
    - Ring fence the public health budget

4. Over the following days and weeks the Government published a series of documents and supporting White papers which outlined the process for managing the change as well as providing more detail on the proposed changes. These documents include:

    - Framework for transition – detailed letter from NHS chief Exec
    - NHS Outcomes framework
    - Commissioning for patients
    - Local democratic legitimacy in health
    - Freeing providers and economic regulation
    - Report of the arm's length bodies review

5. The White Paper: Liberating the NHS and the supporting White Papers have, unlike most White Papers, been issued for comment and consultation. 'Liberating the NHS' requests comments by 5 October, the other papers by 11 October. Details of the other reports are outlined below:

6. NHS Outcome Framework

This paper outlines a range of outcome 'goals' for use across the NHS. Outcomes are identified across 5 domains.

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

While the focus of this White Paper is on the NHS it does mention inequalities:

The NHS Outcomes Framework should recognise the importance of reducing inequalities and promoting equality. For example, because of the social gradient in most health outcomes, the most potential health gain will often be available from the lower reaches of the gradient, from disadvantaged groups and areas.

It also mentions partnership:

There will, of course, be outcomes that can only be delivered for patients and carers if the NHS works in partnership with the new public health service that will be created and with social care services. The Department of Health will be constructing and consulting on outcomes frameworks for these sectors in coming moths as part of an integrated cross-service approach in the Spending Review. These will be developed so that strategies can be developed to ensure that organisations provide complementary and integrated services.

The paper which runs to 66 pages has 35 specific consultation questions with the consultation closing on 11 October.

7. **Commissioning for Patients**

This White Paper sets out the proposals fo putting local consortia of GP practices in charge of commissioning. It also sets out the role of the independent NHS Commissioning Board and how this range of proposals will be implemented. This White Paper runs to 40 pages, contains 26 questions for consultation with a closing date of 11 October. More detail on the specific proposals are outlined in the next three paragraphs.

8. The NHS White Papers set out a significant change to the NHS and provides a series of opportunities and challenges for Local Government. The consultation ends on 11 October and the Council is currently developing a response to the proposals.

GP Consortia

All GP practices will be a member of a consortium, they will work in partnership with Public Health Service and Local Authorities with incentives for effective commissioning through the GP Commissioning Outcomes Framework (developed by NHS Commissioning Board)

Functions *(powers and duties will be set out in primary and secondary legislation):*

- Responsibility for commissioning services (some jointly with local authorities) and overseeing budgets
- Agree, monitor and hold contracts with providers for locality-based services
- Responsibility for commissioning services for people not registered with a GP practice
- Manage risk
- Lead redesign of local services
- Hold constituent practices to account against objectives (stewardship of NHS resources and outcomes achieved)
- Duty to promote equalities and to work in partnership with local authorities (for health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations)
- Duty of public and patient involvement

- NB: Consortia will <u>not</u> directly responsible for commissioning services that GPs provide or other family health services (dentistry, community pharmacy and primary opthalmic services

Structures & resources:

- Will include an accountable officer
- May chose to adopt lead commissioner role (e.g. for large teaching hospitals)
- May buy in support from external services, e.g. for demographic analysis, contract negotiation, performance monitoring, aspects of financial management
- Will receive a maximum management allowance to reflect costs associated with commissioning, with a premium for high quality outcomes and for financial performance
- Shadow consortia established in shadow form and taking on increasing delegated responsibility from PCTs in 2011/12
- Consortia to take responsibility for commissioning in 2012/13
- Take full financial responsibility from April 2013

9. **NHS Commissioning Board**

Five main functions:

9.1 Providing National Leadership on commissioning for quality improvement

9.2 Promoting and extending public and patient involvement and choice

9.3 Ensuring the development of GP consortia

9.4 Commissioning certain services (family service, specialised services, maternity services)
9.5 Allocating and accounting for NHS resources

Also:

- Support SoS and the Public Health service to ensure resillience/emergency planning
- Standardise good practice through commissioning guidelines
- Promote equality in line with Equality Act 2010
- Take over current CQC responsibility of assessing NHS commissioners and will hold GO consortia to account for their performance and quality
- Promote involvement in research and use of research evidence
- Develop and agree guarantees for patients around choices they make
- Develop an implementation plan for the choice agenda (early task)
- Held to account against national goals outlined in NHS Outcomes Framework: NHS Outcomes framework will be translated into GP Commissioning Outcomes Framework
- Hold consortia to account for stewardship of NHS resources and for outcomes achieved
- Under a duty to establish a comprehensive system of GP consortia with reserve power to assign practices to consortia if necessary with Monitor, ensure that commissioning decision are fair and transparent. And promote competition
- Board will be established in shadow form from April 2011. In 2011/12 it will develop it's future business model, organisational structure and staffing. It will become a statutory body from April 2012
- Make allocations for 2013/14 directly to GP consortia in 2012

- It will <u>not</u> manage providers or be NHS headquarters

10. Commissioning for Patients also sets out proposals for emergent GP Consortia around partnership, public voice and public health. It sets out six specific questions for consultation:

    - How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?
    - Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?
    - How can GP Consortia and the NHS Commissioning Board best involve patients in making commissioning decision that are built on patient insight?
    - How can GP Consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

- How can we build on and strengthen existing systems of engagement such as Local Health Watch and GP practices' Patient Participation Groups?
- What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?
- How can multi-professional involvement in commissioning most effectively be promoted and sustained?

11. **Regulating Healthcare Providers**
This White Paper sets out the freedoms to be enjoyed by provider foundation trusts and the role of monitor to regulate all trusts. This document runs to 31 pages, identifies 21 consultation questions and consultation closes on 11 October.

12. **Local Democratic Legitimacy in Health**
Probably the most pertinent to Local Government is the White Paper Local Democratic Legitimacy in Health. This is a short paper of 20 pages which sets out detail around the transfer of the Public Helath responsibilities to Local Government and the creation of Health and Wellbeing Boards. More detail is outlined below. This paper also asks 18 sepcific consultation questions which are included as Append 1. The DOH has also produced a leaflet for patients and the public on the changes – Appendix 2.

  - Function of joining up the commissioning of local NHS services, social care and health improvement

- NB: <u>No</u> day-to-day involvement with NHS service

Public Health Service
Integration of existing health improvement and protection bodies will form a new Public Health Service

Functions:
- ***Lead role***: Public Health research, evidence and analysis
- Health Improvement
- Health Protection
- Oversee Vaccination Programmes
- Oversee Screening Programmes
- Public Health emergencies
- Employ DsPH in joint role with Local Government

Local Government
- Will have national objectives for improving population health outcomes but will locally determine, working with elected members how to meet objectives, including through commissioning of services from NHS providers

Functions:

- Lead for: JSNAs
- Employ DsPH in joint role with Public Health Service
- Promoting integration and partnership working between the NHS, social care, public health and other local services and strategies
- Building partnerships for service changes and priorities with an escalation process to the NHS Commissioning Board and the SoS (replacing current statutory functions of Health Overview and Scrutiny Committees)
- Existing PCT responsibilities for health improvement will come to local authorities, with ring-fenced funding and accountability to SoS
- Preventative action in Adult Social Care
- New statutory arrangements in local authorities as “health and wellbeing boards” or within existing strategic partnerships to take a strategic approach and promote integration across health and adult social care, children’s services, including safeguarding, and wider local authority agenda:

LIBERATING THE NHS: LOCAL DEMOCRATIC LEGITIMACY IN HEALTH

A consultation on proposals

Executive summary

Introduction

1. The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's strategy for the NHS. Our intention is to create an NHS that is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

2. This consultation sets out how an enhanced role for local government will increase local democratic accountability and invites views on these proposals. It has been produced jointly by the Department of Health and the Department for Communities and Local Government.

Strengthening public and patient involvement

3. Localism is one of the defining principles of this Government: pushing power away from Whitehall out to those who know what will work best in their communities. A strong local voice for patients through local democratic representation is critical to creating a more responsive NHS. Individuals should have a greater say in decisions that affect their health and care and have a clear route to influence the services they receive.

4. We will develop a more powerful and stable local infrastructure in the form of local HealthWatch, which will act as local consumer champions across health and care. Local Involvement Networks (LINks) will become the local HealthWatch. Like LINks, their services will continue to be contracted by local authorities and they will promote patient and public involvement and seek views on local health and social care services. We propose that local HealthWatch be given additional functions and funding, so that they become more like a "citizen's advice bureau" for health and social care - the local consumer champion. The consultation invites views on these issues.

Improving integrated working

5. We are consulting on how best to implement these changes and draw your attention to the full version of the White Paper and to related consultation documents, available on the Department of Health website at www.dh.gov.uk/liberatingthenhs. People want services that feel joined up, and it can be a source of great frustration when that does not happen. Integration means different things to different people but at its heart is building services around individuals, not institutions. Through this consultation we

are seeking views on how to simplify and extend the use of powers that enable joint working between the NHS and local authorities.

6. One of the central features of the proposals in the White Paper is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. In the future, most commissioning decisions will be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. *Liberating the NHS: Commissioning for patients* gives further detail of how GP commissioning consortia and the NHS Commissioning Board will work.

7. Building on the power of the local authority to promote local wellbeing, we will establish new statutory arrangements to strengthen the role of local authorities. Local authorities will have greater responsibility in four areas:
    - leading joint strategic needs assessments to ensure coherent and co-coordinated commissioning strategies;
    - supporting local voice, and the exercise of patient choice
    - promoting joined up commissioning of local NHS services, social care and health improvement; and
    - leading on local health improvement and prevention activity.

8. Through elected councillors, local authorities will bring greater local democratic legitimacy to these roles. These arrangements will give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care.

9. With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder. This has the potential to meet people's needs more effectively and promote the best use of public resources.

10. We are consulting on whether local authorities should work together with local NHS commissioners to devise their own local arrangements or whether a statutory partnership board, hosted by the local authority, would be a helpful focal point for activity. We are also consulting on what processes need to be in place to ensure there is appropriate oversight of the way in which health and care decisions are made.

Local authority leadership for health improvement

11. In future, local authorities will have a stronger influence on the health outcomes of their local area. When primary care trusts (PCTs) cease to exist, we intend to transfer responsibility and funding for local health improvement activity to local authorities. Funding for health improvement includes that spent on the prevention of ill-health by addressing lifestyle factors such as smoking, alcohol, diet and physical exercise.

12. Local authority leadership for local health improvement will be complemented by the creation of a National Public Health Service (PHS). The PHS will integrate and streamline health improvement and protection bodies and functions, and will include an increased emphasis on research, analysis and evaluation. It will secure the delivery of public health services that need to be undertaken at a national level.

13. Local Directors of Public Health will be jointly appointed by local authorities and the PHS. Local Directors will have a ring-fenced health improvement budget, allocated by the PHS; and they will be able to deploy these resources to deliver national and local priorities. There will be direct accountability to both the local authority, and, through the PHS, to the Secretary of State. Through being employees of the local authority, local Directors of Public Health will have direct influence over the wider determinants of health, advising elected members and as part of the senior management team of the local authority.

Conclusion and summary of consultation questions

14. The consultation invites comments on these proposals and the best way to deliver local democratic legitimacy in health by 11 October 2011. Subject to legislation, the new functions will transfer to local authorities from 2012. The Government proposes to make the changes through its forthcoming Health Bill, planned for introduction this autumn.

Responding to the Consultation

15. We are consulting on how best to implement the changes outlined in this summary and draw your attention to the full version of this consultation document and to the White Paper and other related consultation documents, available on the Department of Health website at www.dh.gov.uk/liberatingthenhs. Responses to the questions in the full consultation document should be sent to nhswhitepaper@dh.gsi.gov.uk or to the White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS.

Appendix 2

IMPROVING YOUR NHS: WHAT CAN YOU EXPECT?

We are making changes to improve your NHS. This leaflet explains:

- what these changes mean for you and your family.
- how to have your say.

What will stay the same?

The NHS remains a free, national, public service. Spending on the NHS will increase and not be cut. You have important rights under the NHS Constitution, including the right of access to the treatments and therapies you need, and the right to be treated with respect and not to be discriminated against.

What needs to improve?

At its best the NHS is excellent, but it's not good enough everywhere, all the time. We can do more to help people survive serious illness, cope with long-term conditions and avoid complications. Too often, despite the best efforts of NHS staff, people are expected to fit around services, rather than the other way round and they are not always listened to. People are sometimes treated as "cases" rather than individuals. People looking after sick or disabled family members don't always get enough help. Health staff get tied up in paperwork, and there is too much waste.

What can I expect to see?

We want people and their families to have much more say in decisions about their care and treatment. No decision should be made about you, without you. By 2013, we expect people everywhere to see these changes:

Better information and a listening NHS:

- You will be able to see, own and share your personal health records
- It will be easier to find out what services are available, how good and safe they are and what people think of them.
- It will be easier to communicate with your doctors and nurses, eg online and by email

- Your views will matter and NHS staff will want to hear them. You will be encouraged to rate the care you have received. Things will change because of people's views and comments.

Getting the care I need:

- You will be able to choose or change your GP surgery. You will not be limited to the one that is nearest to your home.
- You will be able to choose the treatments and services that best suit your needs. If you need hospital care you will be able to choose the hospital and the consultant-led team in charge of your care.
- Your doctor will help you understand the choices of treatment and service available, and involve you in all decisions about your care, and the care of your family members.
- Some parts of the country don't have enough family doctors, nurses and other staff. We will start to put that right.
- There will be good, safe care available outside GP surgery hours, with a single telephone number to ring.
- There will be better care at or closer to home, so that people with long-term health conditions and disabilities can live more independently and have less need to go into hospital.

Getting help and support

Local independent organisations called HealthWatch will provide help, information and support, and stand up for your rights. HealthWatch will be able to help you:

- find out what services are available
- make informed choices
- voice a concern or make a complaint
- have your say in the services delivered locally.

Behind the scenes….

To make these improvements we are changing the way the NHS is run. Local health staff and local communities will have more clout and fewer decisions will be taken by Whitehall and by politicians.

Health staff will have to account for the quality of their work and the results they achieve, not the quantity of their work. We will ask: is enough being done to save lives? Help people recover? Improve quality of life? Is care safe? Are people having a positive experience of care?

There will be independent checks on doctors to make sure they remain up to date in their knowledge and safe to practice.

All the agencies providing care and support services will have to work more closely with the NHS so that you get a seamless service, tailored to your needs.

Health staff will have a duty to be honest and open about mistakes, so that the NHS can learn from them and things can be put right as quickly as possible. There will be tough penalties for serious, avoidable mistakes.

The money saved by cutting waste and red tape will be put back into the NHS to improve care.

What do you think?

This is only a summary of the changes planned; you can find more detail at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117782 . We want to hear your views and suggestions and you can make your voice heard by 5 October 2010.

This leaflet applies to England only. It has been produced by the Department of Health and put into plain English with the help of the charity National Voices.

Appendix 3

This document is 68 pages long

Shortcut to:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_117721.pdf

Agenda No

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview and Scrutiny Committee**
Date of Committee	**16th September 2010**
Report Title	**Best Health for Older People in Warwickshire: Joint Director of Public Health Annual Report**
Summary	This report aims to highlight some of the main health and social care needs of this population. It summarises the current services and priority work programmes in place to meet these needs. It will also provide a starting point for talks with our local communities and partners around our older people's needs and how together we can address them.
For further information please contact:	Rachel Robinson Warwickshire PCT Tel: 01926 493491 ext 214
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None.

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☒	Not Applicable
Other Elected Members	☒	Councillor L Caborn, Councillor D Shilton, Councillor S Tooth, Councillor C Rolfe
Cabinet Member	☒	Councillor I Seccombe, Councillor A Farnell
Chief Executive	☐	.....
Legal	☒	Alison Hallworth, Adult and Community Team Leader
Finance	☒	Chris Norton, Strategic Finance Manager
Other Chief Officers	☐	.....

District Councils	☐	.....
Health Authority	☐	.....
Police	☐	.....
Other Bodies/Individuals	☒	Michelle McHugh, O&S Manager

FINAL DECISION YES

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☐	.....
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Further Consultation	☐	.....

Agenda No

Adult Social Care and Health Overview and Scrutiny Committee – 16th September 2010

Best Health for Older People in Warwickshire: Joint Director of Public Health Annual Report

Report of the Joint Director of Public Health

Recommendation

It is recommended that the Overview and Scrutiny Committee consider and comment on the annual report which is attached at Appendix A.

1. Overview

1.1 The population of Warwickshire is ageing at a faster rate than the national average.

1.2 Inequalities continue to persist in this population.

1.3 There are number of specific challenges for people living in rural areas.

2. Main findings

2.1 Healthy lifestyle behaviours vary considerably within our over 50s population.

2.2 Long term conditions are the 'invisible epidemic' for elderly people.

2.3 Elderly people disproportionately use hospital care.

3. Key challenges for health and social care services in Warwickshire

3.1 For the general population aged 50 and above, how do we promote health, independence and well-being? This is the challenge for Public Health.

3.2 For the population aged 75 and above, how do we identify the problems which threaten health, independence and well-being at an early stage and respond appropriately? This is a challenge for Primary Care.

3.3 For the population aged 75 plus, how do we reduce unnecessary needs for hospital care and long term care services. This is a challenge for hospital and community services, working together.

4. Our Plans

4.1 Promoting health, independence and well-being by finding older people every opportunity to stay active, physically and mentally, and to strengthen networks with families and friends to avoid social isolation.

4.2 Reducing unmet needs and risks through participation in a nationally funded project to ensure systematic identification and personalised response to older people's health and care needs.

4.3 Reducing the impact of frailty by an enhanced community response to assess the older person in their own home, expert care to diagnose and treat underlying medical conditions, early transfer for rehabilitation services and a comprehensive multi-disciplinary assessment of longer term care needs.

5. Recommendations

5.1 Life expectancy: NHS Warwickshire, Warwickshire County Council and partners should develop an action plan to reduce the variation in life expectancy and healthy life expectancy at age 65 years across the county.

5.2 Health inequalities: All NHS and local government strategies and action plans for Older People need to explicitly identify how they will tackle health inequalities in older age and how they will address the needs of older ethnic minorities, disabled and other minority groups.

5.3 Prevention: All the statutory agencies and services must develop a greater focus on disease prevention and health promotion among older people. This includes improving access to screening services and promoting healthy eating, physical activity and smoking cessation.

5.4 Fuel poverty: There are over 300 excess winter deaths across Warwickshire each year. We need to clearly identify and action the role of Primary Care and Community Health Services working with local government to tackle this.

5.5 Rural Isolation: Primary Care and Community Services need to clearly demonstrate how their plans and services tackle rural isolation and access to services in rural areas.

5.6 Dementia: The health service and local government across Warwickshire must urgently ratify and implement a simple strategy and pathway of care and support for dementia.

5.7 End of life care: The Gold Standards Framework (GSF) for palliative identification and support to improve skills around care planning and identification of patients in the last year of life needs to be fully embedded in primary care to enable support to more people to be cared for at home and die in a place of their choosing.

JOHN LINNANE
Joint Director of Public Health

Shire Hall
Warwick

September 2010

NHS
Warwickshire

Best Health for Older People in Warwickshire

The 2009/10 Annual Report of the Joint Director of Public Health

and

Section One of the Warwickshire Joint Strategic Needs Assessment

Warwickshire is facing a large scale demographic transition as the population ages at a faster rate than the national average.

This is set against a background of persisting health inequalities and financial pressures.

This shift will have significant implications for the provision of both health and social care services thus increasing strains already in the system.

In Warwickshire we are committed to ensuring that our older population have the best health possible.

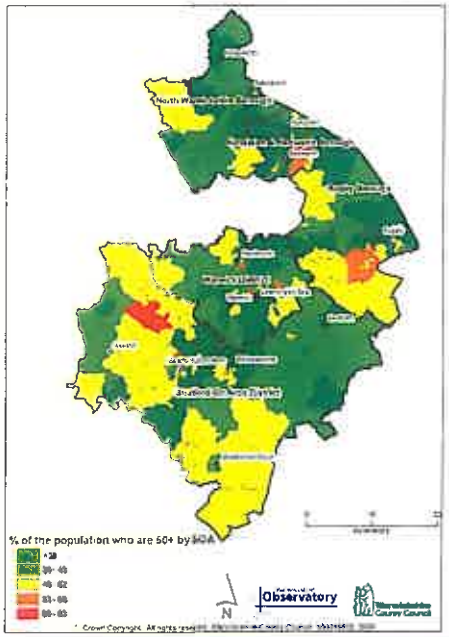
This report is for both service commissioners and the general Public. It aims to:

1. Highlight some of the main health and social care needs of this population.
2. Summarise current services and priority work programmes.
3. Provide a starting point for discussion about how to address the key issues.

The population of Warwickshire is projected to reach 634,900 by 2033; an increase of almost 100,000 people or 19% from 2009.

This is higher than the projected regional and national population growth rates of 13.0% and 18.0% respectively.

The number of people aged over 50 is projected to increase by 35% and those over 75 by more than 100%.

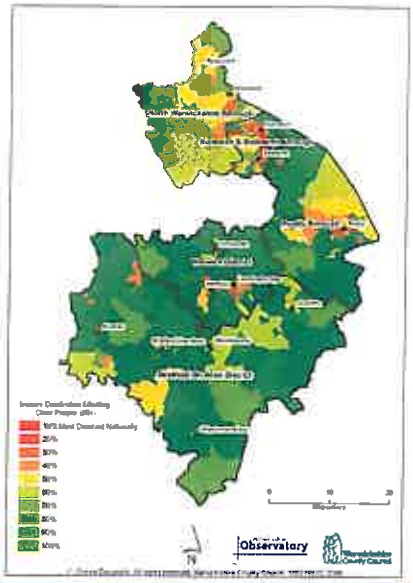


Inequalities continue to persist in this population

- Poverty and ill health are more common in the north than the south of the county.
- Men living in North Warwickshire aged 65 can expect to live 2 years less than men who are 65 living in Warwick. For women the difference is 1.8 years.
- 13% of Warwickshire's population live in fuel poverty; 29,000 households in the county.

Of the 332 Lower Super Output Areas (LSOAs) in Warwickshire, 49 of them are ranked in the 30% most income deprived nationally (based on income in those over 60).

Income deprivation affecting those over 60, Warwickshire, 2007

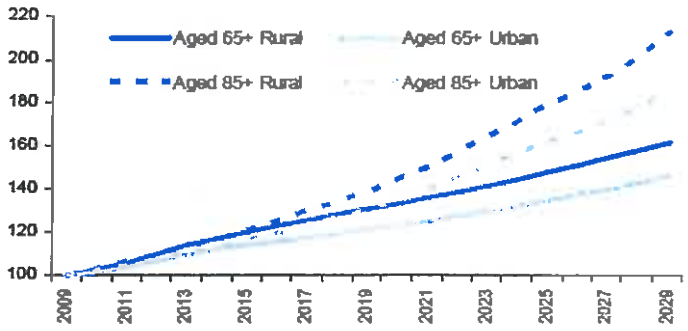


Proportion of Households that are Fuel Poor, Warwickshire Districts 2006

	No. households	No. fuel poor households	% of households fuel poor
North Warwickshire	25,372	3,445	13.6%
Nuneaton and Bedworth	50,901	6,110	12.0%
Rugby	39,046	4,996	12.8%
Stratford-on-Avon	49,961	6,933	13.9%
Warwick	55,981	7,465	13.3%
Warwickshire	221,261	28,949	13.1%
England	21,220,807	2,431,691	11.5%

Source: Department for Energy and Climate Change (DfECC)

Population projections show that rural areas will age faster than urban areas

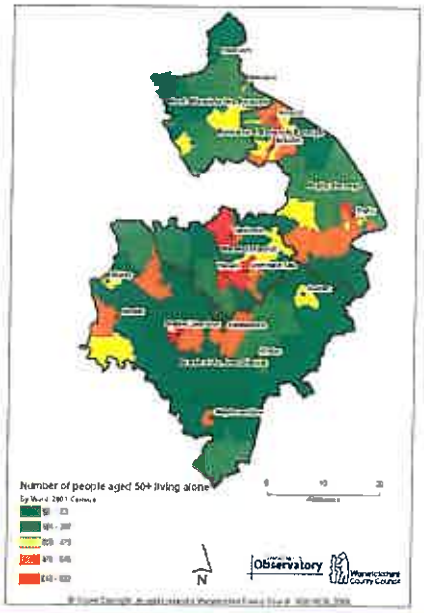


Around 23% of all people in rural areas are of pension age compared with 18% of people in urban England

Healthy lifestyle behaviours vary considerably within our over 50s population

- There a number of screening programmes targeted at this group but uptake varies by age and depending on where people live.
- By 2030 it is estimated that more than 37,000 people over 65 in Warwickshire will be obese with greater risks for diabetes, heart disease and other health problems.

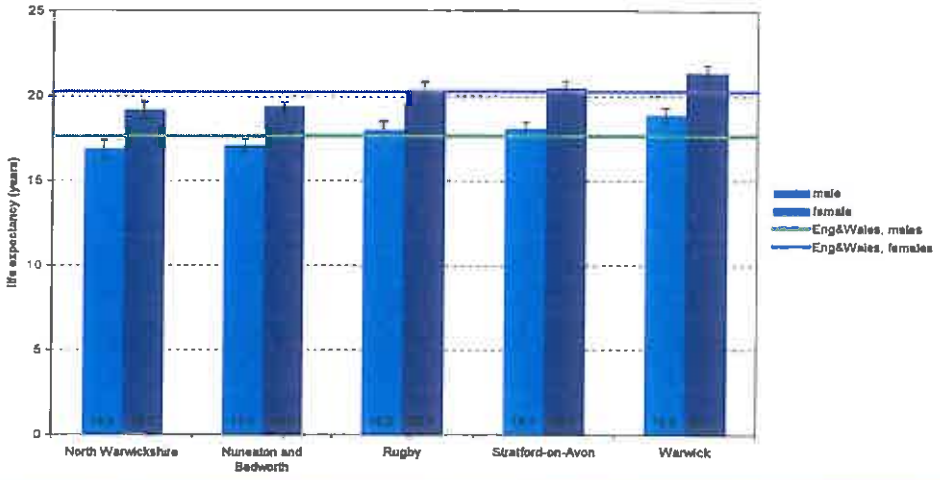
The proportion of over 50s living alone in Warwickshire, by Ward, 2001



Source. Warwickshire Observatory. ONS Living Arrangements

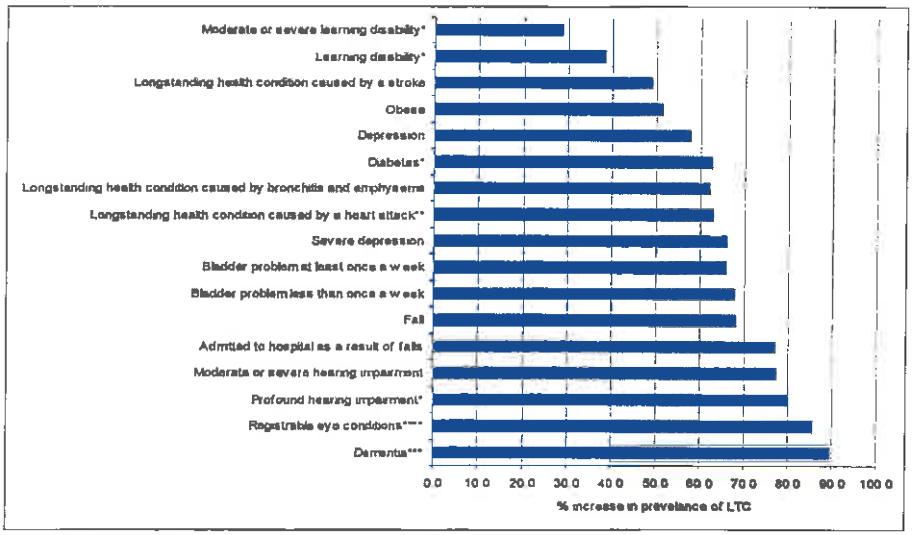
Life Expectancy at 65 in Warwickshire 2006-08

Source: ONS



Warwickshire Primary Care Trust

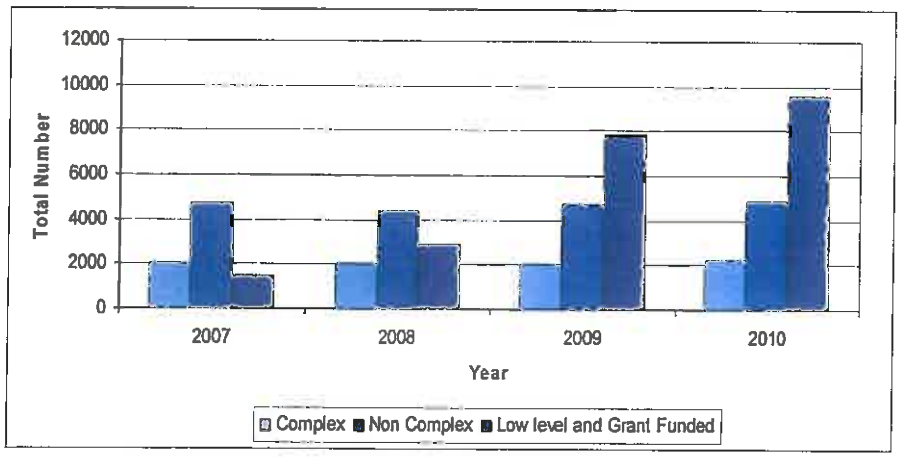
Percentage Increase in the number of Older people (see note below) in Warwickshire predicted to have a Long Term Condition, between 2009 and 2030



Source: POPPI and PANSI (Note populations are over aged 65 except *over 55, ** over 45, ***over 60 and ****over 75)

Warwickshire Primary Care Trust

Total Number of Social Care Clients, in Warwickshire (over 50) 2006/07-2009/10



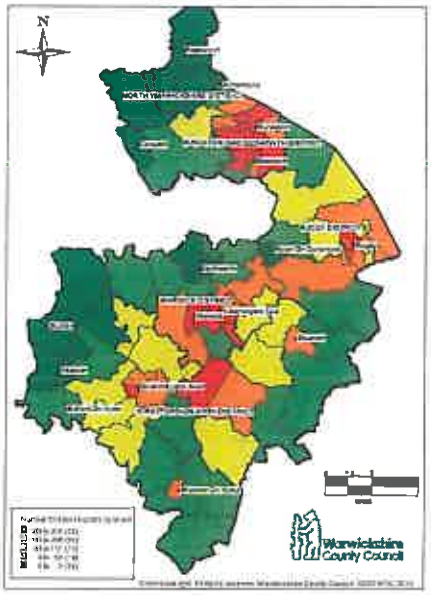
Number and percent of over 65s in Warwickshire predicted to be providing or requiring support between 2009 and 2030

	Current (2009)		Estimates (2030)		% Increase 2009-2030
	Number	% of pop	Number	% of pop	
Population providing unpaid care to a partner, family member or other person	11,218	11.1	16,700	11.9	48.9
Population unable to manage at least one domestic task on their own	38,169	43.6	65,412	40.5	71.4
Population unable to manage at least one self-care activity on their own	31,333	35.7	53,614	33.3	71.1
Population unable to manage at least one activity on their own	17,157	20.1	30,208	18.2	76.1

Source: POPPI

The Distribution of Social Service users, by Warwickshire Ward as at the end of June 2010

Source: AHSC, Warwickshire County Council



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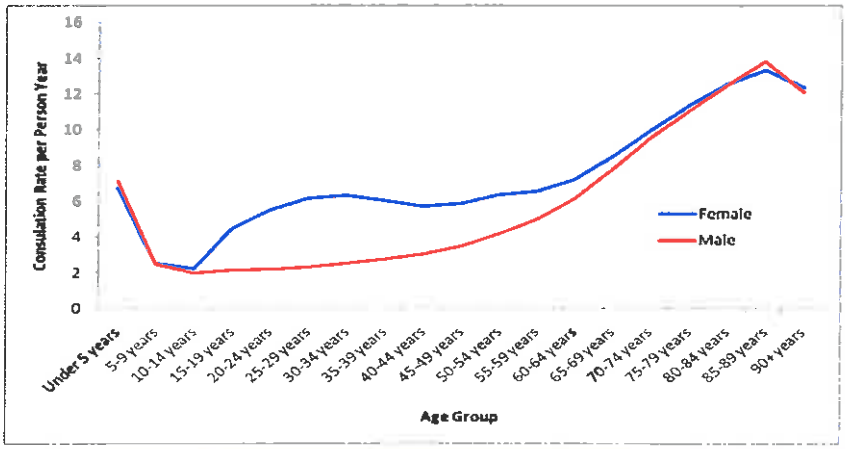
Crude Consultation Rates per person all clinicians, England 2008



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Summary of average proportion and cost of hospital activity for over 50s and over 75s amongst Warwickshire registered patients 2009/10

	Over 50s		Over 75s	
	% of attendances	Total Cost	% of attendances	Total Cost
Population Baseline	37.5%	-	8.2%	-
A&E	36%	£5,350,511	14%	£2,132,554
Outpatients	58%	£30,147,335	17%	£8,753,750
All Inpatients	58%	£116,964,906	22%	£52,973,432

Source HCS and SUS

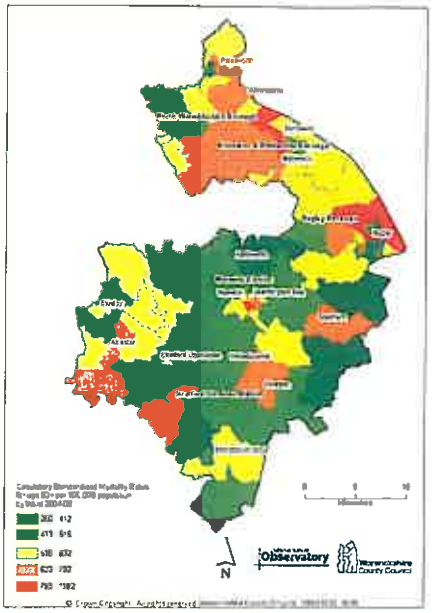
Outpatients and inpatients attendances in over 50s accounted for nearly 60% of all activity compared to a population baseline of 38% - the over 75s accounted for 22% of all activity compared to their population baseline of just 8.2%.

