Adult Social Care and Health Overview and Scrutiny Committee

23 February 2011

Agenda

A meeting of the Adult Social Care and Health Overview and Scrutiny Committee will be held at the **SHIRE HALL, WARWICK on WEDNESDAY, 23 FEBRUARY 2011 at 10:00 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) Minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 24 January 2011

(4) 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 Adult Social Care and Health 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. Health Update

The Committee will receive an oral update from Rachel Pearce, Director of Compliance and Assistant Chief Executive, NHS Warwickshire on current NHS issues.

Adult Social Care items

5. Development of Draft Measures and Targets in Support of the CBP 2011-13

Report of the Assistant Chief Executive

Following the approval of the high level Corporate Business Plan on the 15th Feb at full council, this report presents the proposed measures and targets for inclusion relevant to the remit of the Adult Social Care portfolio.

Recommendation

That Adult Social Care & Health Overview & Scrutiny Committee consider and challenge, where appropriate, the draft measures and targets listed within Appendix A that will support the delivery of the Corporate Business Plan 2011-13.

For further information please contact Kim Harlock, Head of Strategic Commissioning & Performance Management, Tel: 01926 745101 E-mail ***kimharlock@warwickshire.gov.uk*** or Tricia Morrison, Head of Performance Partnership & Performance Unit, Tel: 01926 416319 E-mail ***triciamorrisoon@warwickshire.gov.uk***.

6. Living Well with Dementia in Warwickshire

Report of the Strategic Director, Adult, Health and Community Services.

Adult, Health and Community Services, in partnership with NHS Warwickshire, have produced their Dementia strategy in response to the National Dementia Strategy. The strategy sets out the joint key commissioning intentions in order to meet the 17 national objectives. A stakeholder workshop on the 1st March 2011 will further clarify and endorse Warwickshire approach.

Recommendation

It is recommended that the committee:

1. Consider and comment on the Dementia Strategy and Delivery Plan in their draft form.
2. Endorse AH&CS taking this strategy forward to the Dementia stakeholder event on the 1st March 2011 and thereafter to Cabinet and NHS Warwickshire Board in April 2011.

For further information please contact Christine Lewington, Service Manager, Tel: 01926 743259 E-mail ***chrislewington@warwickshire.gov.uk***.

7. Adult Social Care Prevention Strategy

Briefing Note of the Strategic Director, Adult, Health and Community Services.

This Briefing Note sets out the purpose of the prevention strategy, which is to clearly set out the vision, direction and principles of the approach to delaying the need for those with moderate needs entering the social care system and reducing dependency and need for those already in the system through recovery, rehabilitation and reablement,

For further information please contact Kim Harlock, Head of Strategic Commissioning, Tel: 01926 745101 E-mail ***kimharlock@warwickshire.gov.uk*** or
Andrew Sharp, Service Manager, Older People, Physical Disability, Intelligence & Market Facilitation, Tel: 01926 745610 E-mail ***andrewsharp@warwickshire.gov.uk.***

8. Learning Disability Strategy

Report of the Strategic Director, Adult, Health and Community Services.

The attached consultation and communications plan sets out a programme of activity over three months to inform and consult a wide range of stakeholders on the Learning Disability Strategy.

Through the use of material taken from the original consultation workshops with service users and carers, we will demonstrate a positive response to the outcomes people have defined as important to them. This lends itself to the personalisation agenda and supports the concept of individual choice and control.

Using a range of mediums and techniques including the use of easy material, a robust programme of consultation and communication is detailed in the attached documents.

It is proposed that a final report, detailing the analysis of the consultation process, is prepared and presented to Cabinet in June 2011.

Recommendation

The committee are asked to consider the draft joint commissioning strategy for adults with a learning disability 2011-14, and make recommendations to Cabinet as appropriate.

For further information please contact Chris Lewington, Service Manager, Tel: 01926 743259 E-mail ***chrislewington@warwickshire.gov.uk***.

9. Transformation of Day Centre Services within Learning Disability & Physical Disability

Report of the Strategic Director, Adult, Health and Community Services.

As part of the current transformation programme within Adult, Health & Community Services work is being undertaken to review and revise our models of provision for Physical Disability & Sensory Impairment and Learning Disability Day Services. Specifically this work is looking to re-model our approach to the use of building based day services specifically the focus is on the expansion of the use of Direct Payments and Personal Budgets as an alternative to traditional social care interventions.

Recommendation

The committee are asked to:

1. Consider and review the actions already taken by Directorate Leadership Team to re-shape of physical disability services to date including vacating the Ramsden and transferring customers to alternative bases where appropriate.
2. The committee consider the proposed approach and make recommendations to Cabinet.

For further information please contact Christine Lewington, Service Manager, Adult Social Care (for LD), Tel: 01926 743259 E-mail ***chrislewington@warwickshire.gov.uk*** or Andrew Sharp, Service Manager, Adult Social Care (for PD), Tel: 01926 745610 E-mail ***andrewsharp@warwickshire.gov.uk***.

10. Home Care Commissioning Strategy 2011-14

Report of the Strategic Director, Adult, Health and Community Services.

This report outlines proposals for a new Home Care Commissioning Strategy for the period 2011 to 2014. Since the report to Cabinet in February 2010, which included plans to tender existing home care services, further work has been needed to significantly modify our requirements in light of changing financial constraints and the need to increase the pace of modernisation in line with the latest legislative and policy drivers. Committee is asked to consider the draft Home Care Commissioning Strategy 2011-14 and make recommendations to Cabinet as appropriate.

Recommendation

It is recommended that the Committee:

- Consider the draft Home Care Commissioning Strategy 2011-14 and make recommendations to Cabinet as appropriate.

For further information please contact Kim Harlock, Head of Strategic Commissioning, Tel: 01926 745101 E-Mail ***kimharlock@warwickshire.gov.uk***.

Joint Health and Adult Social Care items

11. Work Programme 2010-11

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.

Recommendation

The Committee is recommended to agreed the work programme, to be reviewed and reprioritise as appropriate throughout the course of the year.

For further information please contact Michelle McHugh, Overview and Scrutiny Manager, Tel: 01926 412144 E-mail ***michellemchugh@warwickshire.gov.uk*** or Ann Mawdsley, Principal Committee Administrator, Tel: 01926 418079 E-mail ***annmawdsley@warwickshire.gov.uk.***

12. 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:

North Warwickshire Borough Council:	Councillor Wendy Smitten
Nuneaton and Bedworth Borough Council:	Councillor Bill Hancox
Rugby Borough Council	Councillor Sally Bragg
Stratford-on-Avon District Council	Councillor Helen Haytor
Warwick District Council:	Councillor Michael Kinson OBE

Portfolio Holders:- Councillor Izzi Seccombe (Adult Social Care)
Councillor Bob Stevens (Health)

The reports referred to are available in large print if requested

General Enquiries: Please contact Ann Mawdsley on 01926 418079
E-mail: *annmawdsley@warwickshire.gov.uk*.

Enquiries about specific reports: Please contact the officers named in the reports.