Crude rate per 1,000 population of hospital activity for over 75s by Borough amongst Warwickshire registered patients 2007/08-2009/10

	A&E	Outpatient	Inpatient	
			Elective	Non Elective
North Warwickshire	405.7	1962.8	235.1	264.6
Nuneaton & Bedworth	477.3	2053.1	251.9	294.2
Rugby	513.4	2432.5	276.0	295.4
Stratford	349.0	2018.0	264.1	249.5
Warwick	452.3	2187.6	277.1	281.5
Warwickshire	435.6	2130.1	263.2	275.9

Source: HCS

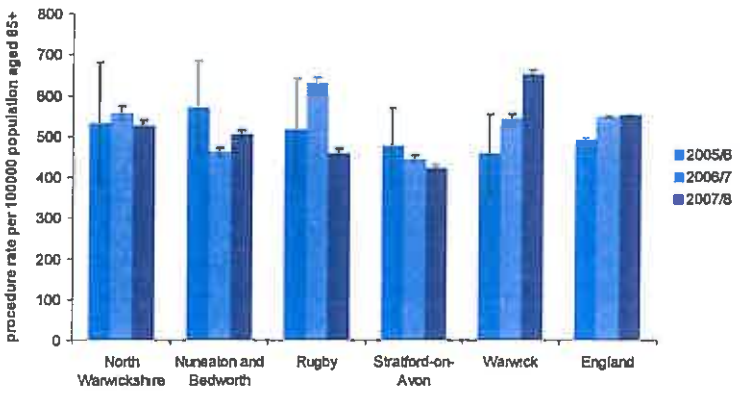
Circulatory Disease Standardised Mortality Rates per 10,000 population in Warwickshire by ward, 2004-08



Source: HCS

Warwickshire Primary Care Trust

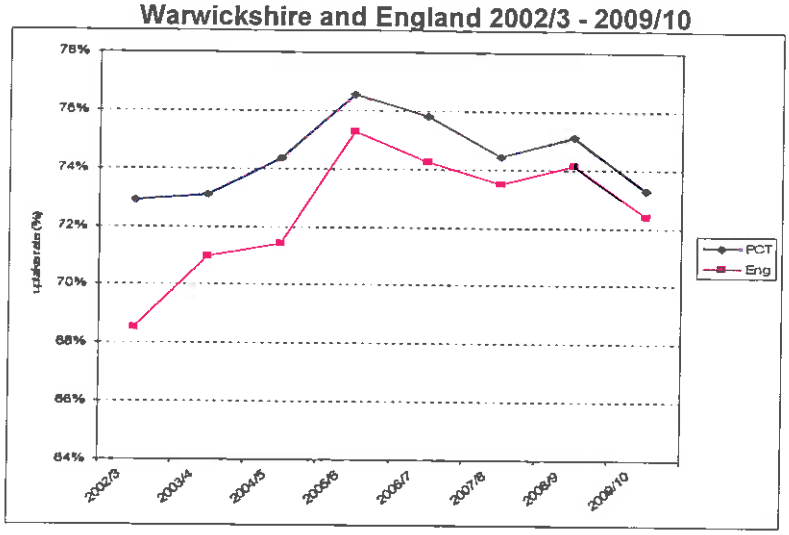
Age Standardised hospital episode rate for revascularisation in Warwickshire and England



Source SUS

Warwickshire Primary Care Trust

Uptake of Flu vaccine in 65+ during the winter months: Warwickshire and England 2002/3 - 2009/10



Warwickshire Primary Care Trust

Place of death for all causes of death 2008/09, Warwickshire

Recorded deaths from all causes	4765	
Expected number of deaths in hospital	499	(based on 11% of population wishing to die in hospital)
Observed number of deaths in hospital	2430	(53% of total number of deaths for time period)
Expected number of deaths at home	2545	(based on 56% of population wishing to die at home)
Observed number of deaths at home	1128	(25% of total number of deaths for time period)
Expected number of deaths in a community/hospice	1182	(based on 26% of population wishing to die in community/hospice)
Observed number of deaths in a community/hospice	987	(22% of total number of deaths for time period)

Source ONS

Nationally 80% of the public state a preference for dying to take place in their community setting. Compared to the West Midlands, Warwickshire has more people dying in hospital and fewer at home. Deaths in acute hospitals are likely to continue to rise with the ageing population unless alternative services are developed within community settings

Warwickshire Primary Care Trust

Recommendations

1. ***Life** Expectancy*: Reduce the variation in life expectancy and healthy life expectancy at age 65 years across the county.
2. ***Health Inequalities***: All Plans for Older People need to explicitly identify:
   - How to tackle health inequalities in older age.
   - How to address the needs of older minority groups.
3. ***Prevention***: Develop a greater focus on disease prevention and health promotion among older people.
4. ***Fuel Poverty***: Work in partnership to reduce 300 excess winter deaths.
5. ***Rural Isolation***: Tackle rural isolation and access to services in rural areas.
6. ***Dementia***: Implement a strategy and pathway of care and support for dementia.
7. ***End of Life Care:*** The Gold Standards Framework (GSF) to be fully embedded in primary care to enable support to more people to be cared for at home and die in a place of their choosing.

And finally …

Awareness of my Annual Report is to be raised at 6 community engagement events:

1. **Horticultural Research Centre, Wellesbourne** - 22nd September, 7pm.
2. **Nuneaton Town Hall, Nuneaton** - 6th October, 7pm.
3. **Shire Hall, Warwick** - 12th October, 4pm.
4. **Mancetter Village Hall, Mancetter** -13th October, 7.30pm.
5. **Shipston High School, Shipston-on-Stour** - 19th October, 7pm.
6. **Benn Hall, Rugby** - 20th October, 7.30pm

It will also be published on both the PCT and County Council websites.

Dr John Linnane
Joint Director of Public Health

Joint Director of Public Health

ANNUAL REPORT

Best Health for Older People in Warwickshire

2009/2010

Warwickshire County Council

Warwickshire Joint Strategic Needs Assessment

NHS Warwickshire

Joint Director of Public Health

Annual Report

Best Health for Older People in Warwickshire

The 2009/10 Annual Report of the Joint Director of Public Health and Section One of the Warwickshire Joint Strategic Needs Assessment

Contents

2009/2010

One of our greatest challenges in Warwickshire today is how together we can ensure that our rapidly ageing population live in the best possible health.

To enable us to deliver this vision, we must first understand the complexity and diversity of our older population the age structure, the distribution of health and wealth and the implications for the future.
It is therefore both appropriate and timely to make this report, a chapter of the revised Joint Strategic Needs Assessment of Warwickshire and my first report as Joint Director of Public Health for Warwickshire, a theme based report on older people. It has three main aims: to make an independent statement about the healthcare needs of our older population in Warwickshire, review current service provision and provoke discussion with the public and partners about how together we can deliver the best health for older people in Warwickshire. This process will be supported by the production of more detailed localised profiles of our older population. Progress will be monitored in future reports and your comments and feedback are welcome. Please direct any comments to publichealthintelligence@warwickshire.nhs.uk

Dr John Linnane, Joint Director of Public Health

Older people in Warwickshire deserve the very best healthcare possible and as we enter a new decade, we are committed to ensuring that this is achieved.
There are a number of factors which contribute to achieving this vision: maintaining dignity in care; encouraging and supporting older people to stay healthy and independent; giving frail older people the opportunity to be cared for in their own homes; and ensuring health problems are tackled at the earliest possible stage. By addressing these key issues we will ensure that Warwickshire's older people will receive the very best healthcare.

Professor Ian Philp, Medical Director, NHS Warwickshire

We need to transform our social care system.The current system does not respond quickly enough or effectively enough when older people are in crisis e.g. after an episode in hospital. We need to help older people get back on their feet and regain confidence after a fall or a hip operation.The services are also inequitable across the county. In addition we are anticipating a significant reduction in the money available to spend on adult social care after the Government's Autumn Spending Review. We have started that process of change in Warwickshire. We are now building a special recovery service which will help older people when they come out of hospital. We want to further develop this service with health to have a single service which will prevent hospital admissions and help people return safely to their own homes. We are looking to make much wider use of the new technologies that are available to help people live independently in the community.
We are also arranging for 20 new housing schemes to be built across the County which will serve older people in a safe and caring environment. We want services that will help both the wealthier members of our population and the poorer people.
We believe that together with our partners we can build a much more responsive and appropriate service for older people across Warwickshire. This is our urgent task - to create this new system whilst the money available to us reduces.

John Bolton, Acting Director of Adult Services, Warwickshire County Council

Acknowledgements
I am grateful to the many colleagues for their help in the production of this report, in particular:
Editor: Rachel Robinson
Editorial Team: Terry Leather, Fran Poole, Remi Omotoye
Contributors: Sarah Chesters, Andy Davis, Emma Doel, Carolyn Forman, Mike Graveney, Jan Humble, Nadia Inglis, Robert Johnson, Helen King, Paul Kingswell, Ben Larard, Chris Liddington, Roger Newham, Angelique Mavrodaris, Kathryn Millard, Vicky Mumford, Ian Philip, Emily Smith, Rosie Smith, Bronwen Spraggett, Martin Stott, Tom Watts, Caron Williams, Jane Wright, Lorna Wright, Warwickshire Observatory
Design: Communications, NHS Warwickshire
Published by: NHS Warwickshire, Westgate House, Market Street, Warwick, CV34 4DE
Telephone: 01926 493491 **Fax:** 01926 495074.
This report is also available on the website: www.warwickshire.nhs.uk and www.warwickshireobservatory.org
Large text version available www.warwickshire.nhs.uk

1.0 INTRODUCTION

Warwickshire is facing a large scale demographic transition as the population ages at a faster rate than the national average. This is set against a background of persisting health inequalities and financial pressures.

This shift will have significant implications for the provision of both health and social care services increasing strains already in the system. Understanding the health and social care needs of this population is crucial for service planning and helping us to work through together how we can do things differently to address this need.

Older people have consistently voiced concerns that they are not treated the same way as younger people. The National Service Framework (NSF) for Older People standard one: 'rooting out age discrimination' aims to prevent age discrimination and inequity in the treatment of older people within the NHS.[1] Since 2006, the Employment Equality (Age) Regulations made it illegal to discriminate against workers because of their age.[2] The Equality Bill in 2010 is an important step towards changing the culture around ageing and addressing stereotypes of older people, but legislation alone is not enough. Real cultural change to help us all benefit from the advantages of living longer needs action from all sections of society to change attitudes and behaviours. [3]

The 2010 report by the Audit Commission Under Pressure highlights the challenge of an ageing population, identifying potential costs and benefits of the changing demographic. The report is one of a number of key documents, strategies and guidance that have been produced nationally and locally to improve services for older people, beginning with the 2001 National Service Framework for Older People. A full list is given at the back of the report. It identifies a number of the challenges of an ageing population, for example Dementia currently costs the UK economy £17 billion a year;[4] in the next 30 years the number of people with Dementia will double, while cost could treble to £50billion. It also highlights the benefits of early intervention and the need for a strategic long term approach.

This report will seek to explore through Section 3, the health and social care needs of older people in Warwickshire. It will look at our current service provision and consider some of the implications of the aging demographic on future service planning. Section 5 will then move on to looking at some of joint initiatives across the NHS and Warwickshire County Council to tackle a number of priority areas. Finally the report contains some wide ranging recommendations for all agencies to help us all to achieve our vision of Best Health for Older People in Warwickshire.

Who are 'older' and 'elderly' people?

There is no clear definition of older people in terms of actual age. The Government defines an older person as anybody over the age of 50. An Age Concern survey showed the average age which the public used to define the start of "old age" was 65. The NSF for Older People defined three groups of older people: those entering old age on completing paid employment and child rearing; those in transitional stage between healthy active life and frailty (typically seventh and eighth decade) and frail older people or social care needs. The Department of Work and Pensions generally refer to people aged 60 years and over as older people but also included people in their 50's as this is a period when many people take early, or prepare for retirement.

Cross-government action to tackle health inequalities stresses the importance of targeting people over 50 through co-ordinated, multi-disciplinary services to reduce the gap in life expectancy. To reach targets around inequalities in health and well being and to reduce the gap in life expectancy will require health improvement and prevention approaches to be directed at people in their 50's.

In Warwickshire, while our universal strategy is for over 50s, we have targeted some of our work on the 75 plus age group. This report contains information and data to reflect this.

2.0 EXECUTIVE SUMMARY

In Warwickshire we are committed to ensuring that our older population have the best health possible.

This report is for both the public and service commissioners. It aims to:

- Highlight some of the main health and social care needs of this population.
- Summarise current services and priority work programmes in place to meet these needs.
- Provide a starting point for talks with our local communities and partners around our older people's needs and how together we can address them.

2.1 Overview

The population of Warwickshire is ageing at a faster rate than the national average

- Almost 200,000 people in Warwickshire are aged over 50; of those over 45,000 are over 75.
- The highest rates of projected population growth are among the age groups 65 and over who are expected to account for over a quarter of the population by 2033.

Inequalities continue to persist in this population

- Poverty and ill health are more common in the north than the south of the county.
- Men living in North Warwickshire aged 65 can expect to live 2 years less than men who are 65 living in Warwick. For women the difference is 1.8 years.
- 13% of Warwickshire's population live in fuel poverty; 29,000 households in the county.

There are number of specific challenges for people living in rural areas

- The rural population of Warwickshire is aging faster than in urban areas this means that their health needs are expected to grow more rapidly.
- While people living in rural areas are in general more affluent than those living in urban areas a similar number are living in poverty with a higher proportion of older people living alone, fuel poverty is also higher. Older people on low incomes in these areas experience greater difficulty accessing services.

2.2 Main findings

1. Healthy lifestyle behaviours vary considerably within our over 50s population

- There a number of screening programmes targeted at this group but uptake varies by age and depending on where people live.
- By 2030 it is estimated that more than 37,000 people over 65 in Warwickshire will be obese with greater risks for diabetes, heart disease and other health problems.

2. Long term conditions are the 'invisible epidemic' for elderly people

- An estimated two thirds of over 75 year olds in Warwickshire live with one or more long term conditions, many of which are not known to the older person's general practitioner.
- In the next 20 years new cancer cases are expected to increase by 70% in males over 70 years and 50% in females.
- Dementia is expected to increase by almost 90% in people over 60.

3. Elderly people disproportionately use hospital care

- Frail older people stay in hospital longer, occupy two thirds of hospital beds and are the main users of long term care services, much of which is unnecessary.
- 22% of all non planned emergency inpatient admissions are to people aged over 75.
- The proportion of spend for hospital activity on the over 75 population is 26% of all activity and 39% of non elective costs

2.3 Key challenges

Three great challenges for health and care services arise from the ageing population in Warwickshire:

1. **For the general population aged 50 and above, how do we promote health, independence and well-being?**
   This is the challenge for Public Health.
2. **For the population aged 75 and above, how do we identify the problems which threaten health, independence and well-being at an early stage and respond appropriately?**
   This is a challenge for Primary Care.
3. **For the population aged 75 plus, how do we reduce unnecessary needs for hospital care and long term care services.**
   This is a challenge for hospital and community services, working together.

2.4 Our plans

1. Promoting health, independence and well-being
Older people need to "use it or risk losing it ". This means finding every opportunity to stay active, physically and mentally, and to strengthen networks with families and friends to avoid social isolation. Much work in this area is led by older people and older people's organisations in Warwickshire such as the Ageing Well programme run by Age Concern Warwickshire.

2. Reducing unmet needs and risks
We are participating in a nationally funded project to ensure systematic identification and personalised response to older people's health and care needs. The range of needs cover communication, mobility, self care, safety and relationships, accommodation and finance, mental health and health promotion. Specific items include, for example, hearing, getting to the shops, continence, falls, home warmth, loneliness and being up to date with vaccinations. Information once collated is shared with health and care practitioners involved in the person's care, with the service response based on the top priorities of the older person for help.

3. Reducing the impact of frailty
This project involves four changes to the ways in which services respond to older people presenting in crisis with confusion, falls or "going off their legs".

- An enhanced community response to support and assess the older person in their home, choosing to admit to hospital if required.
- Expert care to diagnose and treat underlying medical conditions.
- Early transfer for rehabilitation services.
- Comprehensive multi-disciplinary assessment of longer term care needs.

Experiences in other countries which have adopted those changes, have shown it is possible to reduce admissions of frail older people to hospital, reduce the length of time spent in hospital and reduce needs for long term care services, while improving outcomes for older people.

2.5 Recommendations

Based on the challenges identified in this report and our current work programmes, I have identified the following priority recommendations for action:

1. **Life expectancy:** NHS Warwickshire, Warwickshire County Council and partners should develop an action plan to reduce the variation in life expectancy and healthy life expectancy at age 65 years across the county.
2. **Health inequalities:** All NHS and local government strategies and action plans for Older People need to explicitly identify:
   - How they will tackle health inequalities in older age.
   - How they will address the needs of older ethnic minorities, disabled and other minority groups.
3. **Prevention:** All the statutory agencies and services must develop a greater focus on disease prevention and health promotion among older people. This includes improving access to screening services and promoting healthy eating, physical activity and smoking cessation.
4. **Fuel poverty:** There are over 300 excess winter deaths across Warwickshire each year. We need to clearly identify and action the role of Primary Care and Community Health Services working with local government to tackle this.
5. **Rural Isolation:** Primary Care and Community Services need to clearly demonstrate how their plans and services tackle rural isolation and access to services in rural areas.
6. **Dementia:** The health service and local government across Warwickshire must urgently ratify and implement a simple strategy and pathway of care and support for dementia.
7. **End of life care:** The Gold Standards Framework (GSF) for palliative identification and support to improve skills around care planning and identification of patients in the last year of life needs to be fully embedded in primary care to enable support to more people to be cared for at home and die in a place of their choosing.

Overview

The county of Warwickshire is mainly rural, with concentrations of urban areas within the five local authority districts and boroughs across the county. It borders nine Primary Care Organisations (PCOs). (See map 1).

3.1 Demography

3.1.1 Population Age

Warwickshire County is home to over 530,000 people. It has a higher population of people aged over 50 when compared to the national average, 38% and 34% respectively. Over 8% of the population are aged over 75 years[1].

There are over 200,000 people aged over 50 years old in Warwickshire; of those 45,000 are aged over 75. In addition a further 19,000 people over 50 are registered with Warwickshire GPs but live out of the county.

The figure below illustrates this difference in the age structure of Warwickshire compared to that of England and Wales.

There are lower proportions of the very young and people aged 20-35 in Warwickshire compared with the rest of England. There are higher proportions of people in each 5 year age group over 40 years old.

Map 1: Warwickshire showing local health services

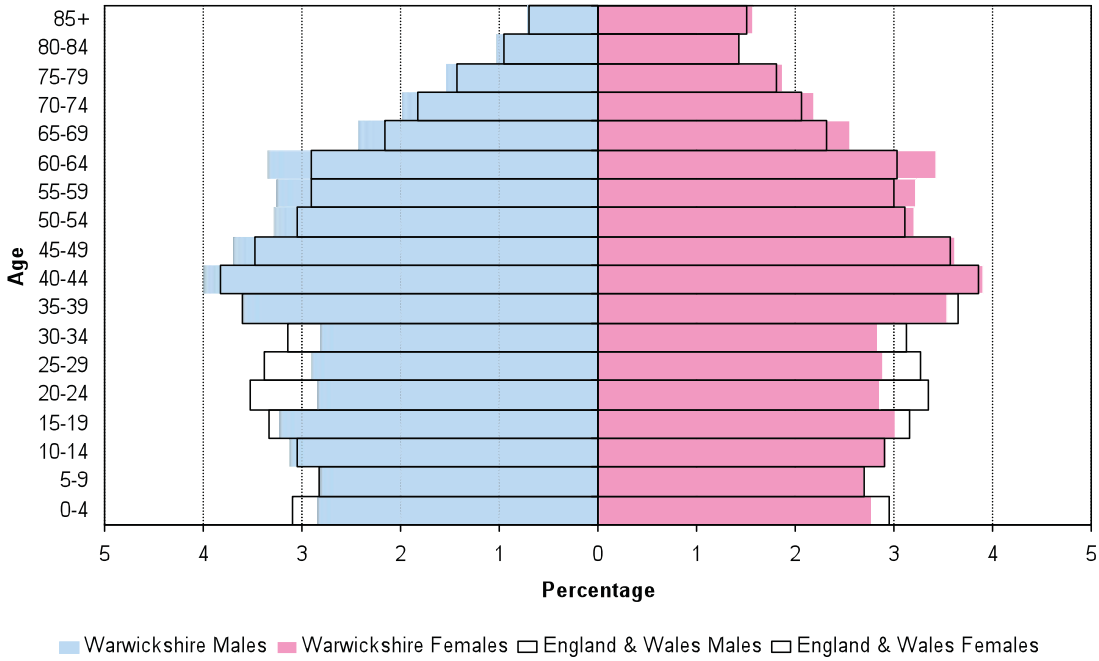
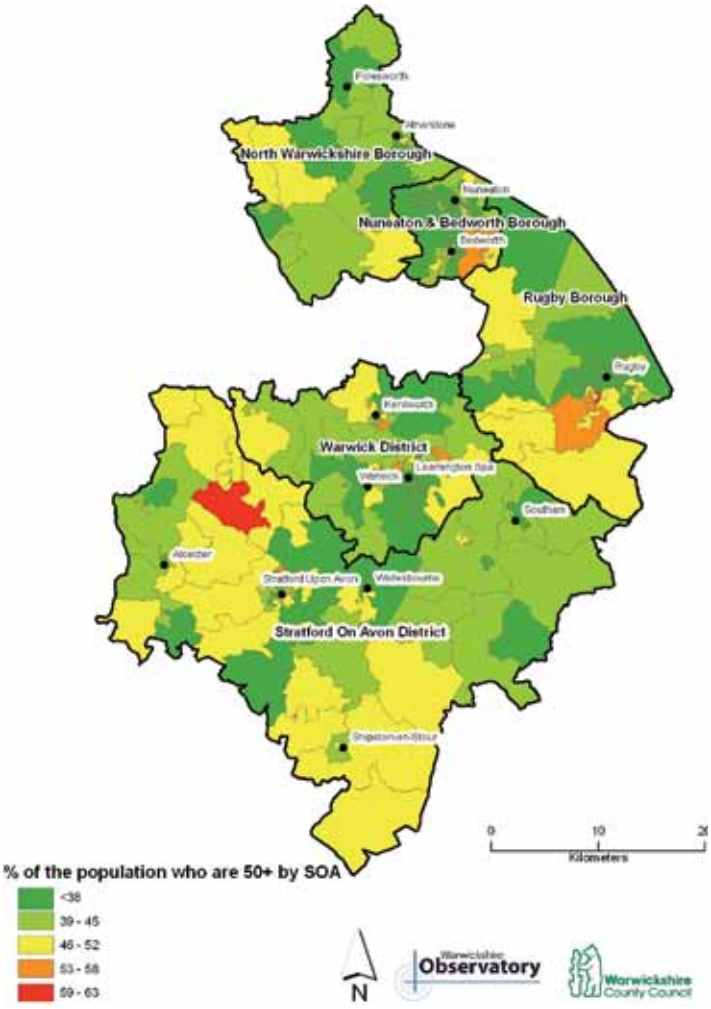


Figure 1: Warwickshire Population Pyramid, Mid Year Estimates, 2008

Source: NCHOD, ONS

The difference in the age structure of the population is also more pronounced in some districts; in Stratford upon Avon 42% of the population are over 50 and in North Warwickshire 38%[2], compared with the national average of 34%. Within the districts there are a number of pockets where the percentage of people aged over 50 is greater then the rest of the county. These tend to be around more urban areas such as Warwick, Kenilworth, Leamington, Bedworth, Stratford and south Rugby. However, the area with the highest proportion of people aged over 50 is Henley, a rural area in southwest Warwickshire.



Map 2: Areas of Warwickshire with above average population over 50 years, 2008 Mid Year

3.1.2 Population Trends

The population of Warwickshire is projected to reach a total of 634,900 by 2033; an increase of almost 100,000 people or 19% on the 2009 ONS mid-year estimate. This increase over the 24 year period is higher than the projected regional and national population growth rates of 13.0% and 18.0% respectively. Growth is not consistent across all age groups. The number of people aged 50 and over is projected to increase by 35% and those over 75 projected to increase by more than 100%. The highest rate of increase in older people is projected in Stratford on Avon.[1] Interestingly North Warwickshire Borough is projected to experience negative population growth for all age groups up to 65 during the period 2010 to 2033. Nuneaton & Bedworth is projected to experience negative population growth for those aged between 50-60 years. This may have implications for the local labour market and local economy.

Source: Warwickshire Observatory, ONS

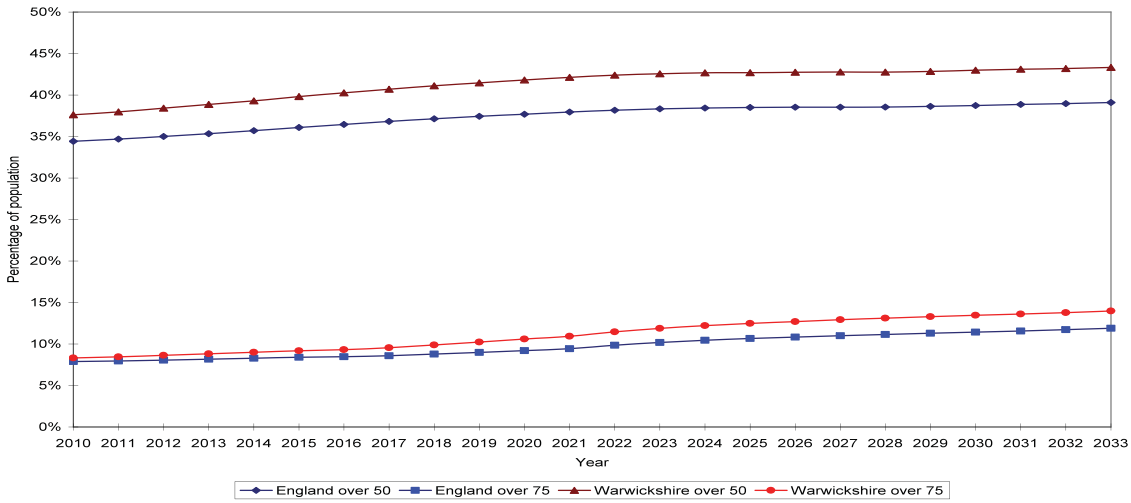


Figure 2: Estimate of the percentage of the population aged over 50, Warwickshire, West Midlands and England and Wales

Source: ONS mid 2006 population estimates

3.1.3 Black and minority ethnic groups

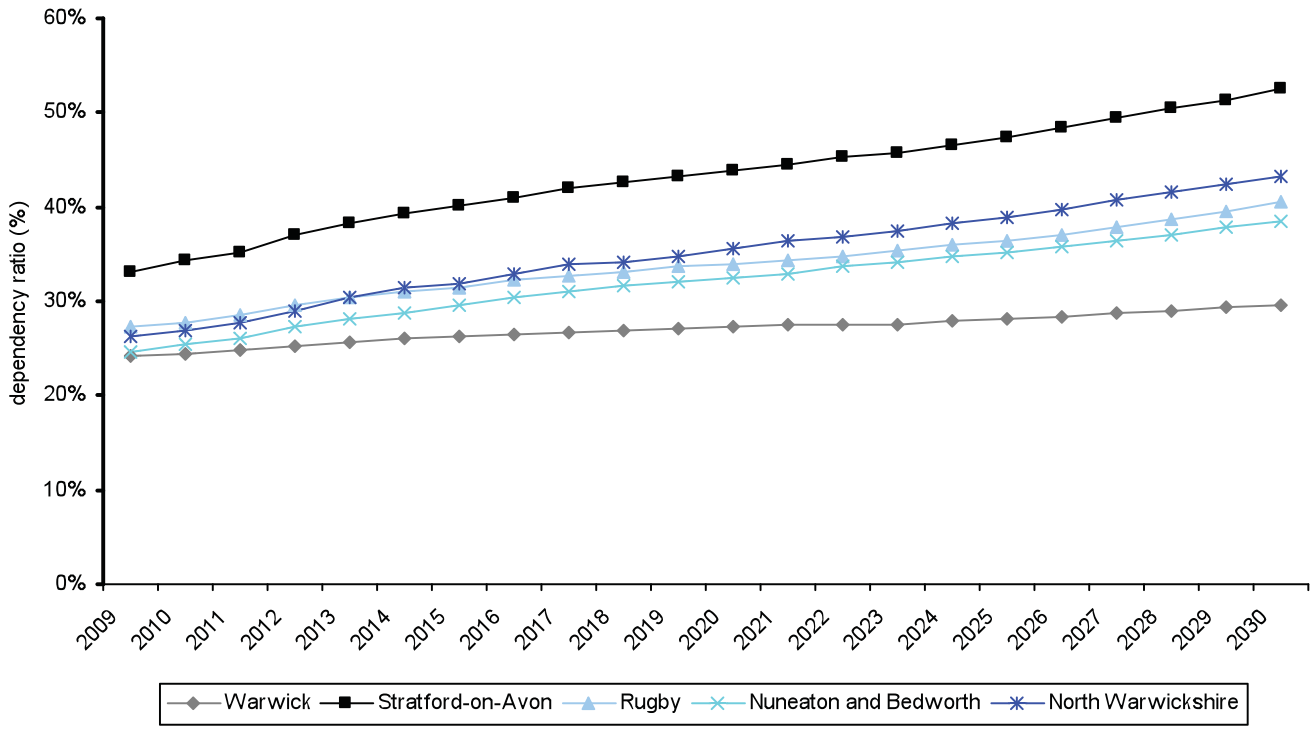
It is estimated there are 6,400 older people from black and minority ethnic backgrounds. Warwick has the highest proportion of non-White British residents, at 14.5%, with North Warwickshire having the lowest at 4.3%. Asian Indian is the largest non-White British ethnic group in the county.[2]

3.2 Income and Wealth

3.2.1 Dependency ratio

Over the next decade the dependency ratio for older people which is the proportion of the older age group depending on the working population is set to increase. As the ratio increases there may be an increased burden on the productive part of the population to maintain the upbringing and pensions of the economically dependent. In 2008, the ratio was around 26%, and set to increase to around 34% in 2020. By the year 2030, the dependency ratio of the over 65s in Warwickshire will be around 40%; with potentially less people paying tax, and more people that need health and social care services. The chart below shows the trend in these changes across the county, the greatest increase set to be in Stratford-on-Avon (50% by year 2030).

Figure 3: Proportion of over 65s depending on the working population in Warwickshire 2009–2030



Source: ONS

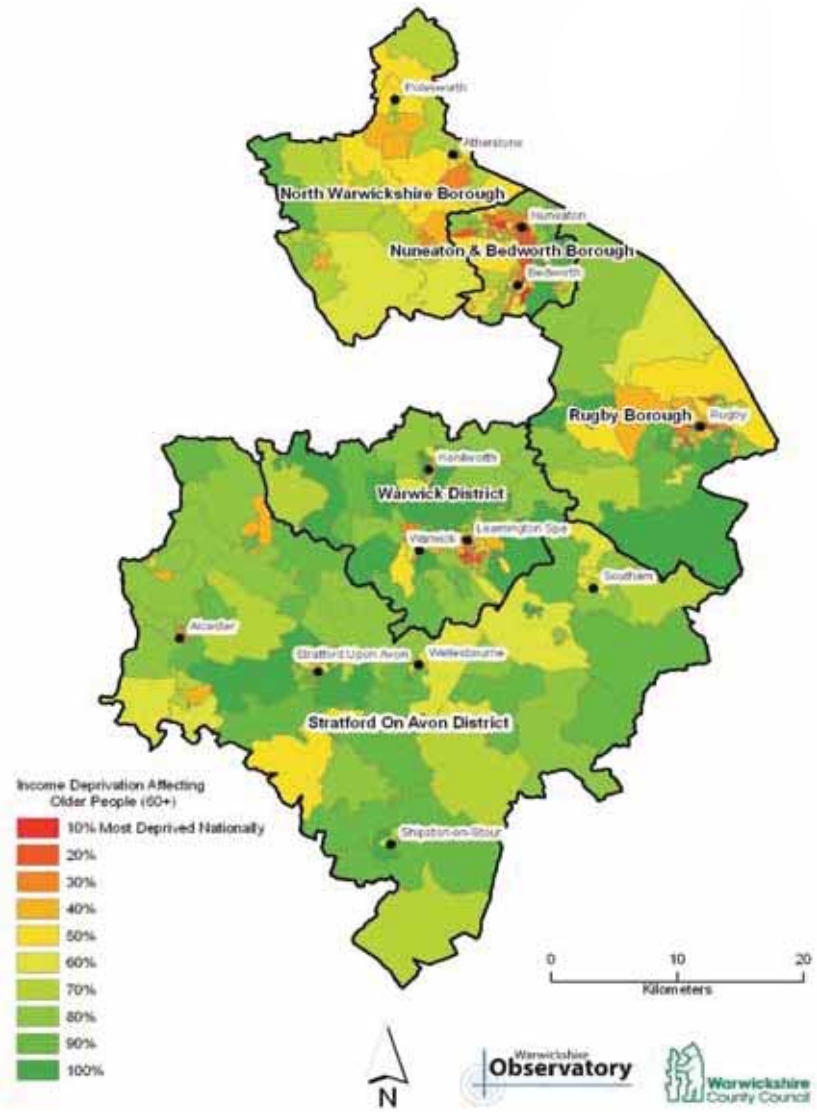
3.2.2 Income deprivation

Of the 332 Lower Super Output Areas (LSOAs) in Warwickshire, 49 of them are ranked in the 30% most income deprived nationally (based on income in those over 60). Half of these LSOAs are from the Nuneaton and Bedworth area. Likewise, 127 of the 332 LSOAs (38.2%) are ranked in the 30% least deprived nationally, with the majority of these LSOAs in the south Warwickshire area
(Stratford-on-Avon and Warwick).

3.2.2 Benefits and pensions

In a recession those most at risk from its economic and social effects including falling standards of living and poorer health due to reduced spending on outgoings such as food and heating, are those on low incomes. This can be sub-divided into the elderly, the disabled and those with young children.[3]

Map 3: Income deprivation affecting those over 60, Warwickshire, 2007



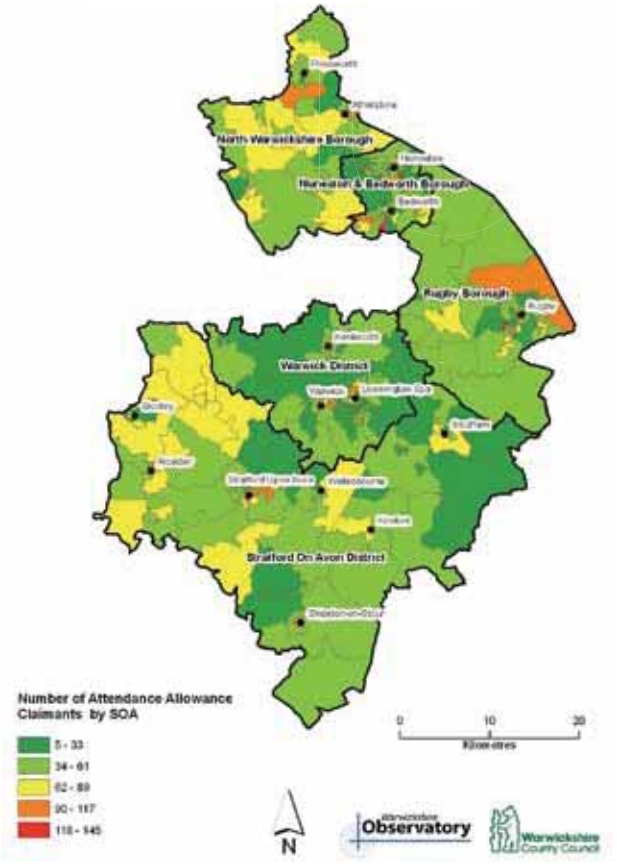
Source: Warwickshire Observatory, Income Deprivation in 2007 IMD, ODPM

In the last five years, pension credit claims (income support for the over 60s) from the Warwickshire population have increased marginally with the proportion of the over 65 population estimated to be claiming rising from 20,950 claimants in 2005 to 21,270 claimants in 2009. Table 1 shows that there are differences in the numbers between the localities, for example in the year ending August 2009, pension credit claimants in the Nuneaton and Bedworth area (5,710) was about twice the number in North Warwickshire area (2,950), and this pattern was consistently recorded since 2005.

Table 1: Pensions Credit claimants (thousands) by district, Warwickshire, Over 60s, 2005-9

District	2005	2006	2007	2008	2009
North Warwickshire	2.82	2.83	2.87	2.91	2.95
Nuneaton and Bedworth	5.68	5.75	5.84	5.74	5.71
Rugby	3.4	3.48	3.5	3.43	3.44
Stratford-on-Avon	4.42	4.46	4.46	4.49	4.54
Warwick	4.63	4.69	4.73	4.66	4.63

Source: ONS, 2008



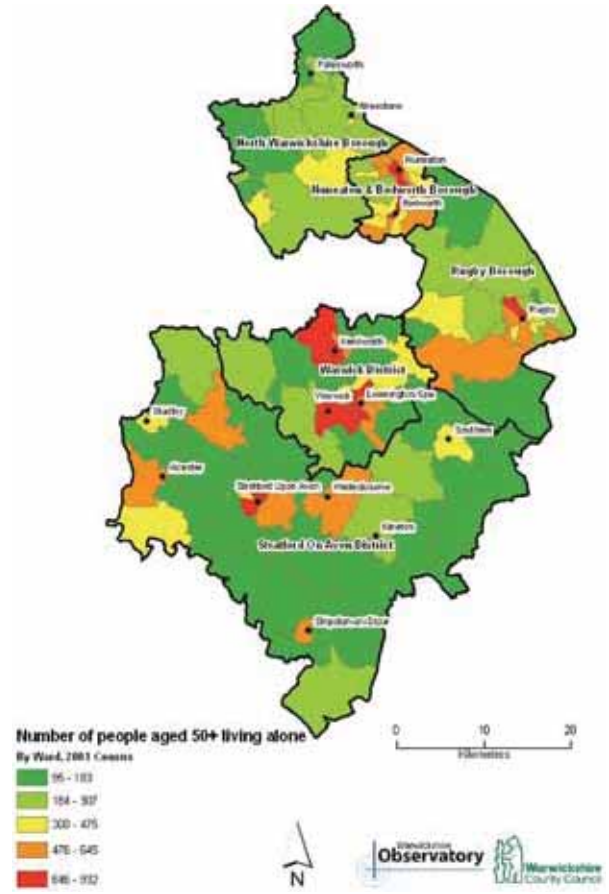
Map 4: Attendance Allowance Claimants in Warwickshire by SOA, aged over 65, May 2009

The number of people claiming Attendance Allowance (a contribution towards the disability-related extra costs of severely disabled people who are aged 65 and over when they claim help with those costs) has shown an increase in Warwickshire over the last 3 years from 13,660 in 2007 to 14,110 in 2009; an increase of just over 3%.

There is variation across Warwickshire with the majority of claimants around Nuneaton and Bedworth, Rugby, to the east of Stratford and near Polesworth in North Warwickshire (see Map 4).

Source: ONS

3.3 Housing



Map 5: The proportion of over 50s living alone in Warwickshire, by Ward, 2001

The majority of older people in Warwickshire live in homes they own, which accounts for 84% of the population over 50.[4] The highest numbers of owner occupiers live in Stratford district with the highest numbers living in social housing in Nuneaton & Bedworth.

In Warwickshire, as for England as a whole, older women are more likely than older men to live alone and the percentage increases as age increases. As women are more likely to be widowed, very few people over the age of 65 cohabit and the death of one spouse becomes increasingly more common at older ages. In over 50s, 20% of males and 30% of females live alone, compared to 34% of males aged over 75 and 61% of females. In Warwickshire this means approximately 22,000 people over 75 live alone. Map 5 shows those living alone in Warwickshire, the number is highest in the urban areas.

It is therefore inevitable that numbers of older people living alone will increase with the increase in the aging population in Warwickshire and with people having a longer life expectancy. There are many health issues which come with living alone including: not having a spouse or partner to provide care at home; having limited or no access to information and services including health services; social isolation, and deprivation due to a household having only one source of income to name but a few.[5]

Source: Warwickshire Observatory, ONS Living Arangements

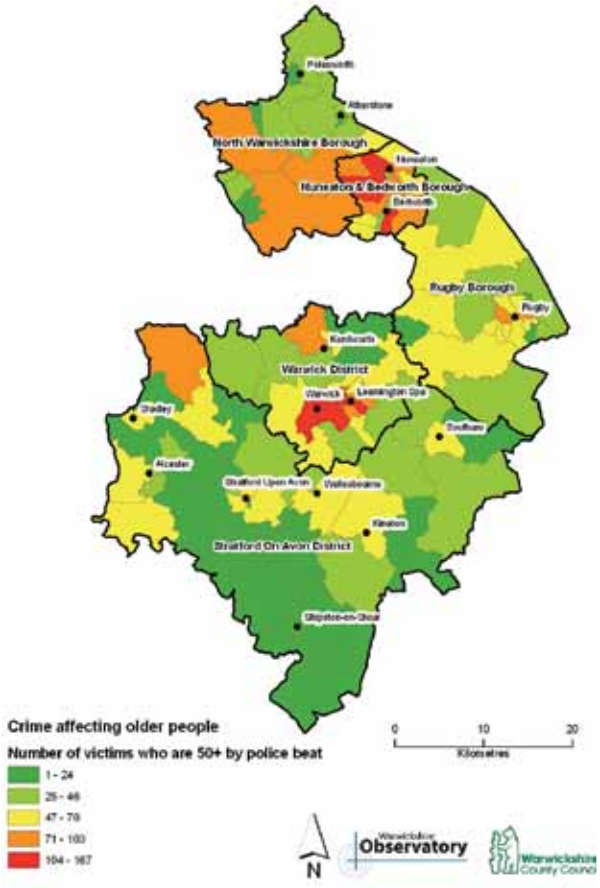
3.3.1 Fuel poverty/Affordable Warmth

Fuel poverty or affordable warmth, is usually defined as a household spending more than 10% of its income on total fuel use (including hot water, lights and appliances) in order to provide an adequate standard of warmth. This does not account for the actual spend on either fuel or the sum remaining once other costs have been met. Causes include; low income, high fuel prices, poor energy efficiency and under occupancy. Data from the Department for Energy and Climate Change in 2006, showed 13% of Warwickshire's total population lived in fuel poverty. This is higher than the UK average with numbers varying by district from 12% in Nuneaton and Bedworth to 13.9% in Stratford. Rates are highest in single person households, or where the occupiers are inactive, or where one person in the household is aged over 60 years.

Table 2: Proportion of Households that are Fuel Poor, Warwick Districts 2006

	No. households	No. fuel poor households	% of households fuel poor
North Warwickshire	25,372	3,445	13.6%
Nuneaton and Bedworth	50,901	6,110	12.0%
Rugby	39,046	4,996	12.8%
Stratford-on-Avon	49,961	6,933	13.9%
Warwick	55,981	7,465	13.3%
Warwickshire	221,261	28,949	13.1%
England	21,220,807	2,431,691	11.5%

Source: Department for Energy and Climate Change (DfECC)



Source: Warwickshire Observatory, ONS

3.4 Crime

Map 6: The number of people aged over 50 who were victims of crime, Warwickshire 2009

A low level of crime continues to be the most important factor in making somewhere a good place to live. This is followed by health services, clean streets, education provision, parks and open spaces. The north of the county has a greater number of crimes then the south; particularly areas around Nuneaton and Bedworth, Warwick and Leamington Spa.

The Partnership Place Survey for Warwickshire contains questions relating to anti-social behaviour and fear of crime. The 2009/10 report shows a large decrease in the fear of car theft, domestic burglary and violence amongst residents in Warwickshire. Fear of crime is lower in Stratford-on-Avon and Warwick than in Rugby, North Warwickshire, and Nuneaton and Bedworth. The report shows that although there may be some relation between fear of crime and crime rates, high levels of fear still exist despite relatively low levels of crime. This suggests that many residents may have an inherent fear of crime that does not depend solely on the prevalence of crime.

People over 45 are most likely to fear domestic burglary (over 50% of those surveyed). Fear of car theft in the older population is highest in the 45-54 age group declining with age (46% to 37% in over 65s). Fear of physical attack is highest in the under 25s and peaks again in the 55 plus age groups, with over 40% of over 55 year olds surveyed fearing physical attack.

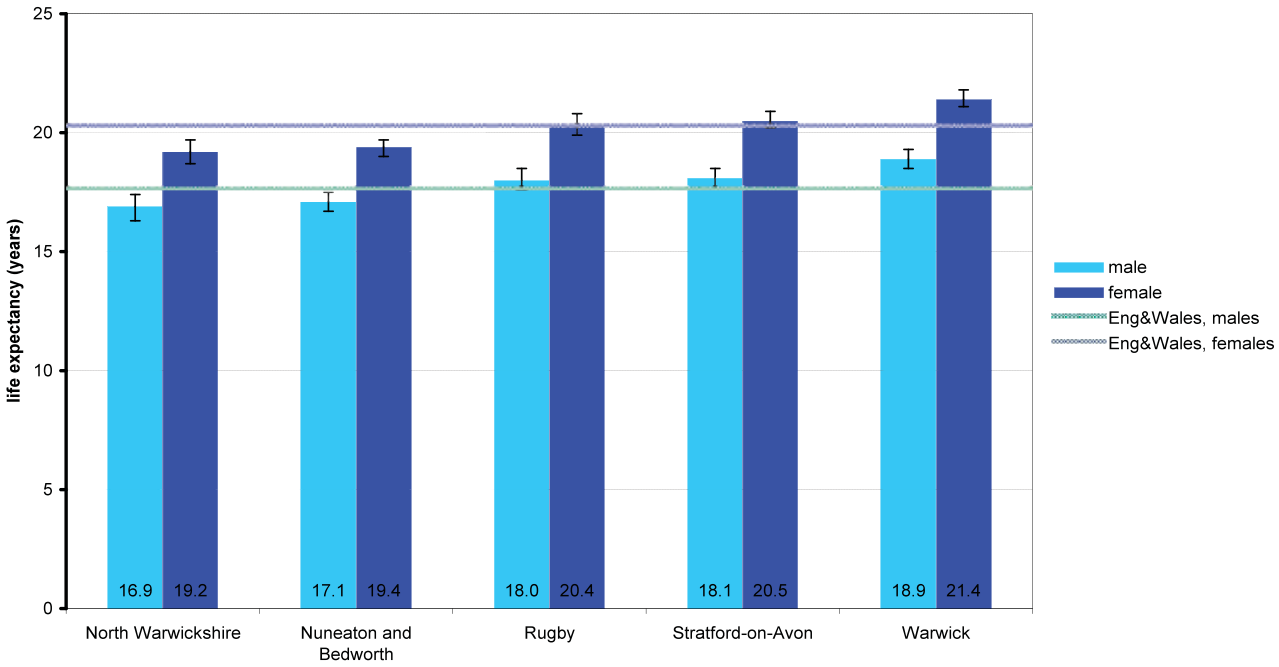
3.5 Morbidity and Life Expectancy

The majority of older people are well, suggesting a need for general prevention and health promotion messages. However, over 16% of the total population aged over 50, and 20% of the population over retirement age regard their health as not good. Moreover, across Warwickshire, 35% of the population aged over 50 have a Limiting Long Term Illness (LLI); nearly half (47%) of the population over retirement age have a LLI. Although these rates are below the national and regional rates, they are increasing and rates remain higher in the north than south of the County. In addition over 17% of the population over 50 provide some form of care on a weekly basis.[2] This data from the Census is now almost 10 years out of date, however it still gives an indication of overall patterns of health.

3.5.1 Life Expectancy

Life expectancy and mortality are commonly used summary indicators of health in a community. Life expectancy is defined as an estimated average number of years an individual is expected to survive if the current mortality conditions at that age group persist throughout lifetime. The pattern of north-south divide in Warwickshire commonly observed with the majority of other key health indicators is equally reflected at this age group. Life expectancy at 65 in Nuneaton and Bedworth and North Warwickshire for both males and females are significantly lower than that for England and Wales, whereas, the reverse is the case in Stratford-on-Avon and Warwick (fig 4).

Figure 4: Life Expectancy at 65 in Warwickshire 2006-2008



Source:ONS

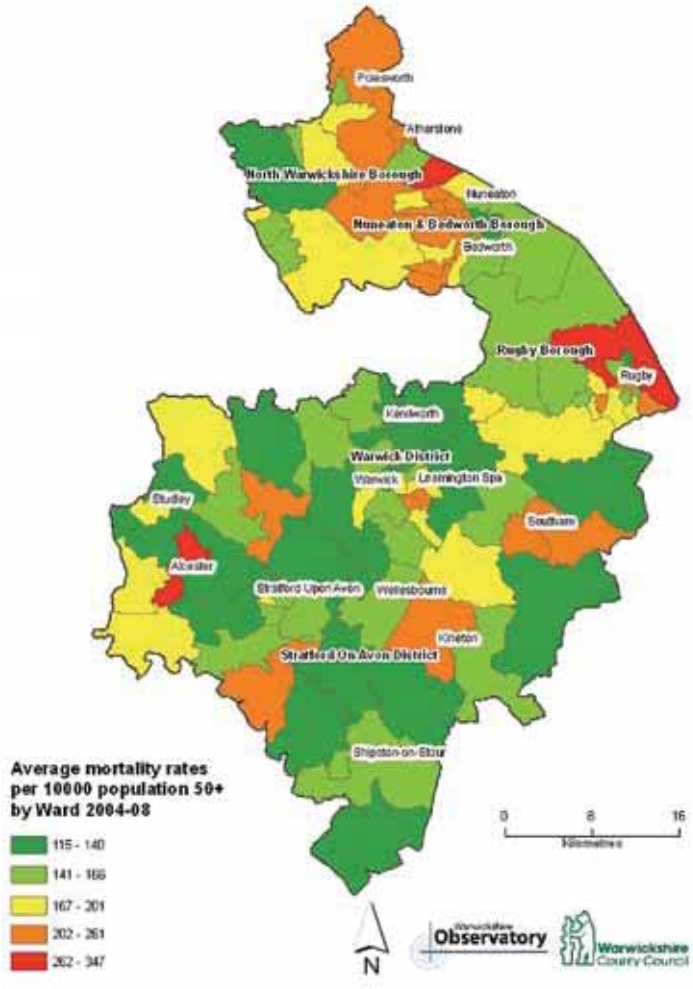
Although the last eight years have seen significant improvements in the additional number of life years for those aged over 65 across the county, the proportion of that time in good health as measured by healthy life expectancy (estimated from self-reported questionnaires assessing health), has been on the decrease, with the female population spending relatively less time (72%) than males (74%) in good health, and the time in good health has not significantly improved in line with life expectancy. (Table 3) In addition, just over half of this time is spent with some form of disability in both groups which indicates a significant proportion of the lives of this population group are spent in poor health, a reflection of and contributory to the extra burden on health and social care services in the county.

Table 3: Life expectancy, healthy life and disability-free life expectancies at age 65, 2000-2

Females	Life Expectancy	Healthy Life Expectancy (Estimate)	Disability-free Life Expectancy (Estimate)
North Warwickshire	18.8	13.7	8.2
Nuneaton and Bedworth	16.4	13.3	7.8
Rugby	19	14.8	9.4
Stratford-on-Avon	19.6	15.6	10.5
Warwick	19.6	15.3	9.8

Males	Life Expectancy	Healthy Life Expectancy (Estimate)	Disability-free Life Expectancy (Estimate)
North Warwickshire	15.6	11.9	7.4
Nuneaton and Bedworth	15.5	11.5	6.8
Rugby	16.7	13.4	8.9
Stratford-on-Avon	16.8	13.9	9.4
Warwick	17.1	13.8	9.2

Source: ONS



Source: ONS

3.5.2 Mortality

Each year approximately 4,700 people aged over 50 die, accounting for 95% of all the deaths in Warwickshire. Mortality rates are falling, for example in the 65-75 age group in last 15 years the rate has fallen by more than 40% across the county with the greatest fall in south.

Map 7: Average Mortality Rates per 10,000 population in Warwickshire by Ward, over 50s, 2004-08

The pattern of mortality in the districts masks variations in the wards. Map 7 shows the variation in mortality by ward. The average death rates (2004-8) for people aged over 50 ranged from 115 to 350 per 10,000 population, the lowest in Park Hill (Warwick), and the highest in Avon and Swift wards in Rugby where the rates are significantly higher than the Warwickshire average. This is in contrast to rates for all ages (including under 50s) which ranged from 36 to 111 per 10,000 population, with the lowest rates in Bardon (Warwick). The presence of care homes within these wards is a contributing factor to these patterns.

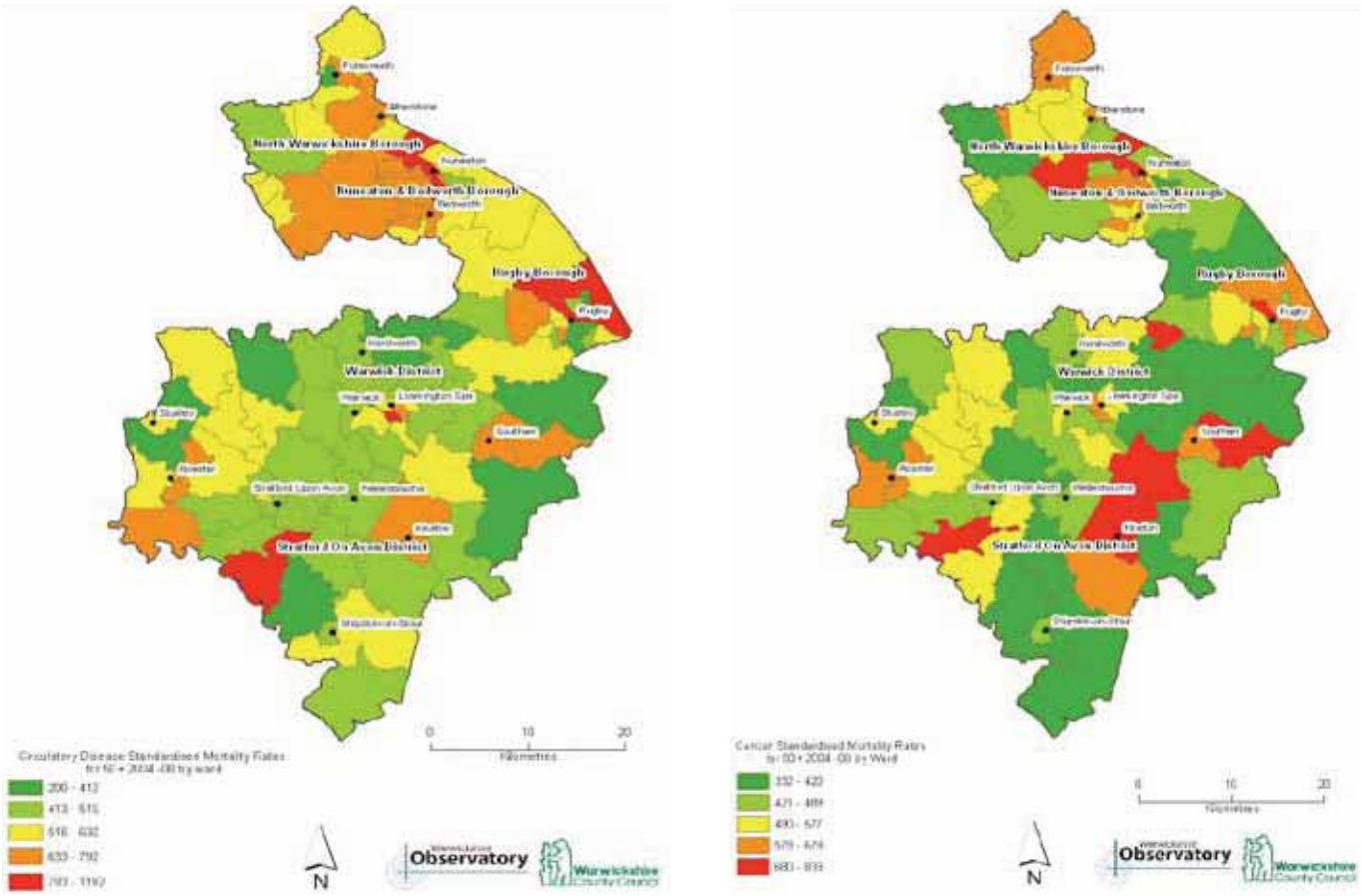
Table 4: Main Causes of Death in for aged over 50 in Warwickshire, 2008

Main Causes of Deaths	Number	Percent
All infectious diseases	89	1.9%
All malignant neoplasms	1290	27.1%
Lung	276	5.8%
Breast	104	2.2%
Prostate	88	1.9%
Endocrine/nutritional/metabolic systems	75	1.6%
Diabetes	61	1.3%
Mental/behavioural disorder	176	3.7%
Dementia	158	3.3%
Nervous system	184	3.9%
Parkinsons	59	1.2%
Alzheimers	48	1.0%
All circulatory systems	1489	31.3%
Coronary heart disease	599	12.6%
Cerebrovascular disease	436	9.2%
Stroke	207	4.4%
Respiratory systems	607	12.8%
Pneumonia	213	4.5%
Bronchitis	194	4.1%
Digestive systems	235	4.9%
Liver	69	1.5%
Genitourinary diseases	147	3.1%
Renal failure	52	1.1%
External causes of morbidity/mortality	199	4.2%
Accidents	164	3.5%
Falls	35	0.8%

Source: PHMF

The most common underlying causes of death in the older population are cancer and circulatory diseases. Deaths from cancers reduced by around a fifth over the last decade to an average of about 700 per 100,000 population in 2006-8, whereas rates for circulatory disease went down quicker - by more than half in the same period to just over 500 per 100,000 population. At national level, comparable death rates fell by around 18.3 percent to 751.6 per 100,000 and 51.8 percent to 510.6 per 100,000 population for cancers and circulatory diseases respectively.

Maps 8 and 9: Cancer and Circulatory Disease Standardised Mortality Rates per 10,000 population in Warwickshire by Ward, 2004-08



Source: ONS

Deaths from long term conditions show considerable variation at ward level - standardised deaths rates for all cancers ranged from 33.2-83.3/10,000 (Leam Valley and Ryton-on-Dusmore both in Rugby); all circulatory disease, ranged from 27.9-119.2/10,000 (Leam Valley and Hartshill in North Warwickshire).

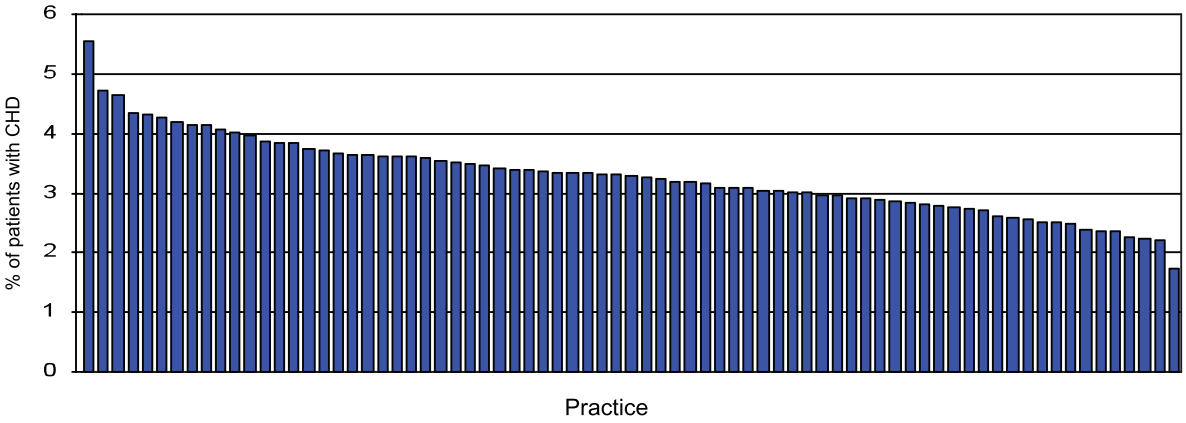
3.5.3 Ill health from long term conditions

An estimated 1 in 3 people in Warwickshire live with one or more long term conditions, in the population over 75 this rises to 2 in 3 people. These are diseases which in most cases can be controlled but at the moment cannot be cured. Evidence from the US suggests that 78% of healthcare spending is consumed by people with chronic conditions. The World Health Organisation has identified that these conditions will be the leading cause of morbidity by 2020, descibed as the "invisible epidemic".

Coronary Heart Disease (CHD)

CHD is one of the most common long term conditions in the UK. The major risk factors are; smoking, diet, physical activity, alcohol, obseity, high blood pressure and diabetes. The Health Survey for England estimated the prevalence at 7.4% of men and 4.5% of women; prevelance increases with age. In Warwickshire the prevalence on practice CHD registers for 2009/10 was 3.3%, however figure 5 shows the variation at a practice level of between 5.7% and 1.7%. This data is not age standardised and therefore maybe skewed towards practices with larger older populations, also a number of practices specialise in treating CHD patients. However, the presence of risk factors in these populations is also important in determining higher prevalence.

Figure 5: Prevalence of Coronary Heart Disease by Warwickshire Practices, 2009/10



Source: QMAS, QOF

Cancer prevalence

There are around 2,400 cases of new cancer diagnosed in Warwickshire residents each year. Breast, lung, large bowel (colorectal) and prostate cancer account for over half of all new cases of cancer. Cancer is predominantly a disease of the elderly. Cancers in those aged under 45 amounted to just over 5.5% of the total for males and 9.2% for females. Rates increase continuously across the age range for both males and females. The peak incidence occurs in the 75–79 age group.[7]

In the UK the age-standardised incidence trends for all cancers between 1993 and 2002 remained relatively stable in men (between 406 and 415 per 100,000), and increased by around 3% in women[8]. The total number of new cases of cancer, however is still increasing by 1.4% per year, mainly as a result of the ageing population, screening and earlier diagnosis.

Assuming cancer incidence rates remain stable, the projected increase in the total number of cases of cancer in Warwickshire by 2031 is:

- 100% increase in males aged over 70.
- 70% average increase in males across all ages.
- 50% increase in females aged over 70.
- 35% average increase in females across all ages.