Minutes of the Meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 24 January 2011 at Shire Hall, Warwick

Present:

Members of the Committee

Councillor Martyn Ashford
" Penny Bould
" Les Caborn (Chair)
" Jose Compton
" Richard Dodd
" Kate Rolfe
" Dave Shilton
" Sid Tooth
" Angela Warner
" Claire Watson

District/Borough Councillors

Bill Hancox (Nuneaton and Bedworth Borough Council)
Michael Kinson OBE (Warwick District Council)
Wendy Smitten (North Warwickshire Borough Council)

Other County Councillors

Councillor Richard Chattaway
Councillor Mike Gittus
Councillor Frank McCarney
Councillor Clive Rickhards
Councillor Jerry Roodhouse
Councillor Izzi Seccombe (Portfolio Holder for Adult Social Care
Councillor Martin Shaw
Councillor Bob Stevens (Portfolio Holder for Health)
Councillor June Tandy

Officers

David Alexander, Service Development Officer
Wendy Fabbro, Director of Adult Services
Nick Gower-Johnson, County Localities and Communities Manager
Anne Harrison, Operations Manager
Ann Mawdsley, Principal Committee Administrator
Richard Maybey, Assistant to Political Group (Labour)
Michelle McHugh, Overview and Scrutiny Manager
Ron Williamson, Head of Communities and Wellbeing/Resources

Also Present:

Parminder Bindi, Lawns Social Group
Glen Burley, South Warwickshire Foundation Trust

Roger Copping, Warwickshire LINks
Frances French, League of Friends of the Shipston on Stour Hospitals
David Gee, Warwickshire LINks
Gloria Godfrey, Warwickshire LINks
Paul Maubach, NHS Warwickshire
Kate Morrison, Warwickshire Community and Voluntary Action
Heather Norgrove, George Eliot Hospital
Rachel Pearce, NHS Warwickshire
Shirley Shaw, Coventry & Warwickshire Partnership Trust
John Wheeler, League of Friends of the Shipston on Stour Hospitals
Caron Williams, NHS Warwickshire

1. General

The Chair welcomed everyone to the meeting.

(1) Apologies for absence

Apologies for absence were received on behalf of Councillors Sally Bragg, Jeff Clarke and Helen Walton.

(2) Members Declarations of Personal and Prejudicial Interests

Councillor Penny Bould declared a personal interest as she receives social care as a disabled person living independently.

Councillor Richard Dodd declared a personal interest as an employee of the West Midlands Ambulance Service NHS Trust.

Councillor Jerry Roodhouse declared a prejudicial interest in Item 4 as his wife was employed by Warwickshire County Council, working in one of the residential homes proposed for closure.

Councillor Dave Shilton declared a personal interest in Item 4 as his mother was a resident of the County Council care home.

Councillor Angela Warner declared a personal interest in her role as a GP and in relation to the possibility that her staff or patients may use care homes or respite care.

(3) Minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 12 October 2010

The minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 8 December 2010 were agreed as a correct record with the following corrections:

Page 1 – 1. General (1) Apologies for Absence

Councillor Penny Bould to be added to the Apologies for Absence.

Page 1 – Other County Councillors

Councillor Jerry Roodhouse (Chair of Warwickshire LINks) to be added to the list of Other County Councillors.

Matters Arising

Page 3 – 3. Questions to the Portfolio Holder

Councillor Michael Kinson OBE (Warwick District Council) reported that Ron Williamson had attended the Warwick Council Meeting on behalf of Councillor Izzi Seccombe and thanked him for his useful presentation.

(4) Chair's Announcements

The Chair reminded Members that they had received an invitation to attend a Tobacco Control Advocacy Training Event at Warwick University on Tuesday 8 March 2011. Any Member wishing to attend should use the booking form provided and notify Janet Purcell to be included on their training logs.

The Chair drew Members' attention to the invitation they had received to attend the Dementia Event on 1 March. Any Member wishing to attend, who had not yet replied could do so through Ann Mawdsley.

The Chair stated that the April 13 meeting would include a morning session looking at changes to the Health service. He added representatives from the NHS, GPs, Advisory Services, representatives working on the Transformation Agenda and the Centre for Public Scrutiny would be invited to participate.

2. Public Question Time

The Chair noted that two public questions had been received, but these would be considered under the relevant item (Item 4 – Care and Choice Programme).

3. Questions to the Portfolio Holder

There were no questions to the Portfolio Holders.

4. Care & Choice Programme – The Future of Warwickshire County Council's Residential Care Homes for Older People

The Committee considered the report of the Strategic Director for Adult, Health and Community Services asking the Committee to scrutinise proposals being taken to Cabinet on 27th January to modernise residential social care, taking into account the consultation as well as the demographic and financial challenges facing the Council in this area of service and other strategies which are already being adopted to tackle the issues.

Councillor Jerry Roodhouse presented the following submission:

"*There seems to be a general agreement that the overall direction of travel in regard to care using Extra Care, reablement, personalisation and living independently is right. There is a lot of evidence to support this direction. The outcome from this move will mean that the care sector economy will change as WCC moves closer to just commissioning care from it.*

Transparency in outcomes: a framework for adult social care, forms part of a suite of documents relating to adult social care the most importantly the Vision for Adult Social Care: Capable Communities and Active Citizens 2. Presents the following principles.

Our vision for a modern system of social care is built on seven principles:

***Prevention**: empowered people and strong communities will work together to maintain independence. Where the state is needed, it supports communities and helps people to retain and regain independence.*

***Personalisation**: individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support*

is available for all local people, regardless of whether or not they fund their own care.

***Partnership**: care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils – including wider support services, such as housing.*

***Plurality**: the variety of people's needs is matched by diverse service provision, with a broad market of high quality service providers.*

***Protection**: there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom.*

***Productivity**: greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.*

***People**: we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here.*

In relation to the agenda item and the proposed closure, I need to place on record my opposition to the immediate closure of these homes and ask that the decision be reconsidered as part of the tendering to the market. Abbotsbury care home is a valuable resource and should be used as the main intermediate and respite care facility in Rugby. The closure of this home leaves the eastern side of Rugby without any local home as the demographic for this area is an ageing above the average. There is an opportunity to develop a healthy centre bringing in other agencies and using the total place principles the County should and could enable this to happen. The report is light on dementia care I hope that the County Council will pursue with vigour in all its contracts and make explicit that staff are trained based on the "Enriched Opportunities Programme" developed by Extracare trust and University of Bradford.

I would also like to raise the following questions relating to the proposals.