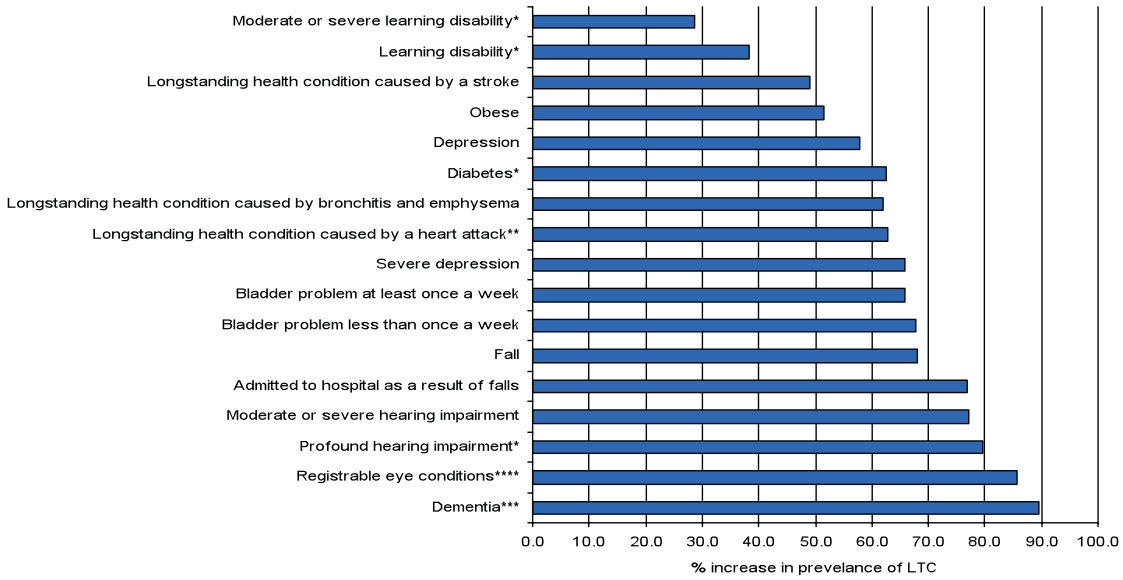
The growth in Warwickshire's elderly population in the next 20 years will mean a large increase in the number of cancers diagnosed in the area. Budgeting for this large increase in cases will need to be considered in order for sufficient care to be provided.

Chronic Obstructive Pulmonary Disease (COPD)

Estimates for the prevalence of choronic obstrutive pulmonary disease vary, but most studies estimate between 3% and 10% of the population have COPD. Prevalence is higher in men and increases with age. It is not usually noticable until after the age of 40. However, COPD is under-diagnosed. In Warwickshire the prevalence rate is 1.4% - ranging between 2.8% in practices in the north of the County to just 0.6% in the south. The main risk factor for COPD is smoking although air pollution and social class are less significant risks.

Projected Growth

Figure 6: Percentage Increase in the number of older people (see note below) in Warwickshire predicted to have a Long Term Conditon, between 2009 and 2030



Source: POPPI and PANSI (Note populations are over aged 65 except *over 55, **over 45, ***over 60 and ****over 75)

Figure 6 shows the estimated increase in the proportion of people predicted to have a number of long term conditions over the next 20 years in Warwickshire. The data shows that the number of patients with a long term condition is likely to grow significantly over the next 2 decades. The largest increase is predicted in the number of people with dementia. Therefore, supporting and treating an ever-increasing burden of long-term conditions will not be sustainable if we continue delivering services in the current way. It is important to remember that these diseases are not exclusive and many patients (an estimated 45% of people) will have one or more conditions. Screening programmes such as the NHS Health Checks mentioned in the next chapter aim to reduce the prevalence of disease by tackling the underlying risk factors. The Quality Innovation Productivity and Prevention (QIPP) workstream for long term conditions will also help address some of these issues and deliver high quality care that meets the needs of people with long term conditions.

3.5.4 Care

The number of people providing and requiring care will also increase over the next 20 years, with predictions of more than a 70% increase in the total number of people who are unable to manage at least one activity on their own. Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level and getting to the toilet.

Table 5: Number and percent of over 65s in Warwickshire predicted to be providing or requiring support, between 2009 and 2030

	Current (2009)		Estimates (2030)		
	Number	% of pop	Number	% of pop	% Increase 2009-2030
Population providing unpaid care to a partner,family member or other person	11,218	11.1	118,700	11.9	48.9
Population unable to manage ay least one domestic task on their own	38,169	43.6	65,412	40.5	71.4
Population unable to manage at least one self-care activity on their own	31,333	35.7	53,614	33.3	71.1
Population unable to manage at least one activity on their own	17,157	20.1	30,208	18.2	76.1

Source: POPPI

Overview

Older people tend to have a much greater need for health and social care services.

The majority of healthcare resources are therefore directed at meeting their needs. For example, the NHS spent 60% of its budget on people aged 45 and over (£15 billion) and 40% on those over the age of 65 in 1998/99. In the same year social services spent nearly 50% of their budget on the over 65s, some £5.2 billion.[1]

In Warwickshire this equates to an estimated £474 million (60% of its £791million annual budget) which will be spent on health services for people over 45 each year (£316 million on over 65s). Personal Social Services Gross Expenditure on older people over 65 (including supporting people) in 2006/07 was £72 million (46% of the total budget). [2]

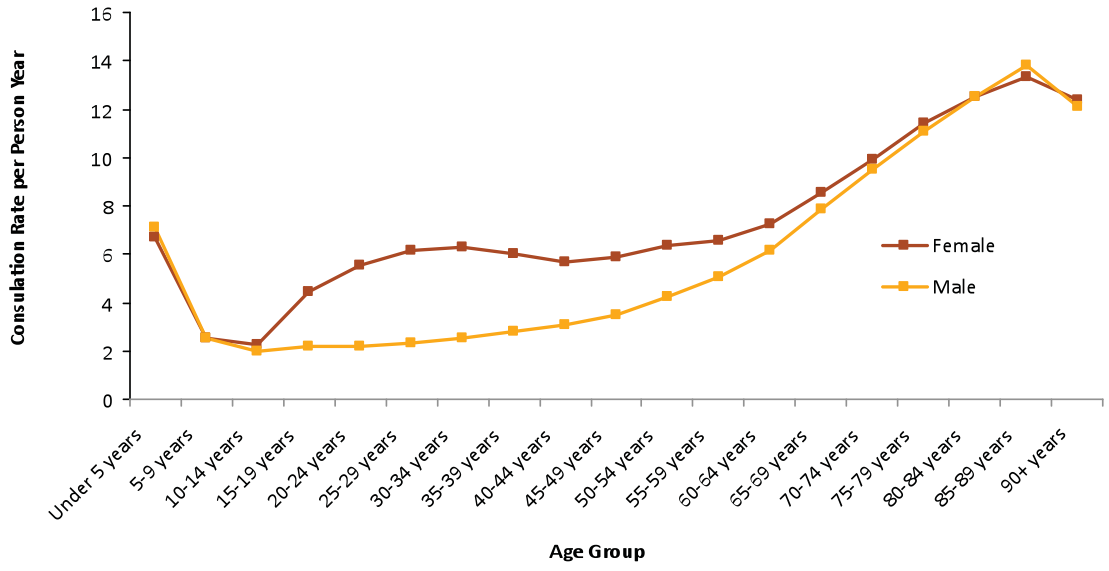
The ageing population also means that the impact on the future provision of these services will be significant. Although people are staying healthier for longer, a greater number of older people suggests that there will be greater numbers in ill health in absolute terms. Such developments are likely to place increased demands on care services. Health and social care providers will have to plan and adapt to the ageing population.[3]

This section of the report seeks to describe the patterns of use of health services by older people in Warwickshire.

4.1 Primary Care

Primary care describes the health services that play a central role in the local community including GPs, dentists and pharmacists. Primary care providers are usually the first point of contact for a patient. They also follow a patient throughout their care pathway.

Figure 6: Crude Consultation Rates per person- year in 2008, all clinicians, England



Source: QRESEARCH

Local data on consultation rates in primary care is difficult to obtain but national estimates based on QRESEARCH show that consultation rates peak in the older population with highest rates in 80-84 year olds (figure 6).

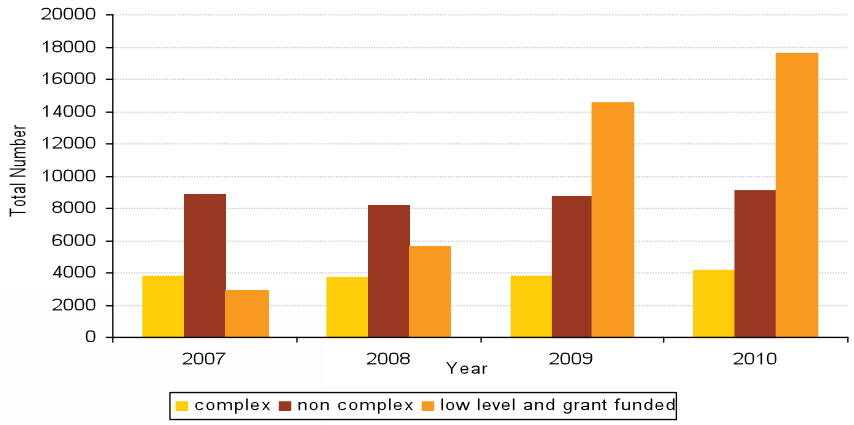
A crude local analysis of access to general practices across Warwickshire showed that 74% of over 50s live within 2.5km of a Warwickshire GP (approximately a 30 minute walk) and 96% live within 5km (approximately a 10-15 minute drive). Those who do not fit within these criteria live mainly within the rural South West and an area south of Stratford.

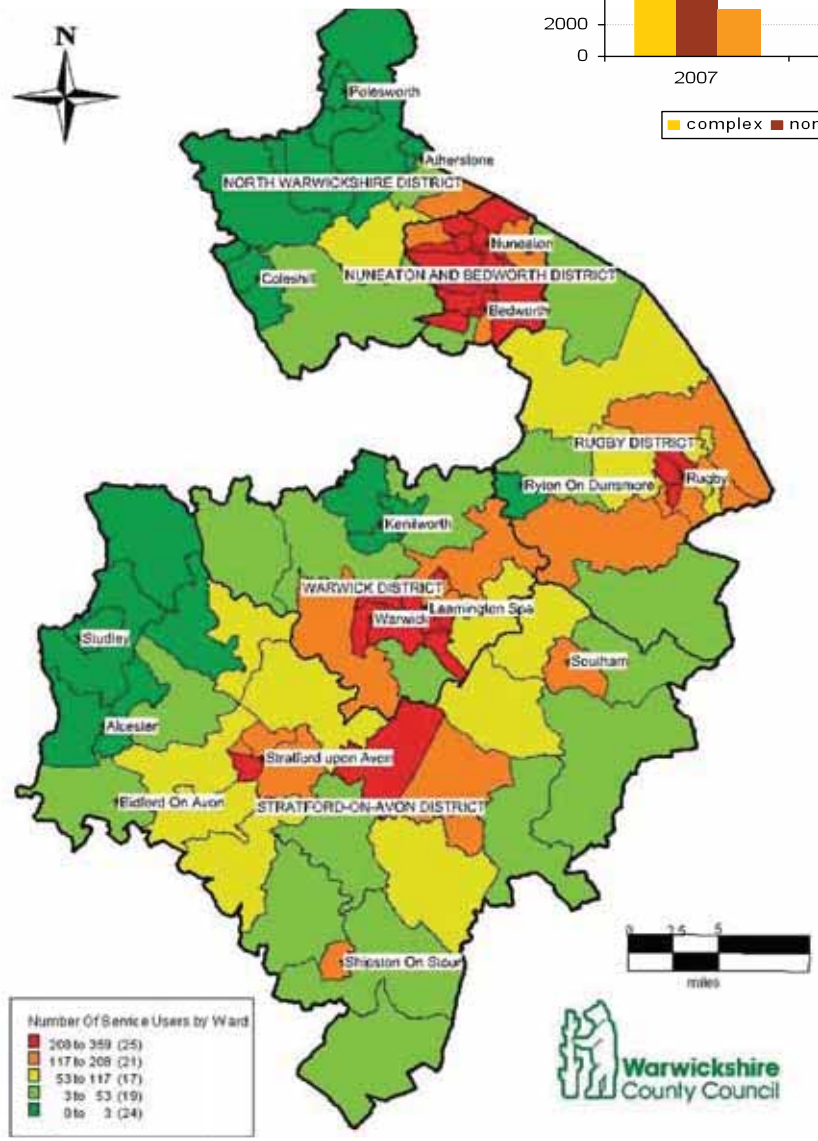
4.2 Social Care

In Warwickshire, the total number of clients over 50 has more than doubled over the past 4 years from over 8,200 at the year ending 31st March 2007 to more than 16,600 at the 31st March 2010. The largest increase has been seen in clients whose needs are classified as low level and grant funded (mainly early intervention/prevention day services for those who refer directly to voluntary sector organisations) and the introduction of the Promoting Health and Independence through Low Level Integrated Support service (PHILLIS) has been instrumental in this increase. The total cost of complex client services (those in residential or nursing care or those receiving 20 hours per week of home care or an equivalent direct payment to cover the costs of 20 hours home care) alone has risen from £860,000 to over £1 million for the same period. Of the clients over 50, more than 85% are over 65 years old.

Figure 7: Total Number of Social Care Clients, in Warwickshire , over 50, 2006/07-2009/10

Source: AHSC, Warwickshire County Council





Map 10: The Distribution of Social Service Users, by Warwickshire Ward as at the end of June 2010

Map 10 provides a snapshot of the distribution of social service users across the county. It shows that the largest numbers of clients are in Nuneaton and Bedworth District with large numbers also living around Rugby and Warwick. This is in part a reflection of population density and need.

Source: AHSC, Warwickshire County Council

4.2.1 Carers

Carers are a key component of families and communities and therefore society as a whole. Estimates show that 3 in 5 of us will become carers at some point in our lives.[4] The 2001 Census found over 17% of the population aged over 50 and 13% of the population over retirement age, provided some form of care for friends, relatives or neighbours, on a weekly basis. Data from the County Council showed that, in March 2010 there were 2,694 carers aged 50+, and 1,855 carers aged 65 and over.

More recently, the business model for social care has changed emphasis to focus more on prevention, re-ablement and recovery. Through this approach we are likely to see fewer older people accessing social care support and for shorter periods. A further key change will be the roll out of personal budgets across the county over the coming months initially for new service users. More integrated intermediate care and re-ablement services are planned through our joint work on Cutting the Cost of Frailty.

4.4 Acute Care

Hospital activity is influenced by the nature of the population in terms of their demography, social circumstances and health behaviour as well as the local health policy. It is only one piece of the jigsaw in terms of service use but accounts for around 28% of NHS expenditure and is often used as a proxy measure of health needs and morbidity within a population. Almost two thirds of general and acute beds are used by people over 65.

Table 6: Summary of average proportion and cost of hospital activity for over 50s and over 75s amongst Warwickshire registered patients 2009/10

	Over 50s		Over 75s	
	% of attendances	Total Cost	% of attendances	Total Cost
Population Baseline	37.5%	-	8.2%	-
A&E	36%	£5,350,511	14%	£2,132,554
Outpatients	58%	£30,147,335	17%	£8,753,750
All Inpatients	58%	£116,964,906	22%	£52,973,432

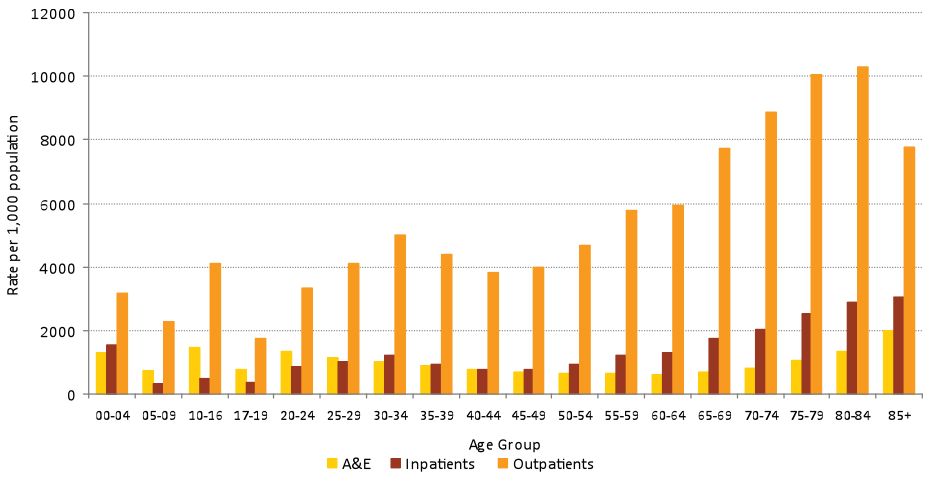
Source: HCS and SUS (Confidence intervals shown in brackets)

Table 6 shows that both outpatients (where a hospital bed for recovery is not required) and inpatients attendances (where a patient is admitted with the intention that they stay at least one night) in over 50s accounted for nearly 60% of all activity compared to a population baseline of 38%. In over 75s the proportion of hospital activity compared to the population is baseline is more than double for outpatients and inpatients use.

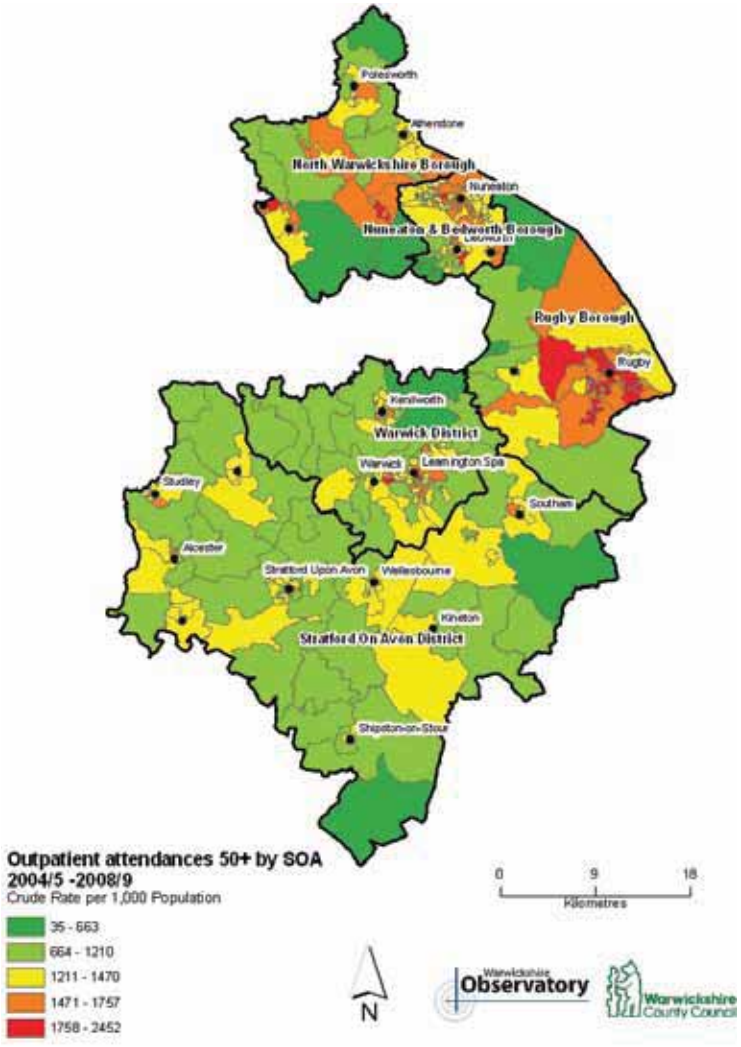
In the over 50s, 36% of inpatient admissions are non-elective (where the admission is not planned or is an emergency), in over 75s 50% of inpatient admissions are non elective or to put it another way; 22% of all non planned emergency inpatient admissions are to people aged over 75 years. The proportion of spend for hospital activity on the over 75 population is 26% of all activity and 39% of non elective costs.

Figure 8: Age specific admission rates, Warwickshire registered patients, all providers 2008/09-2009/10

Source: HCS and SUS



4.4.1 A&E: The most common reason for over 50s attending A&E during the last 2 years was for dislocation, fracture or joint injury. This was in 12% of attendances for this group. Other common reasons for admission (8-10% of patients) were for soft tissue inflammation, gastrointestinal conditions, cardiac and respiratory conditions. 36% of attendances were not classifiable. The highest rates of A&E attendances for over 50s were around the urban areas of Rugby, Leamington, Warwick and Nuneaton. Higher rates of admission were also seen in parts of Rugby Borough and North Warwickshire.

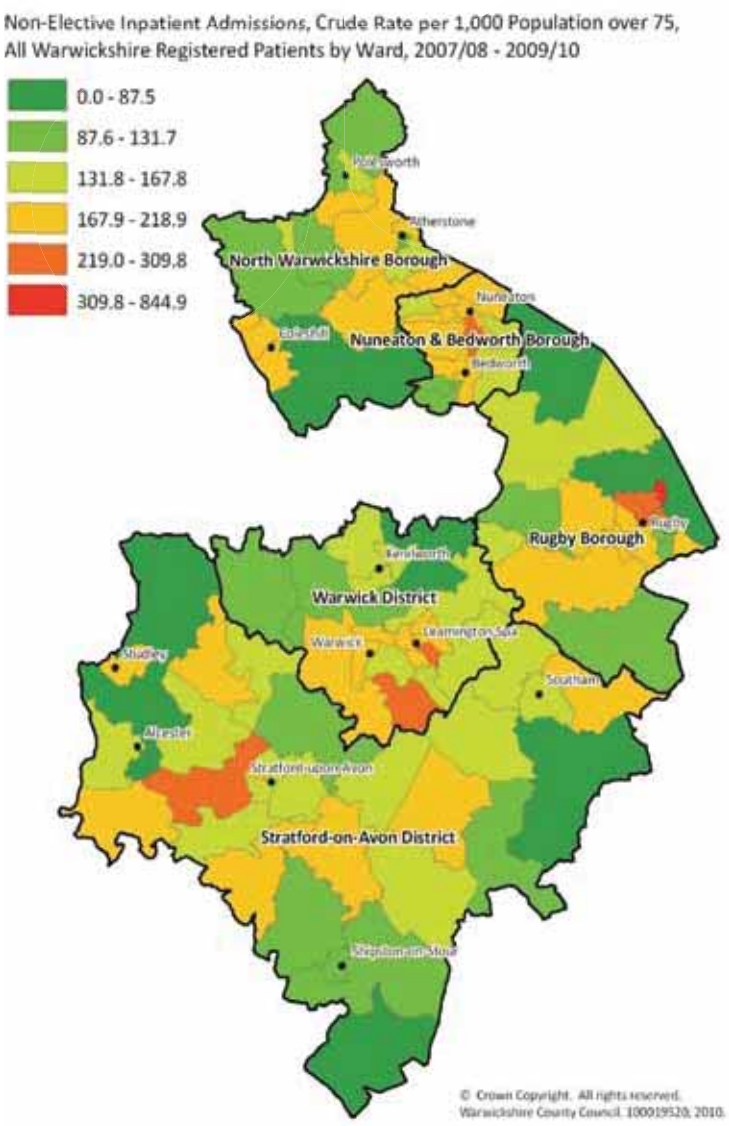


Outpatients: On average, Warwickshire patients over 50 attend more than a quarter of a million outpatient appointments each year, costing more than £25 million. The trends show that both the activity and cost in this age group is increasing. The major specialities were trauma and orthopaedics and ophthalmology accounting for 28% of appointments.

Inpatient Admissions: Over 60% of inpatient admissions for Warwickshire patients between 2004/05 and 2009/10 were elective in the over 50s age group rising to 50% in over 75s. This increased over the period from 61% to 66% in 2008/09. A total of 41% of inpatient admissions were classified as day cases. Therefore the majority of patients (61%) stayed between 0 and 1 day, although 8% had a length of stay lasting 16 days or more. Overall, the greatest activity in this age group was for cataracts (5%), endoscopic or intermediate large intestine procedures (5%), diagnostic and intermediate procedures on the upper GI tract (4%) and minor bladder procedures (3%) costing around £11 million over 5 years. The most costly activities were for hip fractures (£7.8 million) knee procedures (£5.4million), cataracts (£4.3million), Myocardial Infarctions (£3.7 million).

Map 11: Crude Rate per 1,000 population of hospital outpatient attendances in people over 50, Warwickshire registered patients, 2008/09-2009/10

Source: HCS

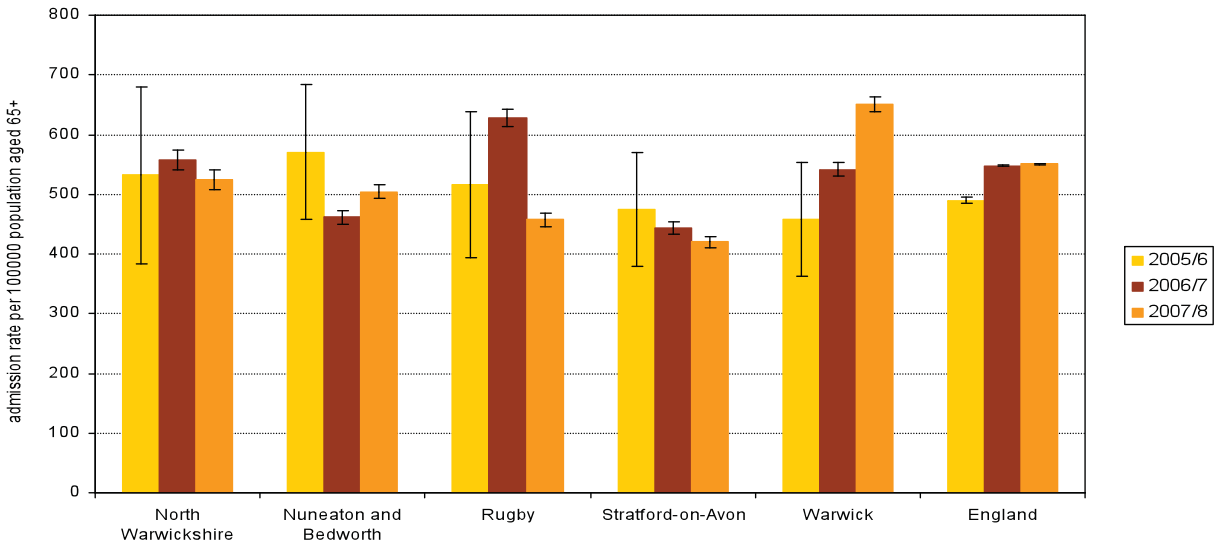


Map 12: Non-Elective Inpatients admissions in people over 75s, 2007/08-2009/10 Source: HCS

Overall the highest inpatient attendances in people over 50 were in North Warwickshire and Nuneaton and Bedworth Boroughs although pockets of higher rates were also found in Wellsbourne near Stratford. This may be associated with the

Focusing on CHD as an example, shows the variation between need and demand at a district level. In the last three financial years, admissions have increased in the northern parts of the county (with highest standardised admission rates in Nuneaton and Bedworth, 882/100,000), and Rugby compared to decreases in admission rates for south Warwickshire residents (Stratford-on-Avon and Warwick) and those at national levels. In contrast, revascularisations are relatively higher in the southern areas of Warwickshire (fig 9). For example, procedures for Warwick residents went up 20% to a rate of about 640/100,000 in 2007/8 compared to an increase of less than 10% (510/100,000) in the Nuneaton and Bedworth area in the same period suggesting a level of inequity in service across the population in this age group. Figure 9 shows the variation which may account for the difference in admission rates.

Fig 9: Age Standardised hospital episode rate for revascularisation in Warwickshire and England 2005/6 - 2007/8



Source: SUS

Table 7 shows the hospital activity across the County. It highlights higher rates of A&E attendances and outpatient appointments are in Rugby and Nuneaton and Bedworth. The highest rates of elective inpatient attendances are in the South and Rugby while the higher rates of non elective inpatients attendances are in the north of the County and Rugby.

Table 7: Crude rate per 1,000 population of hospital activity for over 75s by Borough amongst Warwickshire registered patients 2007/08-2009/10 Source: HCS

	A&E	Outpatient	Inpatient	
			Elective	Non Elective
North Warwickshire	405.7	1962.8	235.1	264.6
Nuneaton and Bedworth	477.3	2053.1	251.9	294.2
Rugby	513.4	2432.5	276.0	295.4
Stratford-on-Avon	349.0	2018.0	264.1	249.5
Warwick	452.3	2187.6	277.1	281.5
Warwickshire	435.6	2130.0	263.2	275.9

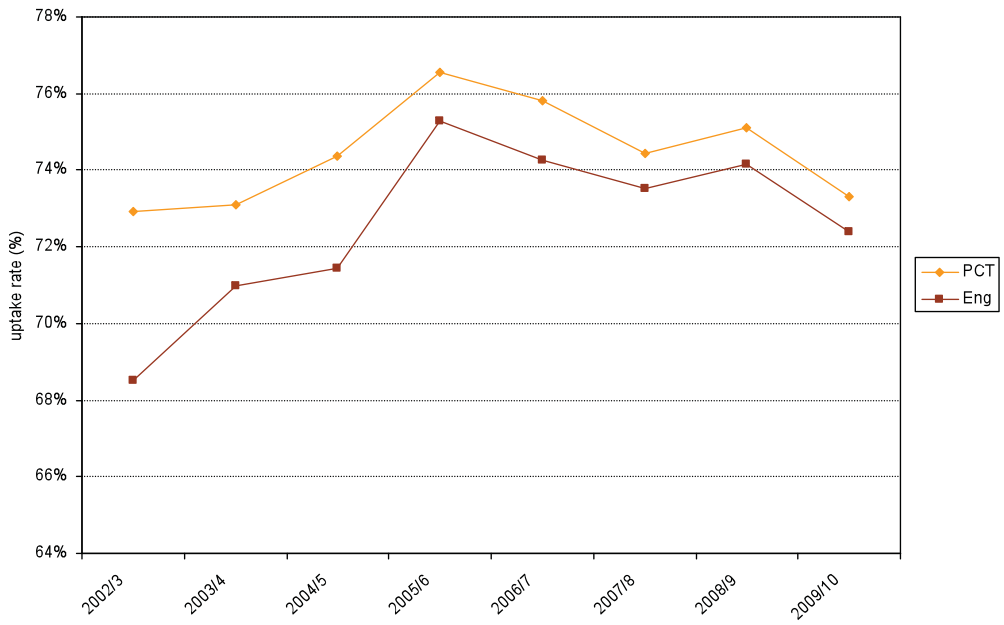
4.5 Vaccine Coverage

4.5.1 Flu Vaccine

Immunisation against flu is especially important for the at risk population, mainly the elderly, and those with long term conditions such as diabetes and heart conditions. The seasonal uptake of the flu vaccine (commonly called winter flu) in the over 65s living in Warwickshire has been on an increase since 2002/3. The national target is for a 70% uptake. Coverage in Warwickshire peaked at 76.5% in 2005/06, most recent figures in 2009/10 have indicated decreased uptake (73.3%). Uptake across the PCT has remained consistently above that for England as shown in the charts, with a similar pattern in coverage after 2005/6 which may suggest a "common event" for example SARS that may have happened in these periods.

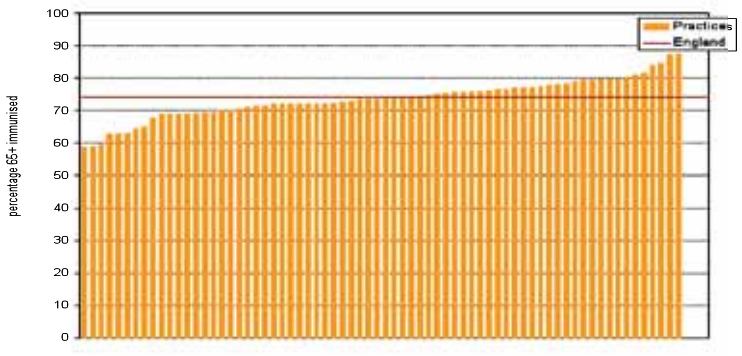
There is variation across the GP practices with some estimates just over half of this population group (57.6%) to as high as 89.1%. At national level, 72.4% of the 65+ age group were administered with this vaccine. Of all the practices in Warwickshire with below England uptake rates, two in three were either from the northern part of the county or Rugby.

Fig 10: Uptake of Flu vaccine in 65+ during the winter months , Warwickshire and England 2002/3 - 2009/10



Source: Department of Health

Fig 11: Uptake of seasonal flu vaccine in the 65+. Warwickshire practices, 2009/10



Source: Department of Health

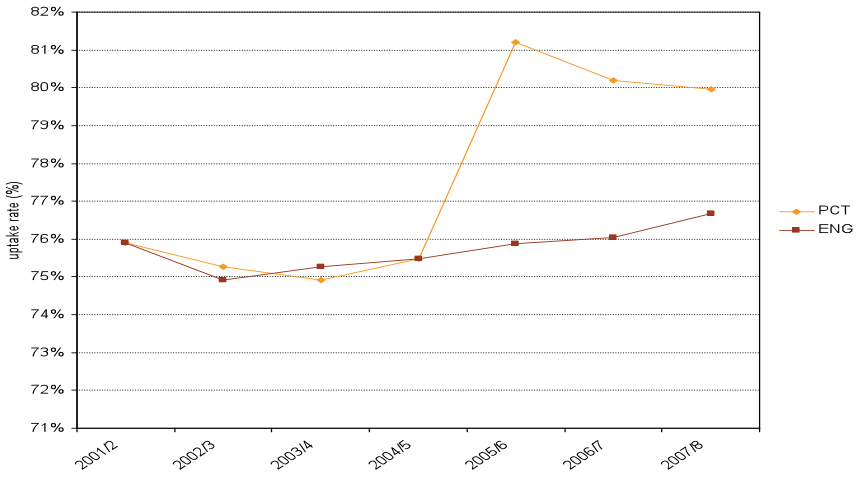
4.5.2 Swine Flu

Swine flu data for 2009/10 indicates that nearly two in five (39.6%) of the registered "at risk" from this population group were administered with the swine flu vaccine. However, coverage is more variable than that for the seasonal flu, with uptake rates ranging from 0% – 78.9% by practice. Anecdotal evidence suggests an association with higher uptake rates much more common in practices that were pro-active in their selective targeting of their "at risk" patients. In addition, the swine flu vaccination is offered to all those aged 65 years and over who are in Department of Health identified clinical risk groups. This is not the same as seasonal flu vaccination which targets all aged 65 years and over.