- *Current projected capacity issues is this right? Page 3 bottom paragraph states ref independent sector "needs to be emphasised that this is a fluid position in that capacity in the private sector is not guaranteed" where is the growth in the market dementia/moving towards more nursing care, then para 2.3 NHSW not subject of this report, who not as the NHS looks to change its provision there is another item on the agenda in relation to Bramcote Hospital?*
- *Whilst the overall strategic approach to changing service delivery looks positive, the consultation versus engagement debate needs to be raised as we saw in the fire station closure programme individuals feel that it is being done to them.*
- *Is a key driver for change and closure the financial savings para 3.3 states 25% savings WCC re Abbotsbury page 19 "potential capital receipt" (also begs the question around the use of the site and any discussions?)*
- *Savings paragraph 10.2 re last sentence "giving away/all of the land and buildings etc relate to this matrix 10.3 and the "waking night cover" I presume this is WCC money? This paragraph is not clear as to how much WCC will be putting in for cover.*
- *Confused by the view that the increase in ECH (non-nominated places) will not be taken up by wealthy folk – thereby also reducing demand for private sector care which might cause some risk to viability of private care homes…so how will we keep an eye on overall market to ensure we have enough capacity of right sort in right place.*
- *Quality and safety standards of care/inspections/dignity WCC homes are good quality homes (para 2.4) and set a standard for others to follow, would you agree? If so, how will you ensure that quality is improved in the care sector? Section 256 funding £6million with NHSW will any of this funding be used to improve the quality and safety?*
- *Respite/day care/carers – where and how will these still be available?*
- *Para 8.4 begs the question as to why not put them all out and see what the market place does?*
- *What does recommendation 4 mean? Contingency arrangement/cost how much/how many people?"*

Having declared a prejudicial interest, Councillor Jerry Roodhouse left the room.

Gloria Godfrey, Warwickshire LINks made the following submission:

"The LINk Council supports the overall proposed model for older people services of increasing the range of ways in which people can retain their independence. However we do have a number of reservations about the current proposals.

The analysis clearly shows that residential places will be needed during the period of development of extra care housing, and beyond that it will continue to be needed for the most vulnerable older people, those with dementia and with the most challenging needs and behaviours, those who will rely on skilled and committed staff and on joint working with health staff and partnerships with communities and other organisations. This is why LINk is doing a project about Dignity in Care Homes to ensure that homes are continuously aware that much is expected of them in this important role.

It is surprising and concerning to the LINk therefore that the report contains no consideration of the role that in-house provision could potentially play in ensuring the best quality, innovative services for this group of people also. Taking dementia as an example, we assume that the Council is not complacent that the current residential care provision and the services and support to carers is as good as it gets – and recognise that there is considerable room for improvement. Perhaps the in-house provision could utilise the investment the County Council has made in training and good conditions of service of the staff by leading the way in developing the range of services and supports that address the needs and anxieties of the growing number of people with dementia, their families and communities.

We also feel that the consultation process has not involved all possible stakeholders. The consultation was limited to those currently living in homes and their families, despite representation from LINk and has not enabled the public, future users of services or communities to have an adequate say. We also do not feel that the proposals have taken sufficient account of the views of residents and relatives – particularly the concern raised at the second consultation that the first re even was a second consultation.

The proposals have been based on the concern that the cost of in-house provision is 40% more than places can be bought in the independent sector. However there has not been any breakdown of the costs, the range of factors that contribute towards them, and we are not told whether it has been investigated if any/all of the elements could be reduced in any way.

Also the comparison with the independent sector is not clear – independent homes do not charge the rate WCC pays unless they have some contracted beds, or some land deal or they are prepared to arrange their fees so that private fee payers subsidise the WCC funded folk. The proposal of JVC allows the possibility of cross subsidy, so would WCC also choose to increase their income by charging full cost (as agreed by Cabinet) in November, but also continuing to admit all those who choose a WCC home rather than restrict places to only those without means (as also agreed at Nov Cabinet), as one means of narrowing the apparent gap.
There are some figures in the report that we have not been able to follow… in Appendix 6(a) – Savings for care homes – there is a 0 figure for dementia customers, but other information indicates 29 dementia places in Stratford.

Also we are not clear whether all potential transitional costs have been identified and included – e.g. will WCC still be admitting new people to the homes or will vacancies push up unit costs further, duplicating the cost of buying the place in the independent sector. Have pension liabilities/redundancies been included, might some properties/sites be left empty whilst disposal/ redevelopment being sorted, incurring security and up-keep costs.

We are not against all change, but we do feel that people should only have to experience a significant change to their circumstances if there is likely to be some benefit to them, and certainly no disadvantage. We had assumed that the CACP would be coordinating new developments in a given locality with full investigation of issues for care home residents in that area and assessing impacts and implications accordingly. This would have ensured that clearer outcomes for individuals could be planned for. We do not feel that the report reassures us about the outcomes for the residents of Abbotsbury/Mayfield and whether, for instance, the strongly expressed concern about maintaining friendships and companionship, will be delivered for them, and it feels that the needs and wishes of the current generation of WCC residents are being overshadowed by those of a future generation of older people and we question the fairness of this. We would urge Cabinet to request specific information about outcomes for residents of Mayfield/Abbotsbury before agreeing the appropriateness of the decisions, and to ensure such analysis is available if other homes become similarly targeted."

Mr Paminder Birdi, attending on behalf of the Social Group attached to the Lawns made a statement to the Committee. He thanked the County

Council and their staff for the excellent care provided in County Council Care Homes, and in particular the Lawns in Whitnash, which was well-run, used to capacity and had received a 2-star rating from CQC for the last few inspections. Mr Birdi made the following points:

i. He urged the County Council to progress Option 2C as set out in the recommendations to the Cabinet (Appendix 4A), adding that the aim in the private sector was to increase profits and the establishment of local community groups would ensure a continuation of service for the community without increased costs.
ii. Would the County Council be able to get the private sector to take up commissioning of beds at the current pricing level and high standards? This looked like a short term solution to a long term problem.
iii. The approach of the Social Group would be similar to the model of school governors, retaining the staff currently running the home with the community running the management side. The Whitnash Town Council had given their support to the proposal and accounting help had been offered on a free basis, as well as free legal support being offered from Wright Hassall Solicitors.

The Chair read out a statement received from Councillor Chris Saint:

"I am sorry that I cannot be at the meeting of the Overview and Scrutiny Committee this morning, but only long standing commitments have prevented my attendance.

I note that the Cabinet, so also the OSC today will ponder over a range of options and it is important to ensure the efficient delivery of services. It is also important to put a wide range of issues in context.

Whereas I support the established moves to enable care at home for the elderly, there remain a number of obstacles. Care at home is not a universal one size fits all option.

A lot of Social Care for the elderly is provided in families. Locally available respite care gives them essential breaks that enables them to cope.

Low Furlong

I represent a local population that has a significant local focus on the residential care home at Low Furlong in Shipston-on-Stour.

While Low Furlong is situated in Shipston-on-Stour, it serves a wide rural area. If residents were displaced, then alternatives could be some considerable distance away.

Family members who support these local residents may have to travel unsustainable distances to visit their loved ones, if there is not a facility local to Shipston. Whilst there are public transport links from Shipston to local towns, Stratford-upon-Avon, Banbury and Chipping Norton, only one of these is in Warwickshire and this is 10 miles away. Onward travel beyond these towns by public transport is often totally impractical.

Many of the parishes in my Electoral Division are classified as having poor access to public services in Warwickshire, a factor when considering rural deprivation.

General Comment

The County Council must ensure that there is sufficient capacity in the alternatives being considered to enable care to be administered locally.

Well established residents of care homes need security in their future as do their families.

Residential care homes contribute to the Council's 'Narrowing the gaps' agenda with a service of established value from public sector involvement alongside the private sector.

Resources are simply not available to bring a wide range of dwellings up to the required specification to enable care at home as a matter of course.

The Council's position as landowner and local authority must underpin the opportunity to guarantee services for those who find it impossible to live in their own homes."

Mrs Frances French Chairman of the League of Friends of the Shipston on Stour Hospitals, read out her public question:

"Considering the high risk residents at Low Furlong in Shipston on Stour, particularly those in the highly valued Dementia Unit, what plans does WCC have to address the wide and varied accommodation needs for vulnerable individuals living within the rural Shipston community, and to promote their quality of life?"

Mr John Wheeler of the League of Friends of the Shipston on Stour Hospitals, read out the following public question from The Shipston Medical Centre:

"*Shipston Medical Centre has worked closely with the staff at Low Furlong for many years and believes the facility to provide an excellent and essential service to those it serves. Low Furlong currently represents the only provision of EMI and residential care in Shipston and surrounding villages, an area where the population of older people is significantly higher than the national average, and the majority of the county. Additionally, Low Furlong provides respite care enabling a significant proportion of older people to remain in their own homes, supported by family and friends.*

The financial constraints upon Warwickshire County Council and the need for service reform are recognised. However, the need for appropriate residential care services in Shipston remains. The practice therefore requests that Warwickshire County Council confirm that alternative provision of services, equivalent in type and quality, will be put in place within the Shipston area before the closure of existing services, if the regrettable decision is made to close Low Furlong. Can you please confirm this?"

Kate Morrison, representing Warwickshire Community and Voluntary Action (CAVA) recorded their support for Option 2c of the recommendations to the Cabinet. She added that there had not been much interest shown by community and voluntary groups due to the lack of wider public consultation and people being unaware of the proposals. She offered the support of Warwickshire CAVA in publicising this option and providing support and advice to interested parties.

Wendy Fabbro, Strategic Director for Adult, Health and Community Services thanked Mr Birdi for his comments in relation to the amount of work carried out by County Council staff and pointed out the effort that had been put in to bring together these proposals, including 140 consultation meetings. She added that it was not the policy of the County Council to close care homes, and these proposals were about modernising the service to ensure that people received the care they wanted, and that services available were good quality and sustainable, including where appropriate, residential care.

Ron Williamson, Head of Communities and Wellbeing/Resources introduced the report and set out the background to the proposals to the Cabinet. He added the following points:

a. In-line with Warwickshire's priority to maximise people's independence, the County Council were working hard with the market to effect change and maintain high quality, appropriate options of care. This included working closely with Warwickshire Care Services.

b. The number of people within residential homes with dementia had increased over the past decade from 9% to 52%. This highlighted the need to continue to develop care for those with high end needs.
c. The consultation carried out in July 2010, focussing on people in residential homes and their needs, was part of a wider strategy that was being worked through since 2008.
d. Keeping services local and the ability to re-provide services within an area were weighted highly in the decision matrix. This explained why Shipston was not high on the list and work was being undertaken to find a solution in this area.
e. There was a large market for respite care and work was being done to continue this provision. This was factored into plans for the future.
f. If closures were agreed, a full team would be involved with families to ensure the right results were achieved for residents and families.
g. In terms of contingencies, the Council had to ensure there were robust processes in place throughout the programme and the ability to work with the market in order to achieve the right outcomes.
h. Challenges faced by different communities was recognised and it was noted that in Low Furlong, there was a real willingness by both Health and Social Care to work together to address all needs, both high and low level. Discussions were also being held with Health around options in Shipston.

Councillor Izzi Seccombe thanked the officers involved for all the effort and commitment on what had been a long and difficult piece of work. She stated that views, concerns and needs of residents and families had been encompassed within the proposals. Councillor Seccombe made the following points:

i. The success of Social Enterprise co-operatives would be reliant on voluntary sector support, particularly in light of ongoing statutory and Care Quality Commission requirements, and the support of Warwickshire CAVA was welcomed.
ii. The County Council would have to continue to commission quality, care and standards to ensure residents in Warwickshire were well looked after.
iii. Every effort would be made to ensure sustainability and continuation while minimising uncertainty for users and families in the future.
iv. The County Council would be working closely with Health to enable people to retain their independence and to keep people out of hospital.
v. The proposals put forward would build in the required capacity, quality and level of support through the market place.

During the ensuing discussion the following was noted:

1. The Customer Engagement Team had operated as flexibly as possible during the consultation exercises, involving families at the request of residents and not interviewing residents who were not capable of participating. Ron Williamson undertook to make enquiries regarding the timing of notification of interviews and the extent of the consultations and to make this information available to the Committee. He added that everything possible would be done to ensure safe passage through the process for residents.
2. Day care and respite care users were consulted in group sessions within homes with those service users who were there at the time, and with all users through postal questionnaires. These services were central to addressing needs and these services would be re-provided where appropriate.
3. The figure quoted in the report of £530 per week covered the running costs of homes and did not include corporate costs. Private businesses were also able to cross-subsidise fees, while local authorities were not allowed to make a profit.
4. In response to queries regarding the closure of Mayfield, it was noted that half of the places available at Mayfield had been closed in 2010 due to lack of demand, despite these places having been offered to people.
5. Low level demands, including milder dementia and physical needs, could be accommodated in extra care housing and residential care in the future would concentrate on high level demands and people with high social care needs with challenging behaviour.
6. The Directorate was facing critical financial issues, and all people currently in receipt of Social Care were vulnerable with challenges and problems. It would not be possible to make savings without impacting on users, but in the future the emphasis would be on responding to significant needs and high level dependency EMI (elderly mentally impaired) and every effort would be made to mitigate that impact.
7. The 10 County Council care homes currently provided approximately 350 beds out of a total of 2,229 beds available in Warwickshire. The majority of beds provided by the County Council were already commissioned through the independent sector. There were many local authorities operating without any in-house care homes.
8. Joint ventures, sale and social enterprise were all part of the available options.
9. If the recommendations were agreed by the Cabinet, formal consultations would be undertaken with affected staff. The trade unions were fully involved already.

10. Members agreed the importance of ensuring information was transparent and accessible throughout the process so that people understood what the situation was at each step.
11. The County Council was not able to offer advice and assistance to potential providers, but would do everything possible to ensure advice was available from other sources.
12. Councillor Izzi Seccombe suggested that the understanding by the public of the procurement process and potential implications for the local community could be built into the proposed 6-monthly reports.
13. There were regulations in place for all care homes to provide stimulation and activities for their residents.
14. David Gee reported that Warwickshire LINks was considering undertaking a programme looking at standards in nursing homes across all sectors in their work programme for the next year.
15. Any group or co-operative was welcome to come forward with an offer within the timescales and requirements set out.
16. The Committee supported the two homes proposed for closure being put to open market prior to any decisions being made on closure.