4.6 Screening Programmes

Screening programmes aim to find cancers or other illness as early as possible. The breast cancer programme for example is aimed at preventing breast cancer by detecting it early for prompt treatment.

Fig 12: Percentage of women aged 53-64 screened for breast cancer



Source: CIS, WMCIU

4.6.1 Breast Cancer Screening Coverage

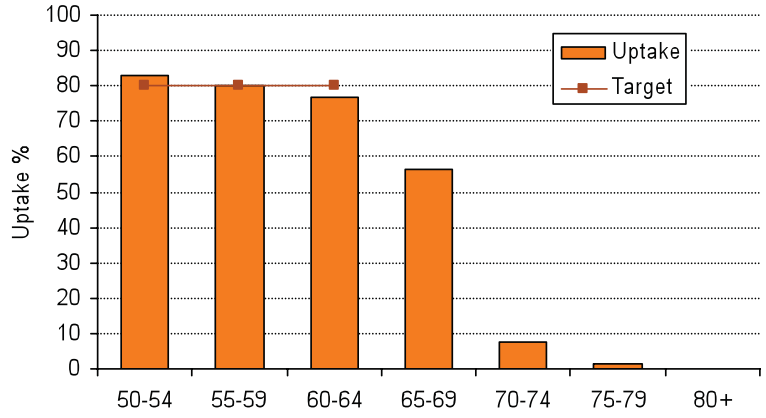
Warwickshire is ranked in the top half of PCTs in the region with screening coverage above that for the national average in 2008/9. The chart shows this trend over time. As with the other 10 consortia in the region, coverage in the PCT was slightly down by half a percentage point from the previous year.

4.6.2 Cervical Cancer Screening.

The NHS cervical screening programme is routinely offered to women aged 25 to 64 years and the Department of Health target is to achieve screening in 80% of the eligible population. From the age of 50, women with a negative screening history are offered the opportunity to have a cervical sample taken every five years which will cease at the age of 64 years if there have been three consecutive negative samples. Women with an incomplete or previously abnormal screening history continue to be offered cervical screening until three consecutive negative samples have been recorded. However, as can be seen from the graph below, uptake in the eligible population declines rapidly over the age of 69 years.

Cervical cancer is predominately a disease that occurs in women aged 30 to 39 years. However, the routine screening programme was only introduced in 1988 and there are cases of the disease found in older women who are part of the previously unscreened population. It is important that all women with an incomplete or abnormal screening history understand the need to continue with cervical screening and are given the opportunity to have the test undertaken when appropriate.

Figure 13: Cervical Screening uptake in Warwickshire, over 50, 2009-10



Source: WMQARC

4.6.3 Bowel Cancer Screening

The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 69. From April 2010 there will be an extension of the age range for bowel cancer screening up to the age of 75. People over 75 can request a screening kit by calling a free phone helpline.

Warwickshire and Coventry began bowel cancer screening in July 2007. The PCT has a target to achieve 60% screening uptake for the programme. The most recent data from the start of the programme until January 2010 shows Warwickshire has the highest uptake in the region at 62.5%. The regional average was 52.5%. Uptake is highest in the 65-69 age group for males and females.

Gender	Age Group	Number invited	Completed Kits returned	Uptake within 30 days	Uptake within 30 days (%)	Uptake (%)
Female	60-64	14,373	9,285	6,330	44.04	**64.60**
	65-69	12,915	8,708	6,389	49.47	**67.43**
	70-74	5,669	3,721	2,881	50.82	65.64
	75+	1	0	0	0.00	0.00
Male	60-64	14,370	8,142	5,138	35.76	**56.66**
	65-69	12,751	7,753	5,292	41.50	**60.80**
	70-74	5,453	3,369	2,490	45.66	61.78
	75+	0	0	0	-	-
Warwickshire PCT		65,532	40,978	28,520	43.52	**62.53**
West Midlands		462.804	228,338	166,497	34.66	**52.54**

Source: WMQARC

4.6.4 Prostate Cancer

Although evidence does not yet support population screening for prostate cancer there is considerable demand for the PSA test amongst men worried about the disease. In response to this the Government has introduced a PSA Informed Choice Programme.

4.6.5 Health Checks

The NHS Health Check programme is a national programme offered to everyone eligible between 40 and 74. Warwickshire is currently beginning the roll out of the programme starting in the Nuneaton and Bedworth area. Modelling of the effects of the Checks is continually being undertaken as more knowledge is developed across the country. Using the Warrington model for example suggests that a 3-4% Risk Factor reduction leads to: 136 less acute admissions (MI, CVA, heart failure, kidney failure) per 5000 screens and 9 less deaths per 5000 screens.

Overview

NHS Warwickshire and Warwickshire County Council are working closely to respond to the challenge of population ageing. We are undertaking joint activities to:

- Ensure early identification and response to 46 specific threats to older people's health, independence and well-being, identified using a common assessment framework of the health and care needs of older people
- Reduce the impact of frailty on the health, independence and well-being of older people, on the well-being of family carers, and on unnecessary need for admission to hospital or long-term care in a care home, through a fully integrated response by health and care services to crises caused by the sudden onset of confusion, falls or immobility in older people
- Improve end of life care (section 5.1)
- Transform care for people with dementia and their families (section 5.2)
- Reduce the risk of falls and fractures in older people (see section 5.3 below)
- Reduce excess deaths during winter months (section 5.4)
- Meet needs arising from social isolation and rural living (section 5.56)
- Encourage healthy living in old age (section 5.6)

5.1 End of Life Care

5.1.1 Overview

The NSF for End of Life Care (EoLC) was published in July 2008 securing it as a government and subsequently an NHS Warwickshire BEST Strategy priority, ensuring that people end their lives in dignity and with a choice of service provision including help to remain in their own homes until they die.

5.1.2 Setting the Scene

It is estimated that 0.88% of Warwickshire's population die each year (approximately 4765 deaths all ages). Of those deaths 29% occur in hospital on a length of stay of less than 14 days. This is the accepted measure of deaths to target for avoidance of EoLC admissions. The majority of deaths occur following a period of chronic illness related to conditions such as heart disease, liver disease, renal disease, diabetes, cancer, stroke, chronic respiratory disease, neurological disease or dementia. However, these patients were subject to multiple admissions in the last year of their life. The top 5 reasons for admission were:

- Pneumonia
- Urinary Tract Infection UTI
- Heart Failure
- Unspecified lower respiratory infection
- Fracture Femur

These spells of care are associated with an ageing population who are living with long term conditions and end their life with complex co-morbidities but general palliative care needs.

Nationally 80% of the public state a preference for dying to take place in their community setting.
Currently in Warwickshire;

- 57% of deaths occur in acute hospitals
- 21% at home
- 22% in community/hospices setting.

Compared to the West Midlands, Warwickshire has more people dying in hospital and fewer at home.
Approximately 2,400 Warwickshire residents die each year in acute hospitals and costs were estimated at just under £17million. Deaths in acute hospitals are likely to continue to rise with the ageing population unless alternative services are developed within community settings.

Table 9: Place of death for all causes of death 2008/09, Warwickshire

Recorded deaths from all causes	4765	
Expected number of deaths in hospital Observed number of deaths in hospital	499 2430	(based on 11% of population wishing to die in hospital) (53% of total number of deaths for time period)
Expected number of deaths at home Observed number of deaths at home	2545 1128	(based on 56% of population wishing to die at homel) (25% of total number of deaths for time period)
Expected number of deaths in a community hospice Observed number of deaths n a community hospice	1182 987	(based on 26% of population wishing to die in a community hospice) (22% of total number of deaths for time period)

Source: ONS

5.1.3 Priorities for action

NHS Warwickshire's vision is that "all people in Warwickshire at the end of life will be supported and cared for, feel safe and listened to and will be enabled to die with dignity and respect." The population of Warwickshire will have the opportunity to access an equitable, comprehensive and high quality range of EoLC and services. These will be person and family focused, promote choice, provide symptom control, respite, psychological, social, spiritual and practical support. They will be sensitive to the individual's needs and wishes and delivered in a timely, integrated and coordinated way. There are a number of areas where change is needed to develop best outcomes:

- Aligning pathways with primary care and acute settings and social care to ensure total coverage of support which will help people to be cared for in a place of their choosing.
- Improvements have been targeted to support GPs with Gold Standards Framework (GSF) for Palliative identification and support to improve skills around supportive care planning and identification of patients in the last year of life.
- Increasing the scope of nursing care into people's homes even if that is a residential home setting increasing the efficiency of current provision with the addition of telehealth residential settings and peoples own homes.
- Closer working with Continuing Health Care patients.
- Reprioritise night sit services and increase access to prevent hospital admission.

5.1.4 Conclusions

Investment is required since these activities need to be in place before we can maximise our benefits from this pathway. GSF capability to level 3 will take 2-3 years to achieve but would be a platform which would make full use of any later investments in the system. Once care co-ordination is fully embedded in primary care additional investments will support more people to be cared for at home and die in a place of their choosing.

5.2 Dementia

5.2.1 Overview

Dementia is increasingly becoming one of the most important causes of disability in older people. In Warwickshire, dementia has been identified as a priority area within the PCT Strategy. In terms of Global Burden of Disease, it contributes 11.2% of all years lived with disability. This figure is higher than stroke, musculoskeletal disorders, heart disease and cancer.[1] Currently however, dementia care services are not as extensive and appropriate as other chronic conditions[2] and as our populations become older, it is essential that policies and services, both nationally and locally, are able to offer the best possible care and support to people with dementia, their carers and families.

Currently in the UK around two-thirds of people with dementia live in private households with the majority of their care provided by primary and community care teams.[2] However, the steady fall in the number of long-term care places available for people with dementia together with the rising numbers of older people generally, will lead to an increasing number of frail older people who will require complex care.[3] Timely and effective primary care to support and enable people to live independent and dignified lives in environments of their choice is necessary.

5.2.2 Setting the Scene

The greatest factor in the development of dementia is age so this suggests a major financial and commissioning challenge for the county, given the projected demographic growth.

- At present, 1 in 14 people over the age of 65 and 1 in 6 people over the age of 85, suffer from a form of dementia.
- Nationally prevalence is estimated to increase rapidly by over 150% from 1 million in 2010 to 1.7 million people in 2050[2] leading to 1 in 3 people over the age of 65 who will be suffering from dementia.[4]
- The most recent numbers of people currently living with dementia in Warwickshire are 6,013 with approximately 2,000 men and 4,000 women over 65 years of age (majority over 75 years) affected. This figure is estimated to increase by 27% in 2016 and by 90% by 2030 (the majority will be aged over 80 years).[5]

5.2.3 Priorities for action

As the prevalence of dementia increases with the growing ageing population and the current economic climate, this poses further challenges for provision of health and support services for those people diagnosed with dementia. As part of a joint strategy, NHS Warwickshire and Warwickshire County Council have agreed five priority areas to be addressed over the next four years:

1. Timely identification and diagnosis: This includes jointly agreed communications so patients and carers receive high quality information when they need it. Awareness will be raised about prevention in the over 50s through vascular screening. Coventry and Warwickshire Partnership Trust have a county wide single point of entry for people who require a diagnosis.

2. A Quality Assured Pathway of Care: Organisations are working together to commission services. This includes work with GPs to review/remove the inappropriate use of this medication which is a particular issue in care homes and which poses medical risk in older people. Work is also underway with intermediate care so that people can remain in the community for as long as possible. This will require good carer support as well as the development of appropriate respite alternatives and crisis planning.

3. Care and Support for the Rest of Life: This is a key role for the voluntary sector so that patients and carers receive timely advice and support that they can access when they need and want it. Warwickshire is a National Demonstrator site for the new Dementia Care Advisor role and this pilot started in the north of the county, Nuneaton and Bedworth in March 2010.

4. Workforce Development: This ensures staff who look after people with dementia and their carers have the right skills and support to do this well. Work is underway to provide understand the capacity and skills profiles available currently; provide education and training support with both community services and service providers through a number of joint project with Universities; and GP training though online training programmes.

5. Accommodation, Housing and Assistive Technology: The needs of people with dementia and their carers feature highly in this work stream led by Warwickshire County Council on Care and Choice in Accommodation. Alongside developing new accommodation opportunities to support people to remain at home for longer, the uptake Assistive Technology will be increased over the life of the Strategy.

5.2.4 Conclusions

In partnership with Warwickshire County Council the aim is to transform the way in which dementia services are delivered across Warwickshire and to improve efficiency and patient/carer experience so that everyone with a diagnosis of dementia is treated with dignity and respect.

5.3 Falls and Bone Health

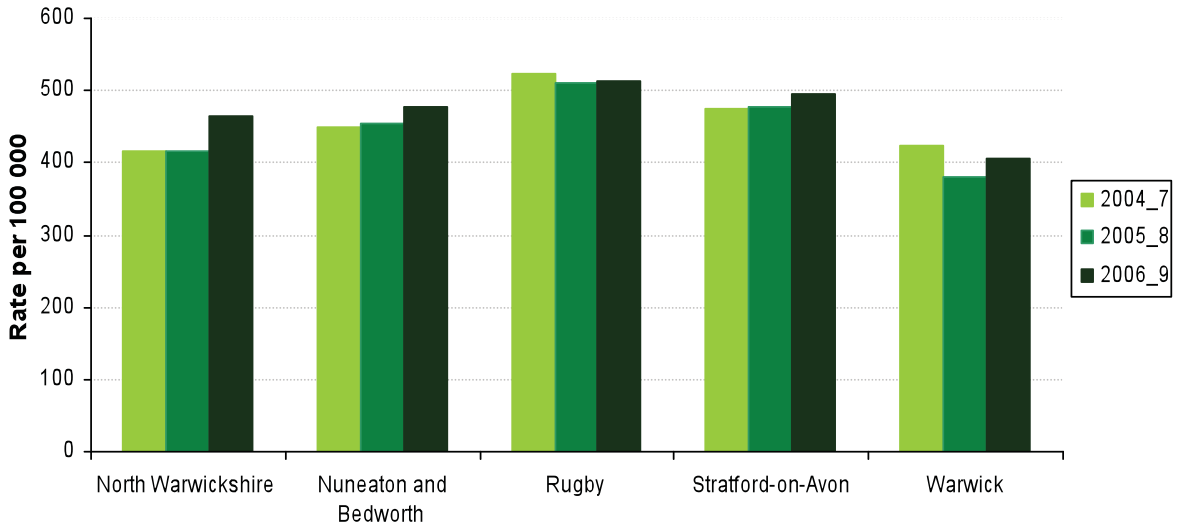
5.3.1 Overview

Falls are a major cause of both physical and emotional ill-health, decreased independence and mortality in older people. Osteoporosis is an important predictor of the risk of sustaining a fracture following a fall. However, both falls and fractures are preventable through using appropriate prevention and treatment strategies.

5.3.2 Setting the Scene

Approximately 30% of the population over-65, 50% of the population over 85s and 60% of nursing home residents in England will fall each year.[1 2] 20-30% of these falls will cause injury.[2] With 30% of admissions to hospital for hip fracture being from patients in care home.[3] Falls are the most common reason for A&E attendance and hospital admission in the elderly.[4] Fractures represent one of the most serious consequences of a falls and osteoporosis; hip fractures in particular. Following osteoporotic hip fracture 50% of people will no longer be able to live independently, with fewer than half returning to their initial place of residence.[3 5] 10% of people sustaining a hip fracture die within a month of admission, and 30% will have died at 1 year following admission.[3 6]

Fig 14: Age Standardised rates per 100,000 registered over 65 population of hip fracture admissions in Warwickshire Districts, 2004-2006



Source: Contract Minimum Data Set

In Warwickshire admission rates for fractured neck of femur are rising year on year, and although these changes are not statistically significant (please see Figure 1), there were 551 admissions for fractured neck of femur in 2008/9 compared with 483 in 2005/6. Rates are increasing in North Warwickshire, Nuneaton and Bedworth and Stratford, and decreasing in other districts. However, Rugby residents have the highest rates. Hip fracture admission rates are the most robust measure we have to use as a proxy indicator for falls, but are not reflective of total fall rates.

5.3.3 Priorities for action

The PCT's priority is to apply its resources where they gain the most benefit to people. Previously the evidence for Falls Service design was based on the publication of NICE guidelines (2004), the National Service Framework for Older People (2001) and the New Zealand study (Campbell). All of these supported the view that a specialist falls services were necessary. However a recent systematic review showed little evidence was found to support the effectiveness of multi-factorial interventions to prevent falls and injuries in older people in community and emergency settings. As the evidence has shifted the PCT have agreed that there are five effective, uni-factorial interventions we can do. They are:

1. Advice on exercise (balance and weight bearing)
2. Medication
3. Vision Check
4. Environmental scan of the home
5. Bone Health

We are planning three external stakeholder work groups. They are:

1. Primary Care Group working with GPs and other Primary Care professionals to use the uni-factorial prevention tools. This group will develop an education and communication strategy.
2. Targeting high risk settings such as Secondary Care, Nursing and Care Homes
3. Setting up an Evidence review group

5.3.4 Conclusions

We are on a rising trend of increasing older people and therefore an increase in fractures and falls. The rate of falls and fractures is increasing nationally and presents a major challenge. It is a fact that there are increasing incidences of falls and fractures due to larger numbers of older people and people's sedentary lifestyles. Our ambition is to slow the growth in falls and fractures in the growing older population.

5.4 Excess Winter Deaths

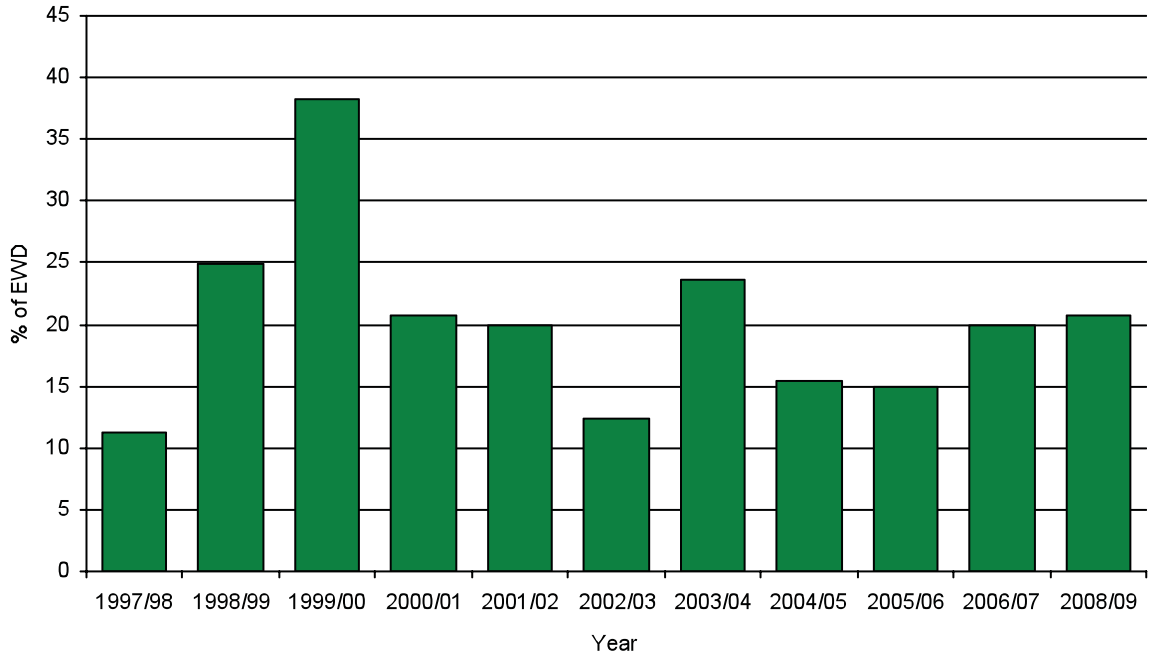
5.4.1 Overview

Proportionately, more deaths occur in the winter months than at other times. In this matter of likely preventable extra deaths the UK has a poor record, with the most recent data for Warwickshire suggesting a significantly high rate of winter deaths. High excess winter deaths are much more than that the cold tends to kill and make coping with illness difficult or of "our British climate". It is a matter of public policy about information, help, housing, health and care intervention, and financial support.

5.4.2 Setting the Scene

The public health threat of excess winter deaths in the West Midlands region was highlighted in the Chief Medical Officers Annual Report 2005, and nationally in his last report1,[2]. In 2005 the regional Excess Winter Death Index for those aged 85+ was the highest of any English region, but has since improved. In Warwickshire the same strong seasonal pattern in monthly deaths occurs as across the whole country. The contribution of the under 65 year olds is seen to be low, with some fluctuation.

Figure 15: Percentage (index) of Excess Winter Deaths in Warwickshire 1997/98 to 2008/09



Source: ONS

The actual number of excess deaths is considerable in absolute terms, especially as widespread evidence from the UK and elsewhere in Europe points to significant reductions in mortality and confirms good interagency co-operation to deal with prevention as a multifactorial problem. The number of excess winter deaths in Warwickshire has risen over recent years.

Across the county there are persistent wide fluctuations and a small degree of ranking (with North Warwickshire generally high and Rugby generally low) – a situation which statistically is not strongly significant.

We know with excess winter mortality that around 40% of these deaths are from cardiovascular disease and around 30% from respiratory disease. The greatest increase in deaths during the winter is seen in older people, particularly people over 85 years. In Warwickshire, as across all Britain, cold spells during a mild winter are generally followed:

- two days later by a rise in heart attacks
- five days later there is a rise in the number of strokes
- twelve days later by a rise in respiratory illness

5.4.3 Priorities for Action

Our priority in Warwickshire is to state clearly in a quantitative way to our partner agencies the continuing challenge, and the scale of the impact that can be achieved by early intervention, for example to identify the vulnerable elderly, especially those with long terms conditions e.g. chronic obstructive pulmonary disease (COPD) and coronary heart disease.

For some years now there has been a system in Warwickshire available through the community respiratory nurse service, whereby COPD patients are directly contact by phone from the Met Office when there is an imminent local cold snap. This is highly valued by patients, and may well benefit from more support and expansion to extend its impact.

The District and Borough Councils and the County Council run winter warm campaigns linking to the Department of Health's "keep warm keep well" campaign messages.

5.4.4 Conclusion

Excess winter deaths are a tractable issue where positive results can be achieved, but interagency working is essential. Preventing avoidable winter deaths is not the only, nor indeed the most demanding facet of the problem. Avoiding winter morbidity and escalating health costs by prompt intervention by GPs and community clinicians is an area that also needs renewed attention.

5.5 Isolation/rural issues

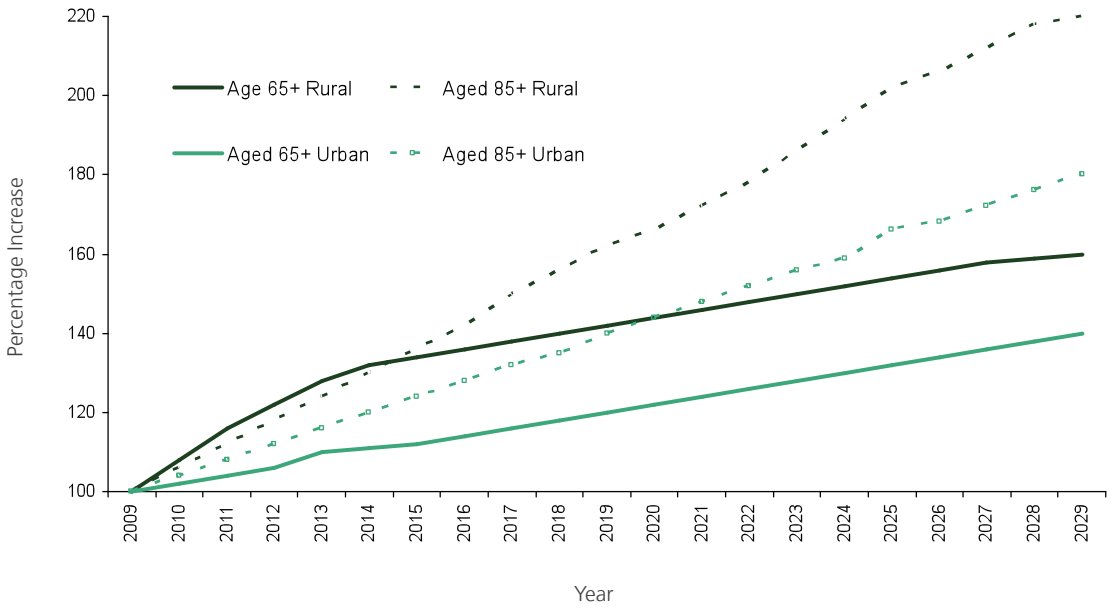
5.5.1 Overview

For a variety of reasons the average age in rural areas is growing faster than in urban areas, in fact they are some 20 years or more ahead of the rest of the country. As people get older there are a number of challenges to people's independence and well-being. People are more likely to become ill or live with a disability, lose a partner or have to reduce their expenditure. When this happens people may rely on others, including health and social services, the voluntary sector and family and friends. Some of these issues may be exacerbated or lessened by living in a rural area but we need to ensure that ageing in rural areas is a positive experience for all.

5.5.2 Setting the Scene

Rural areas have an older age profile than urban areas with the difference in average age between residents in rural and urban areas is nearly 6 years. Around 23% of all people in rural areas are of pension age compared with 18% of people in urban England. In England, around 2.2 million people of pension age live in rural areas, including 820,000 men (38%) and 1.35 million women (62%).

Figure 16: Population projections show that rural areas will age faster than urban areas, Warwickshire



Source: ONS

There are a number of issues of older people living in rural areas. Whilst older people in rural areas are on average more affluent but the proportion of older people in poverty is similar to urban areas. In general older people in rural areas are healthier than those in urban areas but the gap narrows significantly amongst the poorest older people.

- Between 2009 and 2025 older people's health and social care needs will grow more rapidly in rural areas. Depression, stroke, falls and dementia are projected to grow up to between 50% and 60%.
- By 2029 there will be around 930,000 people in England with social care needs living in rural areas. It is estimated that to meet these needs through publicly funded social care will require an additional £2.7m per year.
- A higher proportion of older people in the most rural areas live in poor housing and experience fuel poverty than in other areas.
- Although the number of pensioners in rural areas living alone is high, social support is higher than in urban areas. However, a significant number of pensioners living alone in rural England in 2001 were potentially at risk of social isolation.
- Older people and families with low incomes without access to a private car in rural areas are recognised to have greater difficulty accessing key services than those living in urban areas, this can be influenced by a range of factors, including the location of services, availability of private or public transport, cost of travel, health status and issues concerning safety and security. [2] Current Government proposals on reducing rural bus subsidies and concessionary fares for older people pose a risk for older people without access to a car.

5.5.3 Priorities for action

The Warwickshire Accessibility Strategy outlines a number of ways in which accessibility planning can influence and improve access to health care:

- Improve the availability and awareness of mainstream public transport service to Warwickshire hospitals, through continuous improvement of the public transport network and further provision of Bus Information Points at key locations across the County.
- Improve the availability and awareness of Community Transport and Volunteer Schemes
- Where new health and housing developments are planned, Health and the County Council will work in partnership to ensure that accessibility considerations are taken into account
- A confident traveller programme would help counter the lack of confidence amongst specific groups around the use of public transport
- The County Council will continue to work towards ensuring that each community in Warwickshire has access to at least the minimum level of public transport service. This will help with the PCT's goal of ensuring access to fresh fruit and vegetables.

5.5.4 Conclusions

Older people are a key part of rural communities and contribute significantly to the sustainability of local community life. It is essential that older people have access to appropriate services and support to enable them to stay and remain active within their community.

5.6 Staying Healthy

5.6.1 Overview

"The adoption of a physically active lifestyle can add years to life for previously inactive older people and significantly enhance mobility and independence. Physical activity, even for very frail older people, can help build strength, improve mobility and balance, and reduce the risk of falling. Activities such as walking and cycling, in addition to improving physical health, can increase the sense of well being and promote social interaction, which in turn improve quality of life." Professor Ian Philp

5.6.2 Setting the Scene

A modification of risk factors for disease even late in life can have health benefits for the individual; longer life, increased or maintained levels of functional ability, disease prevention and an improved sense of well-being. Strong evidence exists that older people benefit from increased physical activity and improved diet and nutrition. It is estimated that up to half of the cases of cancers could be prevented by lifestyle changes such as not smoking, cutting back on alcohol and keeping active.

There are a number of financial issues of an ageing population. The evidence shows that small investments in services such as housing and leisure can reduce or delay care costs and improve well being and that early intervention can improve well being and save money. Primary prevention maintains and improves older people's physical, mental and social well being, reducing the demand for care services.

Smoking

Smoking greatly increases the risk of numerous diseases including heart disease, stroke and several types of cancer. Although the earlier in life that smokers quit the better, older smokers still stand to gain extensive healthy benefits by quitting. The evidence shows that if people quit at age 50 they gain 6 years of life. If they quit at 60 they gain 3 years of life. Tobacco is the number one cause of premature death and disease in Warwickshire with over 900 deaths per year (1 in 5 deaths). Smoking related diseases cost the NHS in Warwickshire around £23 million to treat every year. Nationally smoking is lowest amongst the 60 plus age group at about 12% and around 40% of people who set a quit date with Warwickshire Stop Smoking Service in 2008/9 were over 45 years old. Of these 56% were still not smoking at the 4 week follow up.

Physical Activity

Increasing physical activity can enhance mobility, independence, well being, mental health and quality of life. 38% of deaths from heart disease in women are associated with lack of physical activity Nationally only 30% of 65-74 year olds, 18% of 75-84 year olds and 8% of 85 plus years of age undertake the minimal level of 30 minutes of moderate activity only once per week. People can gain benefits from becoming more active even if they previously have been inactive until middle age or beyond. Adult men aged 45-84 who exchanged an inactive adult lifestyle for a more active one over 11-15 years reduced their risk of coronary heart disease.

Diet and Nutrition

Reducing obesity levels is one of the overarching priorities because of its association with heart disease, cancer, mental health, diabetes, stroke, high blood pressure and high cholesterol and osteoporosis. While obesity has many negative effects on health it must also be noted that being underweight can increase the risk of hip fracture in older women. And also, in 2008 32% of people aged 65 and over who were admitted to hospital were found to be malnourished at the time of admission. 47% of deaths from heart disease for women are linked to high cholesterol levels and 6% are caused by being overweight.

A recent local Partnership Place survey carried out on Warwickshire residents gave an indication of the lifestyle characteristics of the older population. Key findings of the survey indicate the following:

- A third of the older population aged 65 and over eats at least five or more portions of fruits and vegetables every day; this was estimated to be nearly 27% at national level.
- Almost a third of the population (27%) take at least 30 minutes of moderate physical activity five times a week. Nearly one in three (29%) older male population, and one in four (23% of the female population undertake similar activity at national level
- The majority of the population are either non-smokers or ex-smokers with around 90% of the population surveyed identified in this category. At national level, an estimated 87% of the older population do not smoke.
- Extrapolation of the national figures shows that by 2010 an estimated 25,500 people or 26% of Warwickshire's over 65 population will be obese. By 2030 the overall number will increase to more than 38,000.

The Health Survey for England shows that overall alcohol consumption decreases with age, with weekly alcohol consumption falling from 20 units per week in men under 65 to 14 units in over 65s. Similarly for women consumption fell from 10 units per week in under 65 year olds to 5 units in those over 65.

The adoption of healthy lifestyle behaviours varies considerably at a district level. Estimates by Mosaic show that the number of households with an older person likely to be obese and smoke is higher in the north than the South of the County. However, the proportion of households with older people likely to be drinking more than 3 times a week is highest in the south, particularly in Stratford District.

5.6.3 Priorities for action

- To encourage and support older people in undertaking more physical activity.
- To encourage and support older people in consuming a healthy diet.
- To encourage and support older people to stop smoking.
- To encourage and support older people to participate in immunisation and screening programmes.