The Chair, seconded by the Councillor Dave Shilton, moved and a vote was taken with six in favour and four against that:

The Adult Social Care and Health Overview and Scrutiny Committee, having scrutinised the proposals in the report to Cabinet on 27 January in relation to the Future of Warwickshire County Council's Residential Care Homes for Older People, proposes the following recommendations to the Cabinet:

1. That Cabinet notes the rationale and evidence of demand for residential services in the light of the strategic direction and approves closure of two homes, Mayfield and Abbotsbury, calculated to be surplus to requirements, subject to putting the two homes out to the open market for consideration as a joint venture or sale as ongoing concerns as outlined below under recommendation 2.

2. That Cabinet agrees that officers should invite expressions of interest in the following options for procurement in relation to its current internal care homes provision:

a) Purchase of any or all of the homes as "going concerns" maintaining quality and charging in accordance with CRAG regulations.

b) Entering into a partnership with the Council to operate a joint venture company for any homes not eliciting market interest in order to facilitate careful strategic scheduled transformation.
c) Establishing social enterprise/local community co-operatives where quality, safety and value for money can be assured.
d) Exploring further the potential for the Total Place solution in relation to Low Furlong in Shipston.

3. That subject to the outcome of recommendation (2) Cabinet agrees a priority schedule of closures based on the matrix set out in Appendix 3(d), recognising that changes in the data may still affect the actual priority order.

4. That temporary contingency arrangements should be put in place to ensure that sufficient provision is retained in the independent sector to ensure that capacity is retained while closures are implemented.

5. That the Cabinet agree that Overview and Scrutiny monitor all transitional arrangements undertaken under the plan at 6 monthly intervals throughout the whole programme.

6. That the Cabinet agree that Overview and Scrutiny monitor the assurances of quality and standards of care for transferred residents at 6 monthly intervals.

7. That the Cabinet explore the legal position in relation to the transfer of the care home buildings to other providers to ascertain whether a covenant can be embedded within any agreement to ensure that the assets are retained for the elderly and communities within the social care landscape.

5. Bramcote Hospital Consultation

Rachel Pearce, Director Compliance/Assistant Chief Executive, NHS Warwickshire and Caron Williams, Associate Director of Community Services, NHS Warwickshire introduced the reports that had been presented to the NHS Board on the outcome of the consultation in relation to Bramcote Hospital. Rachel Pearce noted that the NHS Board had been recommended to accept Option 3, in line with the consultation, and this had been agreed.

David Gee, Warwickshire LINks, outlined the points referred to in his submission, which had been received by members of the Committee. He stated that the consultation process carried out by NHS Warwickshire had

been flawed and the proposals were flawed as Virtual Wards would take 6-12 months to be in place.

In response, Rachel Pearce noted the following:

i. A variety of views had been expressed at the public meetings and in documented responses and these had been included in the report.
ii. The Nuneaton and Bedworth GP Consortium had supported Option 1 and the North Warwickshire GP Consortium had supported Option 3. The North Warwickshire Consortium had a larger patient base, but the Board had been asked to consider both responses. Assurances had been given to both consortia that with Option 3, the intermediate care service would be enhanced with the purchasing of a further 10 care home beds.

Caron Williams explained virtual wards as the proactive identification of clients who may be subject to increased episodes or use of health care because of unstable long-term conditions. The BUPA health dialogue tool was used to identify people's risk and care plan to reduce their attendance at hospital.

A discussion followed and it was noted:

1. The agreed way forward was about change and reproviding care in peoples' homes. It was acknowledged that there would always be a need for 24 hour access for a small number of people.
2. There was currently capacity within care homes to accommodate the additional 10 beds that had been agreed.
3. The patient admission to Bramcote had been varied, including stroke victims. The changes in acute stroke care had increased the percentage of patients supported to return to their own homes, and this had reduced the number of patients going to Bramcote.
4. There were currently concerns as Bramcote was used to step down from George Eliot Hospital. Assurances were made that more appropriate care would be provided through the capacity in intermediate care and nursing capacity in the area.
5. These proposals formed part of the national Transforming Community Services programme, which included virtual wards, and the pilot on this carried out in North Warwickshire had been very successful.
6. Members agreed to the screening of a video clip on Virtual Wards by NHS Warwickshire at their April meeting.
7. Work was ongoing with the GP consortia to assess the opportunities and changes that would arise from Option 3.

The Chair thanked Rachel Pearce and Caron Williams for their contributions, noting that the decision regarding Bramcote had been an

NHS Warwickshire decision to make. The Committee requested an update in three months.

6. Adult Social Care Annual Performance Assessment Improvement Plan

The Committee considered the report of the Strategic Director for Adults, Health and Community Services outlining the actions being undertaken to address the issues that arose from the Care Quality Commission (CQC) Annual Performance Assessment.

During the discussion that followed, these points were made:

1. In response to a query regarding adaptations, Wendy Fabbro stated that the third set of monies allocated by Government by a Section 256 transfer from the PCT to the County Council, included the capacity to transfer some of that money into adaptations. This was currently being considered with the PCT management.
2. Professionals were keen to ensure that things like telecare were available across the board, but there were no conclusions at this stage in relation to full reablement monies and plans.
3. Wendy Fabbro undertook to e-mail to the Committee the current position in employing Occupational Therapists in different areas of the county, as well as any backlog with adaptations, including trends.

The Committee welcomed the report and endorsed the actions planned to address the areas for improvement highlighted by the CQC. An update was requested for the end of the year, particularly in relation to Outcome 7.

7. The Report of the Adult Social Care Prevention Services Task and Finish Group

The Committee considered the report of the Chair of the Adult Social Care Prevention Services Task and Finish Group setting out the findings and recommendations of the Task and Finish Group.

Councillor Claire Watson thanked everyone for their contributions to the Task and Finish Group, particularly for the valuable support received from Alwin McGibbon, Scrutiny Officer.

The Chair thanked the Task and Finish Group for the work they had done, adding that the recommendations would be useful in moving forward with the change programme.

Wendy Fabbro, Strategic Director for Adult, Health and Community Services acknowledged the work done and supported the recommendations.

During the ensuing discussion the following points arose:

1. Concern was raised at the potential reliance on the Third Sector.
2. Members agreed that there needed to be a focus on including BME communities in this work and that this should be approached with sensitivity.
3. In future when Task and Finish Groups were set up there needed to be more Directorate input into the scopes.

Having considered the Task and Finish Group's Report, the Committee agreed to:

1. forward the recommendations to the Cabinet and appropriate partners for consideration
2. receive a further report on progress in 12 months time.

8. NHS Warwickshire - Update

Paul Maubach, Director of Strategy and Commissioning, NHS Warwickshire updated the Committee on progress made following decisions to reduce activity and the Commissioning Plan for 2011/12, including the long-term reduction in beds.