5.6.4 Conclusion

Measures to improve health such as stopping smoking, eating a healthy diet, undertaking physical activity, drinking alcohol in moderation, taking part in screening and immunisation programmes are key for the over 50's age group to achieve the overall benefit of living a longer and healthier life.

GLOSSARY
KEY DOCUMENTS
REFERENCES

GLOSSARY

Admissions	Admission of patient into hospital. Used when calculating number of patient stays.
Admission rate	A measure of the annual rate of hospital admissions. Calculated as the number of persons admitted divided by the target population and expressed as a rate per thousand. e.g. Total Number of Admissions in 2007 x 1,000 Population Estimate for 2007 N.B. Sometimes expressed as rate per 100,000
Acute hospital	Acute hospitals provide a wide range of specialist care and treatment for patients. Typically, services offered in the NHS Acute sector are diverse. They include: consultation with specialist clinicians (consultants, nurses, dieticians, physiotherapists and a wide range of other professionals); emergency treatment following accidents; routine, complex and life saving surgery; specialist diagnostic procedures; and close observation and short-term care of patients with worrying health symptoms.
Algorithms	An organised procedure for performing a given type of calculation or solving a given type of problem. An example is long division.
All age all cause (AAAC) mortality	Mortality (death) rate from any cause at any age.
Attendance Allowance	Provides a non-contributory, non-means-tested and tax-free contribution towards the disability-related extra costs of severely disabled people who are aged 65 and over when they claim help with those costs. It can be awarded for a fixed or an indefinite period.
Chronic condition	A disease that persists for a long period of time longer than 3 months
Co-morbidities	Co morbidities or multiple conditions indicate the existence of two or more disease processes
Community hospital	Description of a community hospital's functions (from the Department of Health) • A modern community hospital service aims to provide an integrated health and social care resource for the local population to which it belongs. These local facilities develop as a result of agreements between local people, service providers and the NHS. • Community hospitals are an effective extension to primary care with medical support provided largely by GPs. • The health and social care provided may include medical care, rehabilitation, palliative care, intermediate care, mental health, maternity, surgical care and emergency care.
Confidence intervals	95% confidence interval. These indicate the level of uncertainty about each value. Longer/wider intervals mean more uncertainty. When the two intervals do not overlap it is reasonable certain that the two groups are truly different.
Complex Clients	Complex clients are defined as those in residential or nursing care or those receiving 20 hours per week of home care or an equivalent direct payment to cover the costs of 20 hours home care.
COPD	COPD (Chronic Obstructive Pulmonary Disease) is a general term that includes the conditions chronic bronchitis and emphysema.
Coterminous	Having matching boundaries.
CQUIN	Commissioning for Quality and Innovation
Crude rates	Unadjusted for age, gender or deprivation.
Day case	A patient admitted electively (i.e. from a waiting list) during the course of a day with the intention of receiving care without requiring the use of a hospital bed overnight. If the patient treatment then results in an unexpected overnight stay they are counted an Elective Inpatient
Demography	The study of populations - their size, structure and distribution and changes over time and place.
Denominator	The total number of people at risk in the population.i.e. for deaths, the whole of the population is at risk of dying in that time period therefore the whole population is used as the denominator, whereas for the stillbirth rate, only those babies being born are at risk of being stillborn, so total births is used as the denominator.
Discrete	Separate and distinct.
Elective admissions	Elective admission, when the decision to admit could be separated in time from the actual admission a planned admission to hospital (i.e. not an emergency) admitted from a waiting list
Emergency Admissions	Emergency admission, when admission is unpredictable and at short notice because of clinical need.
Excess Winter Deaths	The excess winter deaths percentage is: (100 - % (the average number of deaths in the winter (December to March) to the average number of deaths that in the remainder of the year). The year runs from August to July.
Exeter database	The Exeter system is a database of all patients registered with an NHS GP.
Grant Funded	The Council pay voluntary sector organisations grants to provide services to customer who would refer directly to the organisation. It tends to be day services and what we would badge as early intervention/prevention.

Healthcare Resource Groups	Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments that use common levels of healthcare resource.
Fuel Poverty	When in order to heat its home to an adequate standard of warmth a household needs to spend more than 10% of its income on total fuel use
Hypertension	The medical term for high blood pressure.
ICD10	ICD-10 is an abbreviation for the International Statistical Classification of Disease and Related Health Problems (10th revision). It is used in the NHS acute sector to record diseases and health-related problems (the diagnosis or reason for a patient episode of healthcare). The codes are mandatory for use across England.
Incidence	The number of new events, e.g. new cases of a disease in a defined population, within a specified time period.
Index of Multiple Deprivation 2007 (IMD 2007)	Index of Multiple Deprivation 2007, Social Disadvantage Research Centre, University of Oxford, for The Department of Communities and LocalGovernment. The Index of Multiple Deprivation 2007 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation.
Inequalities	Differences in people's health between geographical areas and between different groups of people
In patient	A patient admitted with the expectation that they will remain in hospital for at least one night. If the patient does not stay overnight after all they are still classed as an inpatient
LA	Local Authority / Council District
Long Term Conditions and Limiting Long Term Conditions	Long Term Conditions or chronic diseases arethose which can be controlled but cannot be cured at present They are health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age
Life expectancy at birth	Life expectancy at birth is the mean number of years that a newborn child can expect to live if subjected throughout his life to the current mortality conditions
LSOA	Lower Layer Super Output Areas (LSOA) Minimum population 1000; mean 1500. Built from groups of OAs (typically 4 to 6) and constrained by the boundaries of the Standard Table (ST) wards used for 2001 Census outputs.
Matrix	A data array of two or more dimensions
Morbidity	Refers to the occurrence of diseases in a population
Mortality	Death; the mortality rate is the rate of death in a given population
Mosaic	Mosaic is a household-based consumer classification system used by organisations to analyse the socio-economic composition of UK consumers at household address or postcode, in order to analyse potential and existing markets for their products and services.
National Service Frameworks	National service frameworks (NSFs) are long term strategies for improving specific areas of care. They set national standards, identify key interventions and put in place agreed timescales for implementation
NCHOD	National Centre for Health Outcomes Development. The Clinical and Health Outcomes Knowledge Base is a one-stop source of all information on health outcomes generated by NCHOD. It includes comparative data for 700 health and local government organisations in England plus advice on how to measure health and the impact of healthcare.
NICE Guidelines	The NICE Guidelines provide guidance, set quality standards and manage a national database to improve people's health and prevent and treat ill health
Non Elective	A patient not admitted from a waiting list i.e. either admitted as an Emergency (e.g. A&E), Maternity or "Other" (e.g. transfers other than in an emergency).
ONS	Office for National Statistics
Palliative care	Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments
Payment by Results (PbR)	The funding system for care provided to NHS patients in England
Pension Credit	Income support given to UK residents aged 60 and over so as ensure this group are able to live on an income of not less than a guaranteed amount of £109.45 a week, (£167.05 a week for pensioner couples).
Per capita	Per person
PHBF	Public Health Birth File
PHMF	Public Health Mortality File

GLOSSARY

Prevalence	Prevalence is how common a particular characteristic (for example a disease) is in a specific group of people or a specific population.
Primary Care Organisation	Primary Care Organisations (PCOs) e.g. Warwickshire PCT, are responsible for the management of independent primary care contractors and are central organisations in the NHS
Primary diagnosis	Primary diagnosis is the main condition treated or investigated during the relevant episode of healthcare.
POPPI	Projecting older people population information system
PANSI	Projecting Adult Need and Service information system
QOF	The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004.
Outpatient	An attendance at which a patient is seen and the patient does not use a hospital bed for recovery purposes. (If a bed or trolley is used for a specific short procedure rather than because of the patient's condition this does not count as a bed.
Quintile	A fifth portion or band of a set of data. A quintile is a proportion of a set of data that has been ranked and divided into five equal groups (or bands), where each group contains an equal number of data items.
Resident population	The population living within a specified geographical boundary.
Responsible population	People who are registered with the Primary Care Trust's General Practices. Also known as capitation.
SHA	Strategic Health Authority
Spearhead area	Fifth of areas with the worst health and deprivation compared to England as a whole.
Standardisation	Age standardisation facilitates comparisons across geographical areas by controlling allows comparisons to be made between local and neighbouring LAs.
Standardised	Indirect standardisation follows the same principle as direct standardisation with one very important difference. In indirect standardisation a standard population, e.g. England, is used to provide the age specific rates and these are applied to the local population. Indirectly standardised rates can only be compared with the original population used to define the rates i.e. NHS Warwickshire can be compared to England but not compared with other Primary Care Trusts.
Mortality Ratio (SMR)	The ratio of the number of deaths observed in a study population to the number that would be expected if the study population had the same specific rates as the standard population, multiplied by 100. England is usually taken as the standard population and its SMR is always 100. Areas with a value above 100 have a greater than expected number of deaths and those with a value below 100 have a lower than expected number of deaths. Derived using indirect standardisation.
Statistical significance	Statistical significance means that the results are not likely to have occurred by chance alone. In such cases, we can be more confident that we are observing a 'true' result.
Synthetic estimate	The synthetic estimates are not estimated counts of the number of people or prevalence of a behaviour, e.g. smoking in a ward. They are estimates based on a model and represent the expected prevalence of a behaviour for any area, given the demographic and social characteristics of that area.

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This report is also available on the websites: **www.warwickshire.nhs.uk**, **www.warwickshire.gov.uk** and **www.warwickshireobservatory.org**

Agenda No

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview And Scrutiny Committee**
Date of Committee	**16 September 2010**
Report Title	**Children and Adolescent Mental Health Services (CAMHS) Joint Scrutiny Review**
Summary	This report presents the report and recommendations from the Joint Scrutiny Review of the CAMHS.
For further information please contact:	Michelle McHugh Overview and Scrutiny Manager Tel: 01926 412144 michellemchugh@warwickshire.gov.uk Richard Maybey Assistant to Political Group (Labour) Tel: 01926 476876 richardmaybey@warwickshire.gov.uk
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☒	N/A
Other Elected Members	☒	Cllr Caborn, Cllr Rolfe, Cllr Tooth, Cllr Tandy
Cabinet Member	☒	Cllr Stevens, Cllr Timms
Chief Executive	☐	.....
Legal	☒	Victoria Gould
Finance	☐	.....
Other Strategic Directors	☒	David Carter, Strategic Director for Customers, Workforce and Governance, Marion Davis, Strategic Director for Children, Young People and Families
District Councils	☐	.....

Health Authority	☐	.....
Police	☐	.....
Other Bodies/Individuals	☐	.....

FINAL DECISION NO

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☒	Report and recommendations to be forwarded to Cabinet for consideration
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Further Consultation	☐	.....

Agenda No

Adult Social Care and Health Overview and Scrutiny Committee - 16 September 2010

Scrutiny Review of the Children and Adolescent Mental Health Services (CAMHS)

Report of the Chair of Joint Review Group of the former Children, Young People & Families and Health Overview and Scrutiny Committees

Recommendation

The Committee is recommended to agree the report and recommendations of the Joint Scrutiny Review of the Children and Adolescent Mental Health Services and to forward the report and recommendations on to Cabinet for consideration.

1. Introduction

1.1 Following a series of reports into the provision of Specialist CAMHS (dating back to December 2007), a joint scrutiny review was commissioned by the Children, Young People & Families and Health Overview and Scrutiny Committees. Primarily, this was to consider:

- Lengthy waiting times for assessment and treatment across the county
- Inconsistent access to services and delivery of services across the county.

1.2 The final report of the Review Group is attached as Appendix A.

2. Recommendations

2.1 Recommendation A – Choice and Partnership Approach

That the CAMHS Scrutiny Panel **endorses the implementation of the Choice and Partnership Approach (CAPA)** as CWPT's model for redesigning Specialist CAMHS in Coventry and Warwickshire and requires updates to be provided to the Adult Social Care and Health O&S Committee when appropriate.

2.2 Recommendation B - Improving the link between Specialist CAMHS and schools

That CWPT ensures communications between Specialist CAMHS and Warwickshire schools be improved by the following :

- Providing an **information pack to all schools by the start of the new school term in January 2011**, that gives clear guidance on the latest procedures, referral processes and other relevant information (such as the right of benefit claimants to claim travel expenses).
- Implementing the necessary arrangements for **parents/guardians to give permission for case information to be shared with schools** (appointment dates, progress of treatment etc). This would allow schools to assist families in attending appointments, and implement strategies (as advised by Specialist CAMHS) to support students during their treatment.
- Acknowledging **receipt of referrals made by schools within 5 working days**, and providing an outline of expected waiting times for an appointment.
- Developing greater communication between Specialist CAMHS and schools regarding appropriate strategies that schools can adopt to support students. Specialist CAMHS should check with schools on the appropriateness of any strategy before informing parents that these will be undertaken.
- Introducing greater flexibility for where and when Specialist CAMHS appointments should be held. **CAMHS staff to agree a preferred time and location with parents and service users**, which could be school, community or home settings. This would avoid service users and parents having to travel long distances to appointments, and therefore increase the likelihood of attendance.
- Establishing a **single named point of contact** within both Specialist CAMHS and schools to ensure all parties know who to contact and how.

2.3 Recommendation C - Communication between Specialist CAMHS and parents/guardians

That CWPT ensures Specialist CAMHS:
- Provides parents/guardians with clear estimations of waiting times.
- Provides parents/guardians with regular updates on progress of the referral.
- Reviews how parents/guardians are informed and reminded of appointments, and introduces the use of SMS and email alerts.
- Pays due attention to individual family circumstances, such as two-household families and non-parental childcare (grandparents, carers etc).

2.4 Recommendation D - Referral through CAF

That CWPT and WCC encourage the use of CAF as a referral mechanism, and make arrangements for increased promotion, training and support of CAF within schools.

2.5 Recommendation E – Early Intervention

That CWPT and the CAMHS Joint Commissioner place greater emphasis on early intervention. In particular, consideration should be given to:

- Appointing more Primary Mental Health Workers to provide training and advice on emotional health and well-being within schools.
- Extending the Targeted Mental Health in Schools (TAMHS) pilot project across the county.
- Greater promotion of early intervention services, such as the counselling and therapeutic services offered by Relate, so schools and GPs are aware of the different support available and how these can be accessed.
- Extending the promotion of Kooth.com both to children within schools and to teenage parents via marketing in Children's Centres.

2.6 Recommendation F – Collaboration with Partners

That communication and collaboration with partners be improved through:

- Better information-sharing between Specialist CAMHS and EPS on issues such as assessment and intervention outcomes.
- Possible co-location of CAMHS and EPS workers.
- The inclusion of Tier 1 and Tier 2 practitioners on strategic and operational boards.
- The full involvement of Tier 1 and Tier 2 service providers in the CAPA service redesign.
- The greater use of CAF as a mechanism to share information between relevant partners.

2.7 Recommendation G – Using modern, technology-based services

That the service redesign of CAMHS incorporates creative, flexible, technology-based solutions, such as the Kooth.com online counselling service.

2.8 Recommendation H – Understanding User Views

That CWPT undertakes a survey of current CAMHS users to understand their views on the current services, and uses this information to inform the service redesign.

2.9 Recommendation I - Communication between Commissioners and CWPT

That CWPT provides the CAMHS Commissioner with more timely and accurate performance and financial information.

CLLR ASHFORD
Chair of Joint Review of
CAMHS
Shire Hall
Warwick

17 August 2010

Warwickshire County Council

Children and Adolescent Mental Health Services (CAMHS) Joint Scrutiny Review

Foreword by Councillor Martyn Ashford, Chair of CAMHS Scrutiny Panel

The emotional health and well-being of children and young people across Warwickshire is a very important issue. In today's fast-paced, ever-changing society, young people are faced with increasingly complex lives and a diverse set of challenges. And for many, this can lead to emotional problems and mental ill health.

To provide young people with the best chance in life, they require appropriate support to overcome these issues, delivered by appropriate professionals, in an efficient and timely manner.

While recognising the many positive outcomes delivered by Warwickshire's Specialist Child and Adolescent Mental Health Services (CAMHS), the provision of these services in recent years has been hampered by long waiting times for assessment and treatment, as well as inconsistent access to services across the county.

Through this review, County Councillors now have a greater understanding of the problems that exist within CAMHS and the work that needs to be done to address them.

I am confident that our recommendations will go some way to bringing waiting times down and improving access to services for everyone within Warwickshire who requires them.

Finally, I would like to thank all those people who have contributed to and supported this review. Without their assistance it would not have been possible.

1. Introduction and background

Warwickshire's Specialist Child and Adolescent Mental Health Services (CAMHS) is run by Coventry and Warwickshire Partnership Trust (CWPT). It provides a range of services for up to 17 year olds with emotional/behavioural difficulties or mental health problems, disorders and illnesses.

Specialist CAMHS refers to tiers 3 and 4 of the broader Comprehensive CAMHS offering, which incorporates:

- Tier 1 – universal services to enhance emotional health for all children
- Tier 2 – targeted services for vulnerable/in-need children
- Tier 3 – specialist services for children with moderate to severe mental health difficulties
- Tier 4 – highly specialist services for children with severe mental health difficulties and high complex cases

Specialist CAMHS are provided by staff with a large mix of skills, including psychologists, psychiatrists, nurses, primary mental health workers, a psychotherapist and an art therapist.

They are commissioned through a Joint Commissioning Manager for Warwickshire County Council (WCC) and NHS Warwickshire, and delivered via four child-centred multi-disciplinary teams based in Coventry, Rugby, Leamington and Stratford. Referral is through professionals such as GPs, educational psychologists, school nurses, head teachers and Relate counsellors.

Following a series of reports into the provision of Specialist CAMHS (dating back to December 2007), a joint scrutiny review was commissioned by the Children, Young People & Families and Health Overview and Scrutiny Committees. Primarily, this was to consider:

- Lengthy waiting times for assessment and treatment across the county
- Inconsistent access to services and delivery of services across the county

2. Objectives of the review

The objectives of the review were set out as follows:

- To reduce waiting times for assessment and treatment
- To achieve clarity and a better understanding of the services being provided
- To address inconsistent access to services
- To improve public awareness of mental health issues, particularly within schools (i.e., so teachers can prompt early intervention)

- To understand the right language and terminology used around mental health issues, in order to reduce stigma
- To achieve better outcomes for young people, their families and schools (via clearer access, accurate referral, shorter waiting times)

3. The CAMHS Scrutiny Panel

3.1 The CAMHS Scrutiny Panel comprised of Councillors from the Children, Young People and Families OSC and Health OSC:

Cllr Martyn Ashford (Chair of Panel)

Cllr Sarah Boad

Cllr Clare Hopkinson

Cllr Frank McCarney

Cllr Carolyn Robbins

Cllr Jerry Roodhouse

Cllr Sid Tooth

Cllr Claire Watson

3.2 The review process

The Panel met for the first time on 27 April 2010 and agreed the scope of the review. From this meeting, the terms of reference were agreed (see Appendix A). Early on in the process, it was acknowledged that the support and knowledge of professionals working in the field of mental health would be required and that the most appropriate method of gathering evidence would be through a full-day select committee.

Recognising that it was important to obtain an insight into the views and experiences of those that engage with CAMHS, the Panel invited evidence submissions from parents, young people, schools, Council officers and other professionals. This resulted in 27 evidence submissions being submitted from a variety of individuals.

The Panel considered the following evidence in its review.

Local Information

- A mix of different views from schools, professionals and parents (via the submissions mentioned above), illustrating different experiences with CAMHS
- A mapping of services across the county (i.e., what's offered and where; from early intervention up to specialist services)
- A breakdown of waiting times for assessment and treatment, by area
- Data on the volume of cases and referrals, by area
- Data on the number of qualified staff, by area
- Health O&S committee reports, December 2007, February 2008, October 2009
- Joint Area Assessment (JAR) and Comprehensive Performance Assessment (CPA) findings, July 2009
- CAMHS Commissioning Strategy

National Information

- National Advisory Council report (assessing the progress of the National CAMHS Review one year on)
- NI50: Emotional Health of Children 2009-10 (DCSF guidance)
- Improving access to child and adolescent mental health services (DCSF and DoH)
- Final report on National CAMHS Review
- The Government's full response to the independent review of CAMHS (DCSF and DoH)

Councillors undertook visits to Specialist CAMHS centres in Leamington Spa and Nuneaton to gain an insight into how the service functions. They also visited their local schools to understand the school perspective relating to CAMHS.

Having collated and assessed the above evidence, the Panel held a select committee meeting, inviting a number of speakers to present their views and experiences. These included:

- David Hazeldine, North Leamington School
- Lynda Pearce, Manor Park School
- Phyllis King, Long Itchington Primary School
- Karen Price, Kingsbury School
- Nigel Barton, Executive Director of Operations, Coventry and Warwickshire NHS Partnership Trust (CWPT)
- Loraine Roberts, General Manager, CAMHS, CWPT
- Jo Dillon, Associate Director of Strategic Joint Commissioning – Children and Maternity, WCC
- Kate Harker, Joint Commissioning Manager - CAMHS, WCC
- Tare Midgen, Acting Manager, Educational Psychology Service, WCC
- Adrian Over, CAF Manager, WCC

- Dr. Jeff Cotterill, GP
- Sarah Curtis, Centre Manager, Relate Rugby and North East Warwickshire
- Elaine Bousfield, Managing Director, Xenzone
- Ann Marie Walker, Solihull Care Trust

4. Key issues and recommendations for improvement

This section summarises the key issues identified by the review and the Panel's recommendations for improvement.

4.1 Choice and Partnership Approach (CAPA)

During the select committee, the Panel heard how CWPT intends to redesign its Specialist CAMHS offering using a model called CAPA. The Panel also heard evidence from Solihull Care Trust regarding their experiences of implementing CAPA.

CAPA is a system flow management tool for CAMHS that reduces long waiting lists and provides a quicker, more responsive service to users. It is informed by demand and capacity theory, Lean Thinking, New Ways of Working, Our Choices in Mental Health and You're Welcome standards. It has been successfully implemented by many CAMHS teams in the UK, Australia and New Zealand.

CAPA provides service users with greater choice when booking appointments. Subject to clinician availability, they are given a choice of when they'd like to attend. They are also designated a clinician who best meets their needs. Under CAPA, clinicians move from being an 'expert with power' to a 'facilitator with expertise'.

- **Choice**

Once a referral is accepted (the threshold for which should be set low to cater for referrals that lack information), the user and their family can book a "Choice" appointment at a time (and ideally a place) to suit them. This appointment should focus on:

- Assessment of the situation
- Risk management
- Motivational enhancement
- Psycho-education
- Goal setting
- Things to try at home or pre-partnership work

At the end of a Choice appointment, users can choose:

- That they do not need further help
- To be put in contact with a more suitable agency to help them
- To return to CAMHS

If the latter, they can choose a "Core Partnership" appointment with one or more clinicians with the right skills to help.

- **Partnership**

Core Partnership is where the bulk of intervention work occurs. It can be done by most clinicians who have extended clinical skills (i.e., they can deliver a range of common CAMHS assessments and interventions).

It involves integrative, multimodal work to help users meet agreed goals. The Core Partnership worker remains the Key Worker during the pathway. Assessment and reformulation continue throughout contact with the family, in the normal way. It involves as many or as few sessions as are needed, and must be regularly reviewed against clear goals, through the use of care planning. Contact with the family ends when a review concludes that goals have been met.

Implementation challenges

One of the identified reasons for long waiting times in Warwickshire, as stated in previous reports to Health OSC, was inappropriate referrals – i.e., too many cases being referred to Specialist CAMHS, when Tier 1 or Tier 2 (early intervention) support would have been sufficient. The Panel acknowledge that the move to CAPA will address this.

However, before the new model can be adopted, CWPT will need to undertake a "blitz" on the current waiting list. This will involve an intense period of assessments over a short period of time to reduce the waiting list. A further challenge will be to align the different processes that currently exist in different parts of the county into one single process.

Recommendation A

That the CAMHS Scrutiny Panel **endorses the implementation of the Choice and Partnership Approach (CAPA)** as CWPT's model for redesigning Specialist CAMHS in Coventry and Warwickshire and requires updates to be provided to the Adult Social Care and Health O&S Committee when appropriate.

4.2 Improving the link between Specialist CAMHS and schools

Following analysis of the written submissions received from schools, as well as the verbal submissions heard at the select committee, the Panel recognises that there is scope to improve the link between Specialist CAMHS and schools. The submissions highlight a number of common challenges that schools have been facing, such as: difficulty in making contact with CAMHS staff (unanswered phone calls, no response to letters and the absence of e-mail addresses); a lack of clarity about the procedures for referral; a lack of consultation with schools regarding appropriate strategies (prior to, during and after treatment); and governance barriers that prevent schools from supporting children and parents during the process.

Recommendation B

That CWPT ensures communications between Specialist CAMHS and Warwickshire schools be improved by the following :

- Providing an **information pack to all schools by the start of the new school term in January 2011**, that gives clear guidance on the latest procedures, referral processes and other relevant information (such as the right of benefit claimants to claim travel expenses).
- Implementing the necessary arrangements for **parents/guardians to give permission for case information to be shared with schools** (appointment dates, progress of treatment etc). This would allow schools to assist families in attending appointments, and implement strategies (as advised by Specialist CAMHS) to support students during their treatment.
- Acknowledging **receipt of referrals made by schools within 5 working days**, and providing an outline of expected waiting times for an appointment.
- Developing greater communication between Specialist CAMHS and schools regarding appropriate strategies that schools can adopt to support students. Specialist CAMHS should check with schools on the appropriateness of any strategy before informing parents that these will be undertaken.
- Introducing greater flexibility for where and when Specialist CAMHS appointments should be held. **CAMHS staff to agree a preferred time and location with parents and service users**, which could be school, community or home settings. This would avoid service users and parents having to travel long distances to appointments, and therefore increase the likelihood of attendance.
- Establishing a **single named point of contact** within both Specialist CAMHS and schools to ensure all parties know who to contact and how.

4.3 Communication between Specialist CAMHS and parents/guardians

The evidence submissions indicated communication weaknesses between Specialist CAMHS and the parents/guardians of service users. Many experience long waiting times without indication of when an appointment will be offered. Appointments are sometimes cancelled at short notice, without reason. And appointment letters can be sent to the wrong address resulting in a missed appointment (as many children have parents that are separated, or they are looked after by grandparents/carers).

Recommendation C

That CWPT ensures Specialist CAMHS:

- Provides parents/guardians with clear estimations of waiting times.
- Provides parents/guardians with regular updates on progress of the referral.
- Reviews how parents/guardians are informed and reminded of appointments, and introduces the use of SMS and email alerts.
- Pays due attention to individual family circumstances, such as two-

household families and non-parental childcare (grandparents, carers etc).

4.4 Referral through CAF

Common assessment framework (CAF) is a mechanism to improve outcomes for children and young people who do not necessarily meet traditional thresholds for statutory or specialist services. It provides an opportunity for this demographic to benefit from a holistic assessment of their needs and gain referral to an appropriate level of service. Where mental health difficulties are identified and certain criteria are met, a referral can be made to Specialist CAMHS or a tier 1/2 service. At the select committee, the Panel were made aware that not all schools within Warwickshire had staff trained as CAF practitioners.

Recommendation D

That CWPT and WCC encourage the use of CAF as a referral mechanism, and make arrangements for increased promotion, training and support of CAF within schools.

4.5 Early intervention

There was broad consensus at the select committee that early intervention services are essential in supporting the emotional health and well-being of children and young people. If accessed early enough, these services can address the majority of mental health issues before they escalate into deeper problems that require the support of Specialist CAMHS. However, based on evidence heard at the select committee, the Panel is unclear whether early intervention is currently being used to maximum benefit. Indeed, it appears that professionals are not always aware of the early intervention services that are available and how these can be accessed.

Recommendation E

That CWPT and the CAMHS Joint Commissioner place greater emphasis on early intervention. In particular, consideration should be given to:

- Appointing more Primary Mental Health Workers to provide training and advice on emotional health and well-being within schools.
- Extending the Targeted Mental Health in Schools (TAMHS) pilot project across the county.
- Greater promotion of early intervention services, such as the counselling and therapeutic services offered by Relate, so schools and GPs are aware of the different support available and how these can be accessed.
- Extending the promotion of Kooth.com both to children within schools and to teenage parents via marketing in Children's Centres.

4.6 Collaboration with partners

The Panel observed that there are many different agencies involved in the delivery of Comprehensive CAMHS across Warwickshire, and there is also an overlap with other services, such as Warwickshire County Council's Educational Psychology Service (EPS). From the evidence heard at the select committee (via presentations and Q&A sessions), the Panel noted that there is scope for closer working between these agencies and neighbouring services.

Recommendation F

That communication and collaboration with partners be improved through:

- Better information-sharing between Specialist CAMHS and EPS on issues such as assessment and intervention outcomes.
- Possible co-location of CAMHS and EPS workers.
- The inclusion of Tier 1 and Tier 2 practitioners on strategic and operational boards.
- The full involvement of Tier 1 and Tier 2 service providers in the CAPA service redesign.
- The greater use of CAF as a mechanism to share information between relevant partners.

4.7 Using modern, technology-based services

During the select committee, the Panel recognised the importance and effectiveness of early intervention services in addressing emotional health and well-being issues. However, it also recognised that there is still a stigma attached to mental health among young people that can act as a barrier for them to seeking help. To address this, the Panel would like to see a broader availability of services, delivered at times most appropriate to young people, in an anonymous and safe environment with no risk of stigmatisation.

Recommendation G

That the service redesign of CAMHS incorporates creative, flexible, technology-based solutions, such as the Kooth.com online counselling service.

4.8 Understanding user views

The Panel welcomed the varied contributors to this review, but also recognised the limited evidence provided by service users themselves. The Panel agreed that it is fundamentally important for the views of service users to be considered as part of the service redesign of CAMHS.

Recommendation H

That CWPT undertakes a survey of current CAMHS users to understand their views on the current services, and uses this information to inform the service redesign.

4.9 Communication between Commissioners and CWPT

The Panel observed that the CAMHS Commissioner lacked the information required to make fully informed commissioning decisions. WCC and NHS Warwickshire require a better understanding from CWPT of how funding for Specialist CAMHS is currently spent, how it is distributed across different interventions and the associated outcomes of interventions. This would allow a value-for-money assessment to be made. The Panel is of the view that Commissioners should move away from a 'block grant' approach towards more intelligent commissioning, based on outcomes and value for money.

Recommendation I

That CWPT provides the CAMHS Commissioner with more timely and accurate performance and financial information.

Scrutiny Review Outline

Review Topic (Name of review)	Provision of Children and Adolescent Mental Health Services (CAMHs) within Warwickshire
Panel/Working Group etc – Yes/No? **Members**	• Cllr Watson (C) • Cllr Ashford (C) • Cllr Hopkinson (C) • Cllr Robbins (C) • Cllr Tooth (L) • Cllr McCarney (L) • Cllr Boad (LD) • Cllr Roodhouse (LD) Due to the absence of two members from the scoping meeting on 27 April 2010, the election of a Chair was postponed until the next meeting on 9 June 2010.
Key Officer Contact	Kate Harker, Joint Commissioning Manager (CAMHs) kateharker@warwickshire.gov.uk Ext: 58 2339 Tel: (01926) 742339
Scrutiny Officer Support	Michelle McHugh, Overview & Scrutiny Manager michellemchugh@warwickshire.gov.uk Ext: 2144 Tel: (01926) 412144 Richard Maybey, Overview & Scrutiny support richardmaybey@warwickshire.gov.uk Ext: 6876 Tel: (01926) 416876
Relevant Portfolio Holder(s)	Cllr Heather Timms, Portfolio Holder for Children, Young People and Families Cllr Bob Stevens, Portfolio Holder for Performance and Health
Relevant Corporate/LAA Priorities/Targets	Relevant LAA priorities (long-term): • We all live healthy, active and independent lives • We all have the opportunity to enjoy and achieve Relevant County Council priorities (medium term): • Raising educational attainment and improving the lives of children, young people and families Relevant LAA indicators (short term): • NI 50, Emotion health of children

Rationale
(Key issues and/or reason for doing the review)
	• Lengthy waiting times for assessment and treatment across the county
	• Access to services and delivery of services has been inconsistent across the county
	• Members require a better understanding of:
	  o The system of services
	  o The timescales involved in referral, assessment and treatment
	  o The transition from children's to adult services

Objectives of Review (Specify exactly what the review should achieve)	• To reduce waiting times for assessment and treatment • To achieve clarity and a better understanding of the services being provided • To improve public awareness of mental health issues, particularly within schools (i.e., so teachers can prompt early intervention) • To understand the right language and terminology used around mental health issues, in order to reduce stigma • To achieve better outcomes for young people, their families and schools (via clearer access, accurate referral, shorter waiting times) • To improve the flow of service information back to Members
Scope of the Topic (What is specifically to be included/excluded)	<u>Include</u> • Length of waiting times • Provision of services across the county • Provision of services across the age range (0 to 18 years) • Performance data, and the mechanisms in place to collect it • How the Coventry and Warwickshire Partnership Trust delivers services across Warwickshire • Referral criteria for clinical psychology (CAMHs) vs. educational psychology (non-CAMHs) • Funding of services • Transition arrangements between children's and adult services <u>Exclude</u> • Quality of care • School exclusions
Indicators of Success – Outputs (What factors would tell you what a good review should look like?)	Formulate recommendations to: • Reduce waiting times for treatment • Improve access to services across the county • Improve consistency of services across the county
Indicators of Success – Outcomes (What are the potential outcomes of the review e.g. service improvements, policy change, etc?)	• Improved user satisfaction regarding access to services • Better emotional health for young people in the county (NI 50)

Specify Evidence Sources (Background information and documents to look at)	**<u>To be provided</u>** • Case studies, showing different routes into CAMHs and a mix of different views from service users (via online submissions) • A mapping of services across the county (i.e., what's offered and where; from early intervention up to specialist services) • A detailed breakdown of waiting times for assessment and treatment, by area • Data on the volume of cases and referrals, by area • Data on the number of qualified staff, by area • National Advisory Council report (assessing the progress of the National CAMHs Review one year on) • Summary of key reports **<u>Already provided</u>** Information Pack • Health O&S committee reports, December 2007 / February 2008 / October 2009 • JAR and CPA findings, July 2009 • CWPT reports, October 2009 / November 2009 • CAMHs Commissioning Strategy • NI50: Emotional Health of Children 2009-10 (DCSF guidance) • Improving access to child and adolescent mental health services (DCSF and DoH) • Final report on National CAMHs Review • The Government's full response to the independent review of CAMHs (DCSF and DoH) • Q3 data set (latest data available – may need explanation from relevant CAMHs representative)
Specify Witnesses/Experts (Who to see and when)	**<u>Prior to the Select Committee hearing</u>** • School head-teachers (Members to visit or request written submissions from local head(s). Officers to request further evidence from head-teachers board to gain a broader perspective) • Children's Centre managers (Members to visit or request written submissions a local Centre, if this isn't possible) • CAMHs Centre managers (Members to visit their nearest Centre, to be arranged by officers) **<u>At the Select Committee</u>** • Loraine Roberts, General Manager (CAMHS), Coventry and Warwickshire NHS Partnership Trust • Nigel Barton, Director of Operations, Coventry and Warwickshire NHS Partnership Trust • Jane Brooks, Service Co-ordinator (CAMHs) • Jo Dillon, Associate Director of Strategic Joint Commissioning - Children and Maternity • Kate Harker, Joint Commissioning Manager (CAMHs) • School mental health workers (to be identified) • Sarah Curtis, Relate (representing the voluntary groups) • Jeffrey Cotterill, GP **<u>After the review</u>** • Portfolio Holders – Heather Timms (CYPF) and Bob Stevens (Health)

Possible Co-Options (Would the review benefit from any co-options e.g. community or voluntary sector representatives?)	None		
Specify Site Visits (Where and when)	**Schools / Children's Centres**: Members to gather evidence/feedback individually from head teachers and Children's Centre managers in their local area. This can be via on-site visits, telephone discussions or by requesting written submissions **CAMHs Centres**: Members to visit in small groups in order to gather evidence/feedback. These visits will be arranged by officers		
Consultation with Stakeholders (Who should we consult?)	None		
Level of Publicity (What level is appropriate and what method should be used?)	Members of the public to be invited to submit their feedback/stories/opinions of CAMHs via email. This could be promoted via newspaper articles, websites and leaflets left in clinics.		
Barriers/Dangers/Risks (Identify any weaknesses or potential pitfalls)	• Insufficient finance and staffing • The review is too broad and loses focus • The review has no influence; nothing improves as a result • Partnership working causes delays/barriers to improvement • The data provided is of insufficient quality/volume • There is a lack of continuity from CAMHS through to adult services		
Projected Start Date	April 2010	**Draft Report Deadline**	
Meeting Frequency		**Projected Completion Date**	
Meetings Dates	• Progress meeting – 9 June 2010, 9am • Select Committee – 30 June 2010 (to be confirmed)		
Committee Reporting Date			
Cabinet Reporting Date			
When to Evaluate Impact	6-12 months		
Methods for Tracking and Evaluating	• Questioning the relevant Cabinet Members on progress • Assessing progress against the recommendations by looking at waiting time data, staffing arrangements, user satisfaction feedback		

Agenda No

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview and Scrutiny Committee**
Date of Committee	**16th September 2010**
Report Title	**Review of Support for Carers**
Summary	In September 2009 the Overview and Scrutiny Board commissioned a review of support for carers in Warwickshire. A panel was formed comprising members from the (then) Adult and Community Services Overview and Scrutiny Committee. Appended to this brief covering report is the panel's main report which contains its findings, conclusions and recommendations.
For further information please contact:	Paul Williams Overview and Scrutiny Officer Tel: 01926 418196 paulwilliamscl@warwickshire.gov.uk
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☒	N/A
Other Elected Members	☐	.....
Cabinet Member	☒	Councillor Izzi Seccombe
Chief Executive	☐	.....
Legal	☒	Alison Hallworth
Finance	☐	.....
Other Strategic Directors	☒	John Bolton, Interim Strategic Director, Adult

		Health and Community Services, David Carter, Strategic Director, Customers Workforce and Governance, David Clarke, Strategic Director, Resources
District Councils	☐	.....
Health Authority	☒	Rachel Pearce, Director of Compliance/Assistant Chief Executive, NHS Warwickshire
Police	☐	.....
Other Bodies/Individuals	☐	.....

FINAL DECISION NO

SUGGESTED NEXT STEPS:		Details to be specified
Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☒	Date to be agreed.....
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Further Consultation	☐	.....

Agenda No

Adult Social Care and Health Overview and Scrutiny Committee - 16th September 2010.

Review of Support for Carers

Report of the Chair of the Member Panel

Recommendation

That the committee agrees the recommendations of the panel and passes them to Cabinet for consideration

1.0 Introduction

1.1 Over the last few months a small panel of councillors has been working with officers and partners to undertake a scrutiny review of support for carers. The review, commissioned by the Overview and Scrutiny Board, was prompted by a growing awareness of the important role that carers play in our society. Fifty three thousand Warwickshire residents act as carers. This equates to just over ten percent of the population, looking after friends or family for no reward but with financial and practical support provided by a range of statutory and voluntary agencies. It is important that we ensure that as much support is provided to these people.

1.2 Appended to this covering document is the panel's report containing its findings, conclusions and recommendations. To assist the committee the recommendations are set out in section 2 below.

1.3 The committee is asked to agree these recommendations and pass the report on the Review of Support for Carers to Cabinet.

2.0 The Panel's Recommendations

2.1 General/Finance

1. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to report annually to the Adult Social Care and Health Overview and Scrutiny Committee on their allocation of resources to support breaks for carers. This report should demonstrate positive outcomes for carers.

2.2 Health

2. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to report to the Adult Social Care and Health Overview and Scrutiny Committee on the relationship between admissions and readmissions to hospital and the support available for carers receiving discharged patients.

3. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to actively encourage GPs to undertake annual health checks of carers aged 60 years and over. Where people are identified as having a caring responsibility GPs should be encouraged to disseminate information on support.

4. That NHS Warwickshire be requested to consider ways in which the Quality Outcomes Framework can be used to ensure that GPs undertake annual health checks for carers aged 60 plus.

5. That the Strategic Director for Adult Social Care and Health be asked to write to the Chief Executive of NHS Warwickshire seeking a commitment that his organisation will actively engage in the Carers Partnership and the Warwickshire Accessible Housing Partnership.

6. That the Chair of the Warwickshire Carers' Partnership be asked to write to the Chairs of the GP Consortia inviting them to be represented on the partnership.

7. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire jointly explore ways in which access to services by carers can be made easier.

8. That the Strategic Director of Customers Workforce and Governance considers ways in which information sharing between the statutory and voluntary sectors can be enhanced.

2.3 Housing

9. That Cabinet be asked to consider making a capital allocation of £1.5 million to clear the backlog of adaptation work required to ensure that carers obtain the help they need at an early stage to prevent more expense at a later stage. A condition of this allocation is that all district and borough councils agree to make their entire Disabled Facilities Grant available for the purpose for which it is intended.

10. That the Portfolio Holder for Adult Social Care writes to the five district/borough councils of Warwickshire encouraging them to

- seek ways of accelerating the adaptation process
- take account of adaptation needs when refurbishing their residential properties.

- Under the Lifetime Neighbourhoods Strategy encourage developers to build houses that can be easily adapted to the needs of the cared for and carers.

2.4 Warwickshire County Council

11. Recognising that many employees of Warwickshire County Council have caring responsibilities the Strategic Director for Customers, Workforce and Governance be requested to give consideration to the establishment of a carers' staff network along the lines of the three that already exist.

12. That officers from the Adult, Health and Community Services Directorate be requested to brief all directorate managers' conferences on caring and carers. This initiative should be linked in to Carers' Week.

13. That the Strategic Director for Adult Social Care and Health investigates opportunities for information on support for carers to be supplied to those undertaking fire safety checks or delivering meals on wheels.

COUNCILLOR KATE ROLFE
Chair of Member panel

Shire Hall
Warwick

29 July 2010

Warwickshire County Council

Review of Support for Carers

Report of the Adult Social Care and Health Overview and Scrutiny Committee

July 2010

INDEX

Foreword by Councillor Kate Rolfe, Chair of Panel

In the UK at present there are estimated to be 6 million carers. This means that 1 in 10 of us looks after someone else on a voluntary basis. The vast majority of carers fulfil their role with a willingness and sense of purpose that would astound many of us. However, they can only continue to do this if they are able to access any support they might require.

This review has been undertaken by a small panel of councillors from the former Adult and Community Services Overview and Scrutiny Committee. (Now the Adult Social Care and Health Overview and Scrutiny Committee). It was commissioned in response to a growing awareness of the significant role carers play in our communities, the increasing numbers of carers and the complexity of the issues they and the people they care for face.

We have been lucky in this review to have had the support of a number of individuals who have assisted us not only in developing a good understanding of carers' needs but also to develop a series of recommendations that I believe will serve to enhance the support we and our partners can offer. I should like to express my thanks to them.

1.0 Introduction

1.1 This report marks the conclusion of several months' work by a small panel of councillors from the Adult and Community Services Overview and Scrutiny Committee. It seeks to summarise the panel's findings without overwhelming the reader with statistics and information. That said it is important that we ensure that we provide enough information for you to understand how the panel has arrived at its recommendations. The report has been divided into several elements. After this introduction you will find the panel's thirteen recommendations. There then follows a section that describes the process followed by the review, an explanation of the position regarding carers at both a national and local level and finally a summary of the panel's findings, their conclusions and a repeat of the recommendations.

1.2 The report does not include the notes of the panel meetings. These can be made available on request.

1.3 The appendices contain an action plan. This provides an indication of

- the cost of implementing each recommendation,
- who will be principally responsible for ensuring the implementation of each recommendation and
- a deadline for implementation.

The Panel's Recommendations

General/Finance

1. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to report annually to the Adult Social Care and Health Overview and Scrutiny Committee on their allocation of resources to support breaks for carers. This report should demonstrate positive outcomes for carers.

Health

2. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to report to the Adult Social Care and Health Overview and Scrutiny Committee on the relationship between admissions and readmissions to hospital and the support available for carers receiving discharged patients.

3. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to actively encourage GPs to undertake annual health checks of carers aged 60 years and over. Where people are identified as having a caring responsibility GPs should be encouraged to disseminate information on support.

4. That NHS Warwickshire be requested to consider ways in which the Quality Outcomes Framework can be used to ensure that GPs undertake annual health checks for carers aged 60 plus.

5. That the Strategic Director for Adult Social Care and Health be asked to write to the Chief Executive of NHS Warwickshire seeking a commitment that his organisation will actively engage in the Carers Partnership and the Warwickshire Accessible Housing Partnership.

6. That the Chair of the Warwickshire Carers' Partnership be asked to write to the Chairs of the GP Consortia inviting them to be represented on the partnership.

7. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire jointly explore ways in which access to services by carers can be made easier.

8. That the Strategic Director of Customers Workforce and Governance considers ways in which information sharing between the statutory and voluntary sectors can be enhanced.

Housing

9. That Cabinet be asked to consider making a capital allocation of £1.5 million to clear the backlog of adaptation work required to ensure that carers obtain the help they need at an early stage to prevent more expense at a later stage. A condition of this allocation is that all district and borough councils agree to make their entire Disabled Facilities Grant available for the purpose for which it is intended.

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    - seek ways of accelerating the adaptation process
    - take account of adaptation needs when refurbishing their residential properties.
    - Under the Lifetime Neighbourhoods Strategy encourage developers to build houses that can be easily adapted to the needs of the cared for and carers.

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11. Recognising that many employees of Warwickshire County Council have caring responsibilities the Strategic Director for Customers, Workforce and Governance be requested to give consideration to the establishment of a carers' staff network along the lines of the three that already exist.

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13. That the Strategic Director for Adult Social Care and Health investigates opportunities for information on support for carers to be supplied to those undertaking fire safety checks or delivering meals on wheels.

2.0 The Review Process

2.1 At its meeting of 2nd September 2009 the County Council's Overview and Scrutiny Board met to agree the work programme for all the overview and scrutiny committees. As well as considering the rolling programme for the committee meetings the board decided (on the basis of ideas put forward by members) which in-depth scrutiny reviews should be undertaken. One of these was a review of support for carers which was to be undertaken under the auspices of the (then) Adult and Community Services Overview and Scrutiny Committee. The driver behind this choice was not that members were concerned over shortcomings in service so much as a view that given the importance of the role of carers in society it is essential that we ensure that everything possible is being done to support them.

2.2 Four councillors were nominated to make up the task and finish group panel. These were,

Councillor Mike Gittus	Councillor Barry Longden	Councillor Kate Rolfe	Councillor Claire Watson
			

2.3 The task and finish panel met for the first time at the end of January 2010. The first meeting was spent scoping the review that is, agreeing its aims and objectives as well as deciding who the panel would wish to speak to and which sources of written evidence it would draw on. The result of this process was the review's terms of reference attached as Appendix A to this report. It may be worth noting at this early stage that it was when the review was scoped that the decision was made not to give specific consideration to the particular needs of young carers. This was not because the panel thought that young carers were of no importance, rather it was felt that their issues may be such that a review of this size would not necessarily be able to give them due attention.

2.4 The panel received information and advice from a number of officers throughout the review. Considerable support came from Chris Lewington the council's Care and Customer Engagement Service Manager.

2.5 Evidence considered can be divided into four categories.

1. Legislation and Guidance – Including "Carers at the Heart of 21st-Century Families and Communities" and "Shaping the Future of Care Together"

2. Statistical data sourced nationally and locally including evidence from the carers' survey.

3. Discussions with carers and representatives from local voluntary organisations. These latter include

- Coventry and Warwickshire Crossroads
- Guideposts
- South Warwickshire Carers Support Service
- Rethink Mental Health Carers Information and Support Services
- Warwickshire Carers Partnership

4. Officers from statutory bodies eg NHS Warwickshire and the WCC HR advisory Team.

2.6 At the same time as the review was being undertaken Warwickshire County Council was running a series of training events called "Who Cares?" This was run in a number of locations across Warwickshire and was offered to a broad range of organisations involved in caring. Members of the panel were given the opportunity to attend these sessions. One of the benefits of the sessions was that they were attended by carers. This gave attendees, including the panel members, an opportunity to question them on their experiences.

2.7 One important aspect of the review was that as well as considering the general support available for carers it also looked at the way in which Warwickshire County Council as a major employer regarded staff who also have caring responsibilities.

2.8 Having met on a number of occasions and considered a wealth of information the panel sat to consider its conclusions and recommendations. It is expected that these recommendations will be presented to the new (from 2nd July 2010) Adult Social Care and Health Overview and Scrutiny Committee before being considered by Cabinet.

3.0 Strategy, Law and Policy

3.1 In June 2008 the Government published its carers' strategy "Carers at the Heart of 21st – Century Families and Communities" This stated that its (the Government's) vision is that "by 2018 carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individual needs enabling carers to maintain balance between their caring responsibilities and a life caring, whilst enabling the person they support to be a full and equal citizen". (Carers for the purpose of this review are those people who voluntarily look after another person or persons). The document then goes on to say that by 2018

- carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role;
- carers will be able to have a life of their own alongside their caring role;
- carers will be supported so that they are not forced into financial hardship by their caring role;
- carers will be supported to stay mentally and physically well and treated with dignity;
- children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes: to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.

3.2 The 2008 Strategy states that,

- 1 in 10 people in the UK are carers at any one time (more women than men)
- In the 2001 census there were 5.2 million carers. (This has now risen to nearer 6 million).
- Of the 6 million carers more than 20% of them spend more that 20 hours a week caring.
- 1 in 7 of the workforce are carers
- 40% of carers of working age would like to work now or at some time in the future.
- 139,000 of under 18s provide some care.

3.3 In addition to the above it is worth noting that not all sections of society have the same caring responsibilities. For example,

- women have a 50% chance of providing care by the time they are 59 years old.

- women are more likely to give up work in order to care.
- Bangladeshi and Pakistani men and women are three times more likely to provide care compared to their white counterparts.

3.4 The 2008 document was not the government's first acknowledgement of the important role of carers the first ever carers' strategy Caring for Carers being published in 1999. In addition to the two strategies a range of legislation exists to protect carers and enhance their lives. This legislation includes,

- The Carers (Recognition and Services) Act 1995 – Giving carers for the first time the right to request an assessment of their own needs.

- The Carers and Disabled Children's Act 2000 – This Act enables local authorities to offer carers support.

- The Carers (Equal Opportunities) Act 2004 – This legislation places a duty on local authorities to inform carers of their right to an assessment.

- Work and Families Act 2006 – Extends the right to request flexible working arrangement to all carers in employment.

3.5 As well as the law carers have Government policy working on their side. **Putting People First (2007)** heralded a complete transformation of adult social care. **Every Child Matters** (alluded to above) is an expression of Government's aim that every child, whatever their background or circumstances to have the support they need. Finally the **NHS Operating Framework for 09/10** calls on PCTs to work with their local authority partners and publish joint plans to show how their combined funding will support breaks for carers in a personalised way.

4.0 The Financial Cost of Caring

4.1 The economic value of unpaid care in England is estimated to be equivalent to £67 billion in substitute formal services. When carers are excluded from the labour market they forego significant earnings. In 2001 all those of working age who were economically inactive and providing unpaid care for over 20 hours a week lost a potential if £5.47 billion in income. This is nearly three quarters of the estimated costs of substituting that care with formal services.

4.2 As more people live longer more care will be needed and as spending on long term conditions is heavily concentrated among older people so care costs will rise. The relative cost of formal care is predicted to rise in relation to other services and goods. As productivity and quality of care are in tension the cost of care services will rise relative to prices in the rest of economy.

4.3 The personal cost of caring is high. 54% of carers are in debt as a result of their caring responsibilities. 75% of carers struggle to pay essential bills whilst 75% could not afford repairs to their homes. It is estimated that an average carer saves the nation around £15, 260 a year.

4.4 To offset some of these costs the Government offers a carers allowance of £48.65 a week. This equates to £3,539 a year or £1.39 an hour.

5.0 The Health Cost of Caring

5.1 Those caring over 50 hours a week are twice as likely to be in poor health as those not caring (21% against 11%). In the 18 to 25 age group this is 3 times more likely. 66% of carers consider that their relationship has suffered with 60% stating that they have little quality time with their partners. Most carers regard their role as “stressful” or “demanding”.

5.2 A study by the Royal College of General Practitioners and Princess Royal Trust for Carers concluded that 80% of carers feel that caring has damaged their health. One third of carers caring for more than 50 hours a week report depression, half report disturbed sleep and a quarter report back and other strains. Finally the prevalence of psychiatric morbidity is significantly higher in those who care for others in their own homes.

6.0 Carers in Warwickshire

6.1 53,000 people in Warwickshire identify themselves as carers. This equates to 10.5% of the population. The challenge is that there are more people with a caring responsibility than actually acknowledge the fact.

6.2 Support for Carers in Warwickshire is steered by the Warwickshire Carers Strategy 2009-2012. The reader is strongly recommended to read this document as it contains more information on carers and carers support than is contained in this review report. It can be found on the internet at Warwickshire Carer’s Strategy 2009-2012

6.3 The strategy contains 14 priorities namely,

Carers Breaks	Employment
Emergency Plans and Services	Emotional Support
Recognition and acknowledgement of the carers' role	Leisure
Information	Carer Involvement
Health and Joint Working	Carers Assessment and Services
Education and Training	Carers Financial Position
Young Carers	Preventative support for "all" carers

6.4 Implementing the strategy is the role of the Warwickshire Carers' Partnership. Set up in November 2007 the Carers' Partnership's objectives are to,

- provide leadership, vision and clarity of purpose for carers issues
- oversee and lead the delivery of the carers strategy ensuring the 14 key priorities defined by carers are achieved, through effective and efficient joint working
- be the voice of carers in Warwickshire, ensuring that the profile of carers issues are raised at a government, council, district/borough and service level.
- ensure that the planning and development of services, across all partner organisations address the needs and preferences of carers.
- establish robust reporting mechanisms between the Carers Partnership and key strategic decision makers, such as the Healthier Community and Older Peoples Block and the Public Service Board.
- encourage joint working across all key partners; Adult Health and Community Services, Children, Young People and Families Services, NHS Warwickshire, District and Borough Housing, Department for Works and Pensions and the voluntary and independent sector
- keep abreast of national and local policy developments

6.5 Membership of the Carers Partnership comprises a lead Member, thirteen carers, four representatives from the voluntary sector, NHS Warwickshire, Officers from Warwickshire County Council and The Department for Works and Pensions. Between these various bodies a range of support and advice is provided for carers. This support includes short breaks, one-off payments to aid the purchase of aids and equipment, carers assessment, emotional support,

social support, signposting to services, advocacy support, respite care and homecare.

7.0 Findings, Conclusions and Recommendations

7.1 The panel has arrived at thirteen recommendations. These are given below. However, before the reader can understand the recommendation he or she will need to understand more of what the panel has discovered and the conclusions councillors have drawn.

7.2 Finding 1

7.2.1 Early in the review the task and finish panel gave some consideration to the funding of support for carers. It learned that in 2008 the Government had announced that it was to double (from £50 million to £100 million) the funding available to provide respite support for carers. The money would be channelled through the Department of Health to Primary Care Trusts. Crossroads Care and the Princess Royal Trust for Carers have alleged that of that increased amount only 23% is being spent on carers. One of the difficulties being encountered is that the money was not ring-fenced by the government being added to existing health budgets. NHS Warwickshire has specific reference to support for carers in its latest strategy "Best Health for Everyone" (2010). There is no evidence that the Primary Care Trust is using the £500,000 made available to it for anything other than carer support.

7.2.2 In addition to the money paid by government to Primary Care Trusts, Warwickshire County Council directs just over £500,000 to support for carers. An element of this is used to pay for breaks for carers.

7.2.2 Conclusion 1

7.2.3 The panel is keen to ensure that any resources made available from the public purse for the support of carers should be used for that purpose. However, as funds become scarcer and the pressure for services increases the temptation for public agencies to redirect non-ring fenced monies to other areas will surely increase. The panel is keen to ensure that not only are resources being allocated appropriately but also that they are producing positive results. To this end it considers that the Primary Care Trust and the Strategic Director – Adult Social Care and Health should report annually on the matter.

7.2.4 Recommendation 1

7.2.5 That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to report annually to the Adult Social Care and Health Overview and Scrutiny Committee on their respective allocation of resources to support breaks for carers. This report should demonstrate positive outcomes for carers.

7.3 Finding 2

7.3.1 The task and finish panel was briefed of the importance of effective hospital discharge processes in assisting carers and those they care for to make the transition from hospital to home. Some conditions, such as a Stroke, can manifest themselves very quickly. This means that a person can go from not being a carer to being a carer in a matter of a few days. They will be under considerable stress and amongst matters they will need to address will be the logistics of having an ill person to care for. A good hospital discharge plan can be used to ensure that equipment is in place, relevant general practitioners have been informed of the situation and that pharmaceutical and surgical supplies are available in a form that can be understood and managed by a carer. In instances where an inadequate plan has been prepared there is a risk that through inappropriate care at home the individual will end up needing to be readmitted to hospital.

7.3.2 Regretfully the task and finish group heard evidence of cases where little thought appears to have been given to discharge. It was reported that notes have been ineligible, envelopes with letters to GPs have been given to confused patients (who promptly forgot about them) and others written hastily seemingly on a scrap of paper. It should be noted that NHS Warwickshire reports that there is no evidence in literature to suggest that hospital bed use would be reduced through better support for carers.

7.3.3 Conclusion 2

7.3.4 The Overview and Scrutiny function involves the collection of statistical and anecdotal evidence. The panel is concerned at what it has heard about possible inadequacies regarding discharge plans from Warwickshire hospital. However, it does appreciate that one person's "inadequate" is another persons "excellent". Whilst the panel has not had an opportunity to explore in great depth the matter of hospital discharge and readmissions it does feel that further consideration should be given to what at this stage appears to be a cause for concern.

7.3.5 Recommendation 2

7.3.6 That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to report to the Adult Social Care and Health Overview and Scrutiny Committee on the relationship between admissions and readmissions to hospital and the support available for carers receiving discharged patients.

7.4 Finding 3

7.4.1 People in care receive regular medical checks from their GPs. However there is no regulated mechanism for carers to receive a similar level of service. The

panel has learned of the cost to health that being a carer can bring. This cost increases as people get older. If a carer becomes ill the impact falls on them, the person they care for and the friends, neighbours or agencies that have to step in to fill the gap.

7.4.2 A significant proportion of the older population, ie those over 60, attend their GP surgeries on a regular basis throughout the year. Many attend for their annual flu inoculation. As a result GP surgeries can serve as a hub for information dissemination. Warwickshire County Council and partner agencies produce a considerable amount of literature regarding support for carers that is used widely.

7.4.3 Conclusion 3

7.4.4 The task and finish panel understand that GP surgeries operate in a semi-autonomous fashion and that short of renegotiating their contract there is little that can be done to oblige a certain course of action. (See Finding/Conclusion/Recommendation 4 below) Nevertheless it is felt that given the personal and wider impact of a carer falling ill it is important that everything should be done to avoid that situation arising. For this reason the panel has concluded that wherever possible GPs should be **encouraged** to put in place a mechanism for offering carers an annual health check. As well as undertaking the check up GPs should be encouraged to disseminate information on the support that is available.

7.4.5 Recommendation 3

7.4.6 That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to actively encourage GPs to undertake bespoke annual health checks of carers aged 60 years and over. Where people are identified as having a caring responsibility GPs should be encouraged to disseminate information on support.

7.5 Finding 4

7.5.1 GP practices are subject to the Quality and Outcomes Framework. This is effectively the contract to which GPs work and is agreed nationally. Local Primary Care Trusts have no direct control over the Quality and Outcomes Framework. Nevertheless they are in a position to express an opinion on what services should be included in it. NHS Warwickshire is currently engaged in discussions with GP leaders to improve support for carers.

7.5.2 Conclusion 4

7.5.3 Whilst in the short term it is good to encourage GPs to improve the support they give to carers it is recognised that a more robust approach may be required. The new coalition government has already announced a review of the GP

contract and there may well be an opportunity to see any revised contract incorporate a component whereby GPs will be required to undertake health checks of carers. The panel feels that NHS Warwickshire should be asked to use its position to lobby government for changes in the Quality and Outcomes Framework to assist carers further.

7.5.4 Recommendation 4

That NHS Warwickshire be requested to explore ways in which the Quality and Outcomes Framework can be used to ensure that GPs undertake annual health checks for carers aged 60 plus.

7.6 Finding 5

7.6.1 The Warwickshire Carers Partnership and Warwickshire Accessible Housing Partnership (concerned with adaptations for people with special needs) constitute two key components of the support structures available to carers. Their effectiveness is dependent on good communication and a willingness of all partners to be fully engaged. For various reasons it has not always been easy for some partners to engage as fully as others might like. NHS Warwickshire is an example of such an organisation. Recently the Medical Director, NHS Warwickshire has established a coordinating meeting with officers from the County Council to oversee work on older people and carers support.

7.6.2 Conclusion 5

7.6.3 The panel is of the view that if bodies such as the Warwickshire Carers Partnership and Warwickshire Accessible Housing Partnership are to fulfil their stated objectives they require a good and consistent level of support from all relevant agencies. The panel appreciates that NHS Warwickshire constantly has to balance its priorities. The new coordinating meetings are to be welcomed but the panel feels that given the increasing importance of carers in society (and the amount of money they save the health and social care economies every year) NHS Warwickshire should endeavour to play a more active role in them the Carers Partnership and Accessible Housing Partnership. .

7.6.4 Recommendation 5

7.6.5 That the Strategic Director for Adult Social Care and be asked to write to the Chief Executive of NHS Warwickshire seeking a commitment that his organisation will actively engage in the Carers Partnership and the Warwickshire Accessible Housing Partnership.

7.7 Finding 6

7.7.1 As noted above the work of the Warwickshire Carers Partnership is dependent on full engagement by the partners who comprise it. There is a place in the partnership for General Practitioners (GPs) but so far this has been inconsistent.

7.7.2 Conclusion 6

7.7.3 It is clear to the panel that GPs have a major and as yet largely untapped role to play in the lives of unpaid carer. The panel is quite aware that GPs are very busy people but for the benefits of carers now and in the future it is important that there is some GP representation on the partnership.

7.7.4 Recommendation 6

7.7.5 That the Chair of the Warwickshire Carers' Partnership be asked to write to the Chairs of the GP Consortia inviting them to be represented on the partnership.

7.8 Finding 7

7.8.1 NHS Warwickshire along with other elements of the health economy is developing a single point of access whereby a person who is concerned about their health can dial a single number and be directed to the right service for them. Carers' supporters have commented that when their clients are seeking assistance they tend to be passed from one agency to another before (hopefully) alighting on the correct one. This can cause distress or even the failure of a person to secure the support they might be in need of. Warwickshire County Council operates a single number for carers to contact. However, this is used to signpost carers to other services. The ideal would be for the single number to be one whereby the caller would receive a more in depth service than simply being referred on. For example details of the issues being faced could be noted, if a carers assessment is required this could be put in train or if respite support is required then it could be booked there and then.

7.8.2 Conclusion 7

7.8.3 Any mechanism that simplifies access to service should be commended. Members consider that by working in partnership the key agencies should be able to identify how a single point of access could be developed for carers.

7.8.4 Recommendation 7

7.8.5 That the Strategic Director of Adult Health and Community Services and NHS Warwickshire jointly explore ways in which access to services by carers can be made easier.

7.9 Finding 8

7.9.1 One of the barriers that support groups for carers report is the reluctance by public agencies including health providers to freely share information regarding carers. Information sharing is controlled by legislation principally the Data Protection Act 1998. This is a problem when, for example, a GP or hospital identifies that a carer's health is suffering as a result of their caring duties. It is not possible under the current arrangements for a third party such a voluntary organisation to be "tipped off" by the health provider. This means that a person's needs may not be met.

7.9.2 Conclusion 8

7.9.3 The panel appreciates that to a large extent public agencies are constrained in what information they can share. However, there is a feeling amongst the panel members that there may be some instances in which properly screened information could be shared. In recognition of the importance of ensuring the well-being of carers (and by extension the people they care for) the panel feels that some further consideration needs to be given to this matter.

7.9.4 Recommendation 8

7.9.5 That the Strategic Director of Customers Workforce and Governance considers ways in which information sharing between the statutory and voluntary sectors can be enhanced.

7.10 Finding 9

7.10.1 In its discussions with the Warwickshire Accessible Housing Partnership (WAHP) the panel learned of the challenges facing statutory bodies including district and borough councils in meeting the demand for housing adaptations. The WAHP manages adaptations that cost over £1000 operating in both private and public housing. It recognises that good housing can resolve many of the health issues in people's lives. As a result the cost of not undertaking adaptations in a timely and efficient way can be high. For example early intervention can postpone the need for hospitalisation or accommodation in a care home. Government provides local authorities with resources via the Disabled Facilities Grant (DFG). These can be used to pay for adaptations up to £30,000. DFG is currently ring-fenced to 2011.