A discussion followed and it was noted:

1. There were currently two GP consortia in Coventry and four in Warwickshire and NHS Warwickshire were facilitating discussions amongst them.
2. GP consortia would assume full responsibility in 2013, but in practice both Coventry and Warwickshire were working towards establishing in shadow form from April 2011.
3. Some procedures with limited clinical value such as acupuncture would be stopped, but there would be no change to a large number of services. There was currently reduced access for non-urgent cases, especially orthopaedics, but this was a small percentage of the overall totality of procedures.
4. The only service area where spend was disproportionate was the higher provision of nursing home places in the south. This was in line with the number of homes and the aging population.
5. As the health sector looked to become more efficient, PFIs (Public Finance Initiatives) would become more important. This was demonstrated by the fact that over the last year Warwickshire spent £71m on GPs, while £70m was spent by UHCW on resourcing buildings and support services over the same period.

6. The loss of staff that had already occurred at NHS Warwickshire was not felt to be critical, but those remaining were starting to feel stretched.
7. Smoking cessation formed part of the community services which were planned to be transferred to South Warwickshire Foundation Trust. Work was being done to maintain these services as the benefits had been substantial.
8. NHS Warwickshire was keen to work with the County Council on their change programme to reduce costs for both the NHS and County Council and increase benefits for patients. It was agreed that there was more that could be done to emphasise reablement and reduce the demand for institutional care. Wendy Fabbro added that there was a considerable amount of strategic alignment, and the NHS and County Council were seeking the same goals and actions required to achieve these.
9. NHS Warwickshire was working with providers to reduce the number of agency staff being used. In response to a query regarding actual numbers, Rachel Pearce stated that this information could be requested from providers, as well as their quality accounts.
10. In response to a query regarding orthopaedic operations, Paul Maubach reported that urgent cases were still being carried out, but there was a cohort of patients waiting for treatment in April. Work was underway to develop a comprehensive process to dealing with demand, and in particular at the GP level looking at levels of referrals to plan for and make the service as efficient as possible.
11. Councillor Jerry Roodhouse asked whether agreement had been reached in relation to the £6m Section 26 monies. Wendy Fabbro confirmed that she and Rachel Pearce would have to conclude negotiations on this. She added that a letter on how to reach decision had been received, and when read in light of the Bill, the intention was to provide detailed plans by 1 April.
12. Rachel Pearce stated that NHS Warwickshire was required to produce a public document setting out a System Plan. This would be considered by the NHS Board early in March and published at the end of March. She undertook to circulate the Plan to members of the Committee.
13. The biggest challenge initially would be to change clinical behaviour following years of parallel growth, the ability to introduce any treatment quickly and the focus on reducing waiting times. The emphasis in the future would be on doing everything more efficiently and not carrying out services that did not deliver improvement. The challenge over the long-term would be outpatient clinic management, managing emergency care capacity and efficiency and reducing the number of beds in the system.

14. It was acknowledged that the interface between the GP Consortia and the NHS was important.

The Chair thanked Paul Maubach for his presentation. He stated that at the meeting scheduled for 13 April, the Committee would look at the future of the NHS as a whole in Warwickshire.

9. Warwickshire Local Involvement Network (LINks) – Progress Report

The Committee received the report of the Strategic Director for Customers, Workforce and Governance describing recent progress made by Warwickshire LINk and giving an update regarding the work programme pursued by LINk in 2010/11 and seeking to gain views of members on the hosting arrangements which might apply on the expiry of the current contractual arrangement and setting the scene for the transition of LINk into local Healthwatch.

In response to a query from the Chair relating to the opportunity for O&S to consider the work identified under the LINks work programme, Councillor Jerry Roodhouse noted that there was an understanding between the different organisations involved as to where information would go.

There was some discussion about the host organisation, and it was noted that there had been improvement over the past year due to improved levels of professional support.

The Committee agreed to:

a) Note the present position in relation to the Warwickshire Local Involvement Network (LINk).

b) Note the current work programme of the LINk for 2010/11 and request that appropriate completed reports be brought to O&S for comment.

c) Notes the position in relation to the transition of the LINk into local Healthwatch.

d) Notes the need to put into place new arrangements for the hosting of the LINk with effect from 1 April 2011 and steps being taken to progress this.

10. Work Programme 2010-11

Members noted the revised work programme, taking into account suggestions made during the meeting.

11. Any Other Business

None

……
Chair of Committee

The Committee rose at 15.25 p.m.

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care And Health Overview & Scrutiny Committee**
Date of Committee	**23rd February 2011**
Report Title	**Development of Draft Measures and Targets in Support of the CBP 2011-13**
Summary	Following the approval of the high level Corporate Business Plan on the 15th Feb at full council, this report presents the proposed measures and targets for inclusion relevant to the remit of the Adult Social Care portfolio.

For further information please contact:	Kim Harlock Head of Strategic Commissioning & Performance Management Tel: 01926 745101 kimharlock@warwickshire.gov.uk	Tricia Morrison Head of Performance Partnership & Performance Unit Tel: 01926 416319 triciamorrisoon@warwickshire.gov.uk

Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	Cabinet Report 27/01/2011 Corporate Business Plan 2011 – 13, Full Council Report 15/02/2011 Corporate Business Plan 2011-13

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	
Local Member(s)	☐	NA
Other Elected Members	☐	
Cabinet Member	☐	All Portfolio Holders
Chief Executive	☐	Jim Graham
Legal	☐	Jane Pollard
Finance	☐	
Other Strategic Directors	☐	
District Councils	☐	

Warwickshire County Council

Health Authority ☐

Police ☐

Other Bodies/Individuals ☐

FINAL DECISION

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 5

Adult Social Care and Health Overview & Scrutiny Committee - 23rd February 2011.

Development of Draft Measures and Targets in Support of the Corporate Business Plan 2011-13

Report of the Head of Strategic Commissioning & Performance Management and Head of Performance Management

Recommendation

That Adult Social Care & Health Overview & Scrutiny Committee consider and challenge, where appropriate, the draft measures and targets listed within Appendix A that will support the delivery of the Corporate Business Plan 2011-13.

1.0. Background

1.1. The high level Corporate Business Plan (CBP) will have been approved by Council on 15th February 2011 identifies where we are going by articulating our repositioned ambitions and outcomes for 2011-13 and sets out how we will achieve them.

1.2. Following Cabinet's approval of the ambitions and outcomes contained within the CBP, the fist draft set of measures and targets in support of these were considered by members of the Corporate Performance Group under the Chairmanship of Cllr Bob Stevens on the 7th February.

1.3. This paper brings together the first draft of measures and targets that are relevant to the Adult Social Care & Health portfolio for inclusion within the Corporate Business Plan.

2.0. Approach

2.1. In previous years, the Corporate Business Plan, containing the measures and targets, has traditionally been set over the three-years and were reviewed as part of the annual review and refresh cycle.

2.2. The Corporate Business Plan takes the Organisation through to 2013 in reflection of the Government's move to the provision of two year grant settlements and sees the Council through to the end of the current Administration.

2.3. With the abolition of the National Indicator Set, we are now in a position to develop more locally appropriate measures that reflect and support the ambitions for Warwickshire.

2.4. All Directorates have been involved in developing the draft measures and targets and the CBP will be supported by a suite of Directorate Business Plans which in turn will shape the work of service, division, team and individual plans thus ensuring the delivery of our outcomes.

2.5. In some areas, new measures have been developed by directorates as these are the only measures the Service has to ensure that they are meeting both corporate and operational needs. For these new measures, we are unable to provide targets for 2011/12, as this year will provide the baseline from which future targets will be set.

2.6. The proposed measures and targets included in the Corporate Business Plan will also be picked up in the relevant Directorate Business Plan and performance against all of these indicators will be managed through the performance reporting process.

2.7. The outcomes presented in the high level CBP have been formally approved by full Council on the 15th February. We now need to consider and challenge where appropriate the proposed draft measures that support these agreed outcomes and the following principles should form the basis for this judgment

Principles for developing the right Measures and Targets: Together they should:-

- ☆ Articulate and specify what we will do and how we will do it in the pursuit of the overall objective(s)
- ☆ Identify and achieve accountability
- ☆ Ensure we have a clear, shared understanding about what we are trying to achieve, and that this is cascaded down through the whole organisation
- ☆ Make these aims measurable, so as to focus planning and to make managing performance meaningful
- ☆ Quantify the impact of increased, re-directed or decreased resources can have upon performance

2.8. A more detailed guide to setting measures and targets is available through the performance pages of the Intranet.

3.0. Next Steps

3.1. The high level Corporate Business Plan will have been considered by Full Council at its meeting on the 15th February alongside the Council's budget-setting proposals.

3.2. Throughout February, March and April, each Overview and Scrutiny Committee is being asked to consider and challenge where appropriate, the measures and targets by which to assess progress on delivering the ambitions articulated in the Corporate Business Plan.

3.3. The full suite of measures is to be presented to Overview and Scrutiny Board on the 10th March.

3.4. Following this consultation, the final suite of measures will then be considered by Cabinet at its April meeting and once adopted these measures will form the accountability base for the Corporate Business Plan once it goes live in April 2011.

3.5. Additionally, the WCC Performance management framework is being reframed in light of the changing landscape and central government requirements and this review includes consideration of the best ways to engage with a range of stakeholders in performance management.

3.6. At the next Member Performance Reporting group and the forthcoming Member Seminar on the 3rd March this will be discussed further.

4.0. Recommendation

4.1. Consider and challenge, where appropriate, the draft measures that support the agreed outcomes that are listed within Appendix A using the Principles of developing good measures and targets as set out in 2.7 of this report.

Kim Harlock
Head of Strategic Commissioning & Performance Management
Adult Social Care & Health
Shire Hall
Warwick

Tricia Morrison
Head of Performance
Partnership & Performance Unit
Shire Hall
Warwick

Appendix A

Ambition 3 Care and Independence

We aim to:

- Fulfil our duty of care to older and vulnerable people
- Ensure that all those eligible are offered an adult care personal budget
- Increase the scope of re-ablement services
- Improve numbers of older people living independently in their own homes
- Continue improving our relationship with Health services whilst managing changes to the Health community
- Embrace the Public Health Service within our responsibilities

Outcome	Measure	Target		
		2011/12	2012/13	2013/14
Warwickshire's residents have more choice & control	(NI136 derivative) The proportion of those using social care who have control over their daily life (high is good)	New measure baseline to be set following 2011/12 results		
	The proportion of people using social care and carers who express difficulty in finding information and advice about local services (survey based – low is good)	New measure baseline to be set following 2011/12 results		
The number of home care packages is decreased	Proportion of older people (65+) who are still at home after 91 days following discharge from hospital (high is good)	New measure for 2011/12. Arrangements being made with PCT to record this		

Outcome	Measure	Target		
		2011/12	2012/13	2013/14
Warwickshire's vulnerable residents are supported at home	Admissions to residential care homes per 1,000 population (low is good)	54.0	50.0	TBC
	(NI130 exact match) Proportion of people using social care who receive self directed support (high is good)	45%	60%	75%
Residents of Warwickshire have greater access to specialist residential care	(NI131 exact match) Delayed transfers of care (low is good)	15.0	10.0	TBC
The successful transfer of the Public Health Service to the Local Authority*	Arrangements of the Shadow Health Well Being Board in place no later than April 2012 Further measures to be developed following the first shadow health & well being board meeting March/April 2011	Project Plan on Track Yes / No + commentary		

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview and Scrutiny Committee**
Date of Committee	**23rd February 2011**
Report Title	**Living Well with Dementia in Warwickshire**
Summary	Adult, Health and Community Services, in partnership with NHS Warwickshire, have produced their Dementia strategy in response to the National Dementia Strategy. The strategy sets out the joint key commissioning intentions in order to meet the 17 national objectives. A stakeholder workshop on the 1st March 2011 will further clarify and endorse Warwickshire approach.
For further information please contact:	Christine Lewington Service Manager Tel: 01926 743259
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 Watson, Councillor C Rolfe, Councillor R Dodd
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	☒	Councillor Mrs J Compton, Dementia Champion

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

FINAL DECISION NO

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☒	Date to be agreed following December consultation event
To an O & S Committee	☐	....
To an Area Committee	☐	.....
Further Consultation	☒	1st March 2011 key stakeholder event

Agenda No 6

Adult Social Care and Health Overview and Scrutiny Committee – 23rd February 2011

Living Well with Dementia in Warwickshire

Report of the Strategic Director of Adult, Health and Community Services

Recommendations

It is recommended that the committee:

1. Consider and comment on the Dementia Strategy and Delivery Plan in their draft form.
2. Endorse AH&CS taking this strategy forward to the Dementia stakeholder event on the 1st March 2011 and thereafter to Cabinet and NHS Warwickshire Board in April 2011.

1. Background

1.1 This strategy describes Warwickshire's response to the National Dementia Strategy and sets out our joint commissioning intentions for people with dementia and their families.

The changing context, at both national and local level, requires us to prepare a strategy which, in uncertain times, sets out a clear vision underpinned by health and social care commitment to dementia. This strategy acknowledges this and has therefore been written in the context of an environment that is unpredictable and challenging in terms of continuous financial changes.

The accompanying strategy Living Well with Dementia in Warwickshire 2011 - 2014 takes its vision and future direction of travel from the National Dementia Strategy (NDS) along side other key national drivers. This draft strategy sets out the direction of travel for Warwickshire and has been developed in partnership between NHS Warwickshire and Warwickshire County Council's Adult Social Care Directorate.

2 Profile and Context

2.1 Warwickshire has a population of 535,000 of which 95,000 people are over the age of 65 years. Locally, it is estimated that over 7,000 people currently live with dementia and this is estimated to increase by 34% over the next ten years.

Those over the age of 85 years are more likely to acquire dementia in later life and given the projected increases within this age bracket this is likely to have a

significant impact on health and social care services as well as informal support.

Warwickshire is predicted to have the 3rd highest number of people living with dementia by 2028 in comparison to the rest of the PCTs in the West Midlands. In addition, based on prevalence rates and population projections there will be significantly more women than men living with dementia in Warwickshire.

2.2 **National, Regional and Local Strategy**

2.2.1 The National Dementia Strategy has set the strategy across four broad themes;

- Raising awareness and understanding.
- Early diagnosis and support
- Living well with Dementia
- Making the change

The need to make the wider public much more aware of dementia and its impact on individuals and those close to them given the stigmas associated with dementia. In addition further public health work needs to focus on informing the general public of the causal effects to dementia around lifestyle issues such as; levels of alcohol consumption.