7.10.2 A major challenge facing the partnership and district and borough councils is that a backlog of up to 18 months for adaptations now exists. This has been caused by a number of factors. One is the demand for adaptations, a second is the lengthy bureaucratic process that surrounds adaptations and the third is a question mark over the future of the Disabled Facilities Grant once it is not being ring-fenced.

7.10.3 Overall the cost of the backlog totals around £1.5 million.

7.10.4 Conclusion 9

7.10.5 The panel has been impressed by the work undertaken by the WAHP and district and borough councils on adaptations. It is however, concerned that the current deficit of £1.5 million is causing so many delays to adaptations that serve not only to enhance people's lives but also to save costs in the medium to long term. Despite the current financial position that the County Council finds itself in the panel feels that an effort should be made to identify funds to cancel out that deficit thus reducing waiting times. A condition that should apply to such a measure would be that the Disabled Facilities Grant paid to district and borough councils must be spent solely on the adaptations for which it is intended.

7.10.6 Recommendation 9

7.10.7 That Cabinet be asked to consider making a capital allocation of £1.5 million to clear the backlog of adaptation work required to ensure that carers obtain the help they need at an early stage to prevent more expense at a later stage. A condition of this allocation is that all district and borough councils agree to make their entire Disabled Facilities Grant available for the purpose for which it is intended.

7.11 Finding 10

7.11.1 Related to Finding 7 (above) the panel learned from professional colleagues of some of the further challenges being faced in terms of adaptations to housing. The bureaucratic process alluded to above has historically been a barrier to rapid adaptation of houses. On average it takes 45 weeks from an initial approach by a client for adaptation to completion of the process. The process involves occupational therapists (who assess a person's needs) and officers from the district and borough councils. Recently the occupational therapists have been relocated to the district/borough council offices. This has enhanced communication but more could perhaps be done to streamline the process.

7.11.2 The panel was briefed on the work that local authorities undertake to refurbish the residential properties they own. The view was expressed that the chance is often missed to take account of the opportunities for adaptation when this refurbishment is undertaken. New build houses can be "future-proofed" by being designed with adaptation in mind. For example they can have a ramp to the front door. If they don't have a ramp then space can be left to accommodate one at a later date. Another consideration is how a person with impaired mobility can move around a house. Tight spaces and sharp angles should be avoided so that a wheelchair (for example) can be negotiated easily.

7.11.3 Conclusion 10

7.11.4 The panel is convinced that good quality housing that has been suitably adapted is one of the keys to the well-being of carers and the cared for. It would appear that for want of a degree of forward planning and process reconfiguration significant savings could be made in the longer term.

7.11.5 Recommendation 10

7.11.6 That the Portfolio Holder for Adult Social Care writes to the five district/borough councils of Warwickshire encouraging them to: ~

a) seek ways of accelerating the adaptation process
b) take account of adaptation needs when refurbishing their residential properties.
c) Under the Lifetime Neighbourhoods Strategy encourage developers to build houses that can be easily adapted to the needs of the cared for and carers.

7.12 Finding 11

7.12.1 From the outset members of the task and finish panel recognised that as the largest single employer in Warwickshire the County Council has a responsibility to ensure that those members of its workforce who have caring responsibilities should be well supported. The Council's policy regarding carers is enshrined in its Family Friendly Policy. On the basis that 1 in 7 employees in the country have caring responsibilities it can be calculated that 3500 employees of the County Council are carers. Whilst the policy defines what a caring responsibility is the council does not currently hold a database of carers in its employment. Staff are expected to identify themselves as carers to their managers should they so wish. The family friendly policy is accompanied by a set of formal procedures that employees can follow if, for example, they wish to work flexibly or take extended leave. In practice it is not always necessary or appropriate to use that approach. Many managers take a less formal approach but if an employee has a grievance over the way they are treated there is an appeals process. Schools and Fire and Rescue operate slightly different policies.

7.12.2 Staff awareness of support for carers (and the need for them to acknowledge themselves as such) is encouraged through Carers Week and Carers Rights Day. An event aimed at raising awareness of carers amongst employers had to be cancelled due to a lack of interest. NHS Warwickshire and National Grid have protocols for carers that are highly regarded (although much of their contents also feature in the County Council's policy)

7.12.3 Conclusion 11

7.12.4 It is encouraging to learn of the policies and processes that are already in place to support carers employed by the County Council. The fact that there are so many carers in the County Council is surprising but it is regrettable that to date no mechanism has been provided for carers to provide mutual support to each other should they so wish. Members are aware that networks have been set up via the intranet for people with disabilities or who are from black and minority ethnic communities or are lesbian, gay or transgender. There networks appear to work well and it is felt that a similar arrangement should be made for carers.

7.12.5 Recommendation 11

7.12.6 Recognising that many employees of Warwickshire County Council have caring responsibilities the Strategic Director for Customers, Workforce and Governance be requested to give consideration to the establishment of a carers' staff network along the lines of the three that already exist.

7.13 Finding 12

7.13.1 Whilst considerable effort goes into increasing awareness of the needs of carers across Warwickshire less is currently done to ensure that managers in the County Council are aware of them.

7.13.2 Conclusion 12

7.13.3 In recognition of the challenges that face carers it is apparent that managers across the county council need to be fully briefed on this matter. The panel is aware of the existence of mangers conferences in each of the directorates and feels that a short briefing to each of these would pay dividends in terms of understanding and awareness.

7.13.4 Recommendation 12

7.13.5 That officers from the Adult, Health and Community Services Directorate be requested to brief all directorate managers' conferences on caring and carers. This initiative should be linked in to Carers Week.

7.14 Finding 13

7.14.1 Early identification of carers is important if they are to receive the support they might need and if their health is to be sustained. People who might be considered vulnerable often rely on home-based support. For example community nurses might visit a house on a regular basis as might the meals on

wheels service. Less frequently the Fire and Rescue Service visits houses to install or check fire detectors. The panel has learned that these people are well placed to identify when a person who might have caring responsibilities is in need of support.

7.14.2 Conclusion 13

7.13.3 It is important that in order to identify carers and their needs the best use is made of people who are well placed to do this. Being sensitive to a person's needs and knowing where to refer them should not be particularly challenging or time consuming. This is definitely an area where those visiting the homes of carers can make a significant difference.

7.14.3 Recommendation 13

7.14.4 That the Strategic Director of Adult Health and Community Services investigate opportunities for information on support for carers to be supplied to those undertaking fire safety checks or delivering meals on wheels.

APPENDIX A

REVIEW OF SUPPORT FOR CARERS – TERMS OF REFERENCE

Review Topic (Name of review)	Review of Carers' Support
Panel/Working Group etc – Yes Members	Cllrs: Gittus, Longden, Rolfe, Watson
Key Officer Contact	Chris Lewington, Carer and Customer Engagement Manager
Scrutiny Officer Support	Paul Williams. Overview and Scrutiny Officer
Relevant Portfolio Holder(s)	Cllr Izzi Seccombe
Relevant Corporate/LAA Priorities/Targets	NI 135 – Carers receiving a service or specific information and advice and an assessment or review.
Rationale (Key issues and/or reason for doing the review)	▪ Carers play a key yet often unrecognised role in society. As well as saving the health service many millions of pounds every year they help to ensure that people in need of care can continue to live within the community. ▪ The number of carers in Warwickshire is increasing annually. ▪ To develop a better understanding of the needs of carers in Warwickshire. ▪ To understand the nature and extent of the support available to carers. ▪ To ensure that carers across the whole of the county have equal access to the information and support they require. ▪ To ensure that Warwickshire County Council is sensitive to the needs of its employees who have caring responsibilities.
Objectives of Review (Specify exactly what the review should achieve)	1) To achieve greater acknowledgement of the importance of carers in the community. 2) To obtain the views of carers. 3) To establish the needs of carers. 4) To consider the impact of caring on carers' health, their general well-being and their financial position. 5) To consider the impact of caring on families, neighbours and communities. 6) To review the services available and the level of support for carers. 7) To determine the extent of joined up working between agencies with respect to carers. 8) To identify any gaps in support for carers 9) To establish the potential future impact of the personalisation agenda on cared for people and therefore on carers. 10) To examine the relationship between health and social care in terms of working arrangements and funding.

Scope of the Topic (What is specifically to be included/excluded)	<u>Include</u> The following is included in the scope of the review: • Unpaid carers • WCC employees who have caring responsibilities <u>Excluded</u> The following falls outside the scope of the review: • Paid carers • Young carers
Indicators of Success – Outputs (What factors would tell you what a good review should look like?)	• Indicators resulting from previous consultation • Results from Carers' survey • Recommendations accepted and implemented to deliver improvements
Indicators of Success – Outcomes (What are the potential outcomes of the review e.g. service improvements, policy change, etc?)	• Recognisable improvements in care of children and young people • Provide public reassurance and promote confidence in Safeguarding services • Raising profile and agenda of Safeguarding within WCC and our partners. • Reassure public/promote confidence
Specify Evidence Sources (Background information and documents to look at)	• County statistics on carers • Legislative background • Report on homecare • Models of single point of contact to be identified • Examples of good practice from around the country • Emerging model of support (C.Lewington)
Specify Witnesses/Experts (Who to see and when)	• NHS Warwickshire • GP practices • Mental Health Trust • "Guidepost" (Covering the north of the county) • South Warwickshire Carers (Covering the south of the county) • Carers' Partnership • Warwickshire County Council Officer(s) including Carer and Customer Engagement Manager, a Carers Assessment Worker and Human Resources. • Borough Council (Housing related matters eg support and adaptation, Council Tax relief and speed of response) • Housing associations
Possible Co-Options (Would the review benefit from any co-options e.g. community or voluntary sector representatives?)	None identified

Specify Site Visits (Where and when)		• Alcester/Camp Hill (as examples of good practice)	
Consultation with Stakeholders (Who should we consult?)		• Carers' forums to elicit comments	
Level of Publicity (What level is appropriate and what method should be used?)		Publicise once review is complete	
Barriers/Dangers/Risks (Identify any weaknesses or potential pitfalls)		Pride of some carers may lead to reluctance to engage Lose focus/scope too big Miss the obvious Raise expectations to unreasonable levels Sustainability of any new initiatives proposed	
Projected Start Date	Feb 2010	**Draft Report Deadline**	
Meeting Frequency	Monthly	**Projected Completion Date**	July 2010
Meetings Dates		Scoping – 29.1.10 2/3/10 23/3/10 9/4/10	
Committee Reporting Date		Interim briefing note required – April 2010	
Cabinet Reporting Date			
When to Evaluate Impact			
Methods for Tracking and Evaluating			

Review of Support for Carers Action Plan

Recommendation	Officer/Member Responsible	Deadline	Approximate cost (£ or time)
General/Finance			
1. That the Strategic Director of Adult Social Care and Health and NHS Warwickshire be requested to report annually to the Adult Social Care and Health Overview and Scrutiny Committee on their allocation of resources to support breaks for carers. This report should demonstrate positive outcomes for carers.	Strategic Director for Adult Social Care and Health to co-ordinate joint report	March 2011	Officer time in producing report
Health			
2. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire be requested to report to the Adult Social Care and Health Overview and Scrutiny Committee on the relationship between admissions and readmissions to hospital and the support available for carers receiving discharged patients.	Strategic Director for Adult Social Care and Health to co-ordinate joint report	December 2011	Officer time in producing report

Recommendation	Officer/Member Responsible	Deadline	Approximate cost (£ or time)
3. That the Strategic Director for Adult Social care and Health and NHS Warwickshire be requested to actively encourage GPs to undertake annual health checks of carers aged 60 years and over. Where people are identified as having a caring responsibility GPs should be encouraged to disseminate information on support.	Strategic Director for Adult Social Care and Health to co-ordinate joint report	March 2011	Officer time Information to be disseminated will already exist
4. That NHS Warwickshire be requested to consider ways in which the Quality Outcomes Framework can be used to ensure that GPs undertake annual health checks for carers aged 60 plus.	Chief Executive NHS Warwickshire	December 2010	Officer time Possible longer term implications regarding GP contracts
5. That the Strategic Director for Adult Social Care and Health be asked to write to the Chief Executive of NHS Warwickshire seeking a commitment that his	Strategic Director for Adult Social Care and Health	October 2010	Officer time.

Recommendation	Officer/Member Responsible	Deadline	Approximate cost (£ or time)
organisation will actively engage in the Carers Partnership and the Warwickshire Accessible Housing Partnership.			
6. That the Chair of the Warwickshire Carers' Partnership be asked to write to the Chairs of the GP Consortia inviting them to be represented on the partnership.	Portfolio Holder for Health	October 2010	Member and officer time
7. That the Strategic Director for Adult Social Care and Health and NHS Warwickshire jointly explore ways in which access to services by carers can be made easier.	Strategic Director for Adult Social Care and Health	January 2011	Initially officer time but may require resources for implementation of any outcomes of the work undertaken.
8. That the Strategic Director of Customers Workforce and Governance considers ways in which information sharing between the statutory and voluntary sectors can be enhanced.	Strategic Director of Customers Workforce and Governance	January 2011	Officer time
Housing			

Recommendation	Officer/Member Responsible	Deadline	Approximate cost (£ or time)
9. That Cabinet be asked to consider making a capital allocation of £1.5 million to clear the backlog of adaptation work required to ensure that carers obtain the help they need at an early stage to prevent more expense at a later stage. A condition of this allocation is that all district and borough councils agree to make their entire Disabled Facilities Grant available for the purpose for which it is intended.	Strategic Director for Adult Social Care and Health	March 2011	£1.5 million one off payment

Recommendation	Officer/Member Responsible	Deadline	Approximate cost (£ or time)
10. That the Portfolio Holder for Adult Social Care writes to the five district/borough councils of Warwickshire encouraging them to • seek ways of accelerating the adaptation process • take account of adaptation needs when refurbishing their residential properties. • Under the Lifetime Neighbourhoods Strategy encourage developers to build houses that can be easily adapted to the needs of the cared for and carers.	Portfolio Holder Adult Social Care	October 2010	Member time
Warwickshire County Council			

Recommendation	Officer/Member Responsible	Deadline	Approximate cost (£ or time)
11. Recognising that many employees of Warwickshire County Council have caring responsibilities the Strategic Director for Customers, Workforce and Governance be requested to give consideration to the establishment of a carers' staff network along the lines of the three that already exist.	Strategic Director for Customers, Workforce and Governance	March 2011	Officer time in setting up and supporting network.
12. That officers from the Adult, Health and Community Services Directorate be requested to brief all directorate managers' conferences on caring and carers. This initiative should be linked in to Carers Week.	Strategic Director for Adult Social Care and Health	June 2011 (Ahead of Carers' Week)	Officer time
13. That the Strategic Director of Adult Social Care and Health investigates opportunities for information on support for carers to be supplied to those undertaking fire safety checks or delivering meals on wheels.	Strategic Director of Adult Social Care and Health working with other Strategic Directors	January 2011	Officer time

Agenda No

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care And Health OSC**
Date of Committee	**16th September 2010**
Report Title	**Progress Report on Implementation of Recommendations from Review of Falls Prevention in Warwickshire**
Summary	In April 2008, the Health Overview and Scrutiny Committee and the Adult and Community Services Overview and Scrutiny Committee resolved to establish a joint panel to look into the topic of falls prevention and make recommendations which would lead to improvements in the services provided across Warwickshire. This is a progress report on the implementation of the recommendations suggested by both committees.

For further information please contact:	Alwin McGibbon Overview and Scrutiny Officer Tel: 01926 412075 alwinmcgibbon@warwickshire.gov.uk	Michelle McHugh Overview and Scrutiny Manager Tel: 01926 412144 michellemchugh@warwickshire.gov.uk

Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	Review of Falls Prevention in Warwickshire Report - April 2009

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☒	Not applicable
Other Elected Members	☒	Cllr Les Caborn, Cllr David Shilton, Cllr Sid Tooth, Cllr Kate Rolfe
Cabinet Member	☒	Cllr Izzi Seccombe, Cllr Bob Stevens
Chief Executive	☐	.....
Legal	☒	Alison Hallworth

Finance	☐	.....
Other Strategic Directors	☐	.....
District Councils	☐	.....
Health Authority	☐	.....
Police	☐	.....
Other Bodies/Individuals	☐	.....

FINAL DECISION Yes

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☐	.....
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Further Consultation	☐	.....

Agenda No

Adult Social Care and Health OSC - 16th September 2010.

Progress Report on the Implementation of Recommendations from Review of Falls Prevention in Warwickshire

Report of the Strategic Director of Customers Workforce and Governance Directorate

Recommendation

The Committee to:
Consider and deliberate the progress being made with the implementation of the recommendations from the review of falls prevention in Warwickshire

1. Introduction

1.1 In April 2008, the Health Overview and Scrutiny Committee and the Adult and Community Services Overview and Scrutiny Committee resolved to establish a joint panel to look into the topic of falls prevention and make recommendations which would lead to improvements in the services provided across Warwickshire. A copy of the report can be found on the attached link: http://www.warwickshire.gov.uk/Web/corporate/pages.nsf/Links/E1F2A2AB5DC363518025726D0058FC5E/$file/PDF+-+FINAL+Falls+Prevention+Panel+Report.pdf

1.2 Members of the panel were:

- Councillor Jose Compton
- Councillor Anne Forwood
- Councillor Nina Knapman (Chair)
- Councillor Sue Main
- Councillor Raj Randev

1.3 The report summarised the evidence gathered by the panel and outlined a set of recommendations which it believed were necessary to improve the provision and access to falls prevention services in the County.

1.4 The panel concluded that whilst high-quality initiatives in support of the falls prevention agenda exist across Warwickshire, services were fragmented, with limited provision in the north of the County.

1.5 The attached Scrutiny Review Implementation Plan provides information on the recommendations suggested by the joint committee with the responses to their implementation from NHS Warwickshire, the Strategic Director of Adult, Heath and Community Services and the Strategic Director of Environment and Economy.

DAVID CARTER
Strategic Director Customers
Workforce and Governance

Shire Hall
Warwick

10 August 2010

Scrutiny Review Implementation Plan

Key	★	Exceeding target	●	Meeting target	▲	Missing target

	Recommendation	Resp. officer	Delivery objectives/actions	Resource implications	Progress to date	Status
	[THEME 1 (if applicable)]					
	1. NHS Warwickshire allocates appropriate funding to deliver the Warwickshire Falls and Bone Health Strategy 2008-12. Priority should be given to the expansion and development of the South Warwickshire Specialist Falls Service into the rest of the County, and the appointment of a strategic Falls and Bone Health Coordinator.	Professor Ian Philip	Caring for Older People		A Falls and Bone Health Co-ordinator has been appointed and has been in post since November 2nd 2009, filling the role of the previous Falls Co-ordinator. The co-ordinator will continue to report to Occupational Therapy Wheelchair and Specialist Falls services manager. The Co-ordinator will provide day to day management to the Specialist Falls Service and also have a key role in co-ordinating Falls and Bone Health work across the County. Initial discussions are taking place with the aim of ensuring provision of Specialist Falls Service clinics and exercise groups in all 5 of the districts/boroughs. This is being done through reviewing the current service and redeploying existing resource via three work streams by: 1. Working with GPs. Local Authorities and the third sector. The Falls & Bone Health Co-ordinator is in the process of developing a new screening tool around 5 interventions:	●

	Recommendation	Resp. officer	Delivery objectives/actions	Resource implications	Progress to date	Status
					• Advice on exercise (balance & weight bearing) • Medication checks (drugs may increase falls) • Check vision • Environmental acan of home • Bone health 2. Targeted intervention in high risk settings such as Acute Sector & Care Homes 3. Establish an Evidence Review Group	
	2. NHS Warwickshire and the Strategic Director of Adult, Health and Community Services work together to develop and coordinate the provision of information on falls prevention and the services available to Warwickshire's residents. Information should be made available in a variety of formats and in a variety of community locations.	Professor Ian Philip	Caring for Older People		Discussions regarding a marketing campaign with regard to Falls and Bone Health have been initiated with County Council colleagues. It is planned to develop a web page on the NHS Warwickshire website for professionals (initially) and the public, which will link to useful resources regarding falls and bone health. Plans are also being made to secure appropriate information resources to be distributed by a variety of community and housing service colleagues.	
	3. The Strategic Director of Adult, Health and Community Services carries out a feasibility study into the provision of support with customer transport to appointments and programmes delivered by the Specialist Falls Service. The results of the study should be reported back to the Committee within six	Richard Brooks/Julie Humphries	Caring for Older People		Richard Brooks is project lead for the AH & CS Transport Review which is in its second phase. Julie Humphries is supporting this process as strategic commissioning lead. A joint task and finish group is to be set up to look at customer	

	Recommendation	Resp. officer	Delivery objectives/actions	Resource implications	Progress to date	Status
	months.				transport for appointments and programmes delivered by the Specialist Falls Service.	
	4. The Strategic Director of Adult, Health and Community Services carries out an evaluative study into the use of Telecare (e.g. Wander Guard) in its residential care homes and the promotion of this type of technology to partners in the independent care sector. The results of the study should be reported back to the Committee within six months with particular reference to falls prevention.	Joyce Woodings/ Geoff Cobbe	Caring for Older People		A pilot is operating in two WCC homes—Abbotsbury and Rugby and Orchard Blythe in Coleshill. The equipment installed includes falls detectors, bed occupancy sensors and eneuresis sensors. Following initial problems with installation of monitoring equipment the homes have started to use the equipment with both permanent residents and those using the homes for respite. An evaluation form has been devised and approved by both homes and both qualitative and quantitative information is being collected. The pilot will run until February 2011 when a final evaluation will be collated and sent to members. The project officer for Telecare is also visiting the homes bi-monthly to monitor progress and address any equipment issues.	
	5. The Strategic Director of Environment and Economy continues to give priority to the maintenance of pavements and roads in the main footfall areas, in support of the falls prevention agenda and the achievement of Warwickshire's LAA target. A publicity campaign should be delivered to inform residents of the mechanisms through which	Andrew Savage/ Roger Poole	Caring for Older People		The Environment and Economy Directorate have updated their website and footers have been added to periodic press articles to raise awareness on how to report defects. They are also piloting the use of stickers on lamp columns as	

	Recommendation	Resp. officer	Delivery objectives/actions	Resource implications	Progress to date	Status
	they can report a fault to the Authority.				part of their publicity campaign**.**	
	6. NHS Warwickshire and the Strategic Director of Adult, Health and Community Services work together to establish and lead a multi-disciplinary strategic falls group / forum through which good practice and training in the prevention and management of falls can be shared. The group should include relevant health and social care professionals from the acute trusts, community hospitals, residential and nursing care homes, home care agencies, the Ambulance Service, the voluntary sector, and any others considered appropriate. Actions taken to implement this recommendation should be reported back to the Committee within six months.	Professor Ian Philip	Caring for Older People		The Warwickshire Falls and Bone Health Strategy has been out for consultation to all relevant partners and service users and is currently being adjusted in the light of comments received. The implementation plan arising from the strategy, incorporating new Department of Health guidance regarding effective interventions for falls and fractures in health and social care, has been approved in principle by NHS Warwickshire Professional Executive Committee and by the Healthier Communities and Older People's Partnership Board. Plans are at an advanced stage regarding the remit and governance around an overarching strategic group.	
	7. Progress against the recommendations to be reported back to the Committee on a six-monthly basis.	Professor Ian Philip, Joyce Woodings, Geoff Cobbe, Andrew Savage,Roger Poole,	Caring for Older People		NHS Warwickshire, the Strategic Directors for Adult, Health and Community Services, and Environment and Economy did provide a report in November 2009, but a number of the recommendations were not fully implemented at that time. This report replaces the 6 monthly update on progress being made.	

Agenda No

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care And Health Overview And Scrutiny Committee**
Date of Committee	**16th September 2010**
Report Title	**Work Programme and proposed Task and Finish Groups**
Summary	This report contains the Work Programme for the Adult Social Care and Health Overview and Scrutiny Committee and review outlines for the proposed Task and Finish Groups suggested by the Committee at its meeting on 14th July 2010.
For further information please contact:	Michelle McHugh Overview and Scrutiny Manager Tel: 01926 412144 michellemchugh@warwickshire.gov.uk
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☒	N/A
Other Elected Members	☒	Cllrs Caborn, Rolfe, Shilton and Tooth
Cabinet Member	☒	Cllrs Seccombe and Stevens *(For Information)*
Chief Executive	☐	.....
Legal	☐	.....
Finance	☐	.....
Other Strategic Directors	☒	John Bolton - Interim Director of Adult Services *(For information)*
District Councils	☐	.....

Health Authority	☐	.....
Police	☐	.....
Other Bodies/Individuals	☒	Kim Harlock - Head of Strategic Commissioning and Performance Management, Ron Williamson - Head of Communities and Well-Being / Resources *(For information)*

FINAL DECISION NO

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☐	.....
To an O & S Committee	☒	Review outlines for proposed Task and Finsh Groups to be forwarded to the Overview and Scrutiny Board (5th Oct)
To an Area Committee	☐	.....
Further Consultation	☐	.....

Agenda No

Adult Social Care and Health Overview and Scrutiny Committee - 16th September 2010.

Work Programme and proposed Task and Finish Groups

Report of the Chair of the Adult Social Care and Health Overview and Scrutiny Committee

Recommendation

The Committee is recommended to agree

i) the work programme, to be reviewed and reprioritise as appropriate throughout the course of the year

ii) the draft review outlines for the proposed Task and Finish Groups (Low Level Prevention Services and Delayed Discharges and Reablement Services) and forward them onto the Overview and Scrutiny Board for consideration.

1. Summary

1.1 At the last meeting of the Adult Social Care and Health OSC on the 14th July 2010, we discussed the future work programme of the Committee and suggested topics for Task and Finish Group type scrutiny.

1.2 Attached as Appendix A is the draft Committee Work Programme which emerged through this process. The Work Programme will be reviewed and reprioritised throughout the year so that the Committee can adopt a flexible approach and respond to issues as they emerge.

1.3 Attached as Appendix B are review outlines for suggested topics for Task and Finish Group scrutiny. These will need to be forwarded onto the Overview and Scrutiny Board for consideration.

CLLR CABORN
Chair of the Adult Social Care
and Health Overview and
Scrutiny Committee

Shire Hall
Warwick,
27 August 2010

Updated 25 August 2010

Work Programme for Adult Social Care and Health Overview and Scrutiny Committee 2010/11

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	Performance Management	Holding Executive to Account	Policy Review/Development	Overview	Raising Levels of Educational Attainment	Maximising independence for older people and adults with disabilities.	Developing sustainable places and communities	Protecting the Community and making Warwickshire a safer place to live	Cross cutting themes/ LAA
16 Sept 2010	Falls Prevention Scrutiny review Alwin McGibbon	To scrutinise progress made in implementing the recommendations from the Falls Prevention Scrutiny Review		✓				High		Med	
	Report from CAMHS Select Committee, Michelle McHugh, Cllr Ashford (Chair)	To consider the report and recommendations from CAMHS Select Committee	✓		✓		High				Emotional Health of Children and Young People
	Report from Support to Carers Scrutiny Review, Paul Williams, Cllr Rolfe (Chair)	To consider the report and recommendations from the support to carers task and finish group			✓	✓		High			
	NHS White Paper, John Linnane, NHS Warwickshire	Update on consultation papers associated with the NHS White Paper, to consider implications for Warwickshire and likely / proposed response to consultation									
12 Oct 2010	Fairer Charges Consultation Outcome, Ron Williamson	To scrutinise the outcomes of the consultation and proposed charges		✓	✓			High			
	Rugby St Cross Accident and Emergency, Alwin McGibbon	To make a response to the A&E Consultation			✓					High	
	Banbury Obstetric, maternity and paediatric Services,				✓						

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	Performance Management	Holding Executive to Account	Policy Review/Development	Overview	Raising Levels of Educational Attainment	Maximising independence for older people and adults with disabilities.	Developing sustainable places and communities	Protecting the Community and making Warwickshire a safer place to live	Cross cutting themes/ LAA
	Paul Maubach (NHS Warwickshire)										
	Telecare Progress Report, Kim Harlock	To consider progress of implementing Telecare			✓			High			NI 124 People with long term condition supported to be independent
	Joint Commissioning Strategy for Learning Disability Services Kim Harlock / Christine Lewington	To consider outcomes from a refresh of the joint commissioning strategy for learning disability services. The report will include an action plan to address areas for improvement identified through the Learning Disability Partnership Board Annual Self Assessment 09/10. (requested at 16 June 2010 meeting)	✓		✓			High			
Nov - additional meeting (date to set)	West Midlands Ambulance Service (WMAS) –re-modernisation proposals	To consider WMAS re-modernisation proposals			✓			High			
	Transfer of Community Services, NHS Warwickshire, Rachel Pearce	To consider proposed transfer of community services to South Warwickshire Foundation Trust and George Elliot Hospital and to consider how NHS Warwickshire has involved users in the process			✓	✓					
8th Dec 2010, 2pm	Report of the Ante-natal and post-natal services for Teenage Parents	To consider the proposed recommendations from the review			✓						

Updated 25 August 2010

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	Performance Management	Holding Executive to Account	Policy Review/Development	Overview	Raising Levels of Educational Attainment	Maximising independence for older people and adults with disabilities.	Developing sustainable places and communities	Protecting the Community and making Warwickshire a safer place to live	Cross cutting themes/ LAA
	Joint Scrutiny Review										
	The future of WCC's residential care homes for older people, Ron Williamson	To consider the outcomes of the consultation on the future of WCC's residential care homes for older people, prior to Cabinet consideration.		✓	✓			High			
	Long-term reduction in acute beds, Paul Maubach (NHS Warwickshire)	To consider NHS Warwickshire's approach to reducing the demand for hospital beds						High			
9 Feb 2011	Links –Progress Report, Councillor Roodhouse and Nick Gower-Johnson)	To consider the work and progress of the LINk and their future	✓			✓		Med			

BRIEFING NOTES		
Implementation of recommendations – End of Life Care	To scrutinise progress made against the End of Life Care Scrutiny Review *(Alwin McGibbon).*	Received and circulated 02/09/10
Excess Winter Deaths and Fuel Poverty	Update on summit *(Cllr Clare Watson)*	
Director Public Health – Sexual Health Services	Request of the previous committee from concerns raised about uptake of screening programme for Chlamydia, teenage pregnancies etc. Priority also for PCT, LAA targets *(Rachel Pearce)*	Requested by end of Sept

Updated 25 August 2010

Follow up on Community Meals Service Taster Session	Briefing note on response to feedback and details of meals launch *(William Campbell AHCS)*	Requested by week beginning 20th September
Rowan Organisation	Update requested by the Committee at their meeting on 2 March 2010 *(Rob Wilkes AHCS).*	Received and circulated 01/09/10
Supporting People Annual Performance Management	Briefing note –executive summary to be circulated to members Summary *(Rachel Norwood).*	Received and circulated 01/09/10
Lighthorne Heath GP	To update the committee on progress in Lighthorne Heath Surgery *(Rachel Pearce, NHS Warwickshire)*	Requested by end of Sept
NHS Warwickshire –Older People's Mental Health Services in Rugby	Briefing note on responses to NHS Warwickshire's consultation regarding older people's mental health services in Rugby *(Rachel Pearce, NHS Warwickshire)*.	Received and circulated 02/09/10
Caludon Centre – place of safety	Briefing note on what is agreed regarding place of safety (when appropriate *(Paul Maubach, NHS Warwickshire)*	Requested by end of Sept
Dementia Care Working Group	Briefing on progress on implementing the Dementia Strategy *(Jon Reading AHCS).*	Received and circulated 23rd August 2010
Bramcote Hospital	Briefing requested by Councillor Bill Hancox 14.07.2010	
Carers Short Breaks Review	Briefing on the Review of Carers Short Breaks *(Christine Lewington, A,H&CS*) at suggestion of A,H&SC Directorate.	
Annual Report of the Joint Commissioning Strategy for Older People Services	Annual Report of the Joint Commissioning Strategy for Older People Services: Implementation Plan Priorities 2009-2010 *(Julie Humphries*) at suggestion of A,H&SC Directorate..	
Annual Report for the Joint Commissioning Strategy for Physical Disability & Sensory Impairment Services Priorities for 2009-2010	Annual Report for the Joint Commissioning Strategy for Physical Disability & Sensory Impairment Services Priorities for 2009-2010 (*Julie Humphries*) at suggestion of A,H&SC Directorate	

Annual Report of the Quality of Life for an Ageing Population: Implementation Plan 2009 – 2010	Annual Report of the Quality of Life for an Ageing Population: Implementation Plan 2009 – 2010 *(Julie Humphries)* at suggestion of A,H&SC Directorate	