Early diagnosis continues to be a national issue. The main concern is the delay in people being formally diagnosed with dementia which denies them and their families opportunities to plan for the future. Living well with Dementia focuses on better integrated and joint plans to support people well during the life course of their illness. This incorporates the need to ensure that people are not admitted to hospital unnecessarily, are support well through the discharge process back to home, and that family carers are well supported to maintain their caring role for as long as possible. Making the change emphasises the importance of joint working and decisions taking.

3. Warwickshire Dementia Strategy 2011 – 2014

3.1 Warwickshire's Dementia Strategy 2011 - 2014 is underpinned by several key principles encompassing a personalised approach.

- Wherever possible people with dementia should be enabled to live in their own homes.
- People with dementia and their carers are entitled to expect appropriate access to a range of support options regardless of where they live within the County i.e. there should be geographical equity but with due regard to local needs.
- The principles of choice control and personalisation should apply to all customer groups. There should be an assumption that people with dementia have the capacity to exercise choice and control unless there is compelling evidence to the contrary
- People with dementia and their access should have access to multi-disciplinary teams and joined up services
- Good quality information and advice should be available to people with dementia and their carers throughout the care pathway.
- A good second option is extra care housing which has support available

24/7 and can be a good option for some, given the appropriate building design and support.

- People with dementia should be treated with dignity and respect not least during end of life.

3.2 The Strategy provides evidence of the valuable work to date across health and social care. It places Warwickshire in a good position to respond well to the objectives within the National Strategy and the outcomes it desires.

Using the 17 National Objectives, Warwickshire Dementia Strategy provides strong evidence of progress and sets a clear direction for the commissioning intentions for health and social care over the next three years.

3.3 An agreed Dementia Care Pathway has been developed and forms the foundation for future integrated working across health and social care. Developed in partnership, the Dementia Care Pathway is a useful visual tool for people with dementia and their carers, a road map for staff engaged in supporting people and a performance tool to evidence progress against key objectives and milestones over the next three years.

The Dementia Care Pathway has four key components; Early Stage, Mid Stage, Latter Stage and End of Life. Contained within each component are the attributes that constitute high quality services across health and social care. Where there are current gaps, these form the basis of the commissioning intentions and combined will constitute the delivery plan for the Dementia Strategy.

4. Commissioning Intentions

4.1 Based on a thorough market analysis and by shifting resources away from the point of crisis and instead towards early intervention and within available resources the commissioning intentions include:

Key Theme 1: Awareness and Understanding

- Address the understanding of some of the causal affects of dementia and promote healthier lifestyles through the prevention strategy.
- Provide universal information and advice for everyone about dementia.
- Have available advocacy services, including IMCA and access to support to develop living wills.
- Include dementia awareness in induction training for employees within the NHS, Council and partner organisations.
- Ensure any awareness campaign is coordinated with the development of services to ensure that any additional demand that is created through improved awareness is able to be responded to.

Key Theme 2: Early Diagnosis and Support

- Improve referral to the Memory Assessment Services to increase the number of people diagnosed early with dementia.
- Implement the agreed Dementia Care Pathway for Warwickshire.

- Work with GPs to review/remove/decrease the inappropriate use of medication which is a particular issue in care homes and which poses medical risk in older people by xxx
- Review the Dementia Advisor service in the North of the county and the role of the Admiral Nurses including cost effectiveness, to agree model for future provision.
- Commission specialist carer education and support programmes to ensure Carers are equipped with the skills and confidence to manage at home.
- Have access to effective peer support including Alz's/Joe's cafes countywide.
- Establish a referral route to the IAPT services for people newly diagnosed with dementia.
- Improve the awareness and use of advance directives and advance care planning for people with a diagnosis of dementia.

Key Theme 3: Living Well with Dementia

- Utilise personal budgets (and personal health budgets) for people with dementia and carers, to develop innovative and flexible services to support individual needs.
- Increase the take up of Direct Payments by 25% by 2014.
- Increase the use of reablement by 15% for people with dementia.
- Increase the use of intermediate care at point of discharge by 20% by 2014 for people with dementia.
- Promote referral route to aids and adaptations, in particular continence care.
- Jointly review the use of building based day provision and reduce by 30% by 2014.
- Increase the use of intermediate care at point of discharge by 20% by 2014.
- Move to a model of flexible day care support for people with dementia, this will include day and night (24hr) options for support.
- Review respite provision to increase the range and type available
- Commission a range of community based general services that have appropriately trained staff able to respond to people with dementia and promote recovery and continue to enable independence.
- Commission residential and nursing care contracts that reflect the commissioning intentions laid down in the NDS, i.e. an identified Dementia Champion in the home, jointly commissioned in reach services to care homes through CMHT OP services, reduction and adherence to protocols for use of anti-psychotic drugs use.
- Dementia appropriate End of Life services that support individuals to have a 'Good Death'.
- In commissioning housing related support we will work with housing partners, supporting people, housing associations, extra care providers and independent care homes to;
- Through service re-design and within existing resources commission specialist dementia residential care units within key areas of the County each incorporating the provision of respite.
- Decrease the use of residential care by 20% over the next three years at the point of discharge.

- Make available at least 25% of extra care units to people with dementia within the Care & Choice Accommodation Programme.
- Commission a range of housing options that better meet the specialist needs of people with dementia. Include offering people the option (early) of living in Extra care ensuring that families see Extra Care housing as a viable option for people with Dementia.
- Ensure that the supporting people programme offers appropriate housing related support to people with dementia.
- Increase the use of assistive technology to support people to live at home by 10%

Key Theme 4: Managing the Change

- Developing a joint health and social care Workforce Development
- Strategy train 30% of staff to ensure a competent and confident workforce underpinned by the findings from the recent Dementia Education Projects research and outcomes of other regional projects e.g. Strategic Health Authority initiatives
- Including people and their carers in the delivery and evaluation of learning programmes where *appropriate/possible.*
- Ensuring all relevant workers complete a level one development programme.

5. The Delivery Plan

5.1 The Delivery Plan sets out the key tasks and actions to ensure that the commissioning intentions are delivered across health and social care over the next three years. The Delivery Plan has been attached for illustrative purposes only. Although some elements of the plan have been agreed there remain areas for further discussion which will take place at the workshop scheduled for the 1st March 2011. By setting the actions within the context of this delivery plan, both health and social care will be in a good position to monitor progress robustly.

6. Financial Envelopment and Projections for 2011 - 2014

6.1 With the significant financial pressures faced by NHS Warwickshire and Warwickshire County Council combined, coupled with demographic pressures that are well known, any changes in services must ensure the best use of resources to place health and social care in a good position to meet growing demand.

6.2 The financial envelope for dementia services is difficult to quantify given the links with older people services. The spend on people with dementia and their carers is calculated to be in the region of between £8 – 11 million for adult social care. The table below illustrates the current budget for dementia services within adult social care.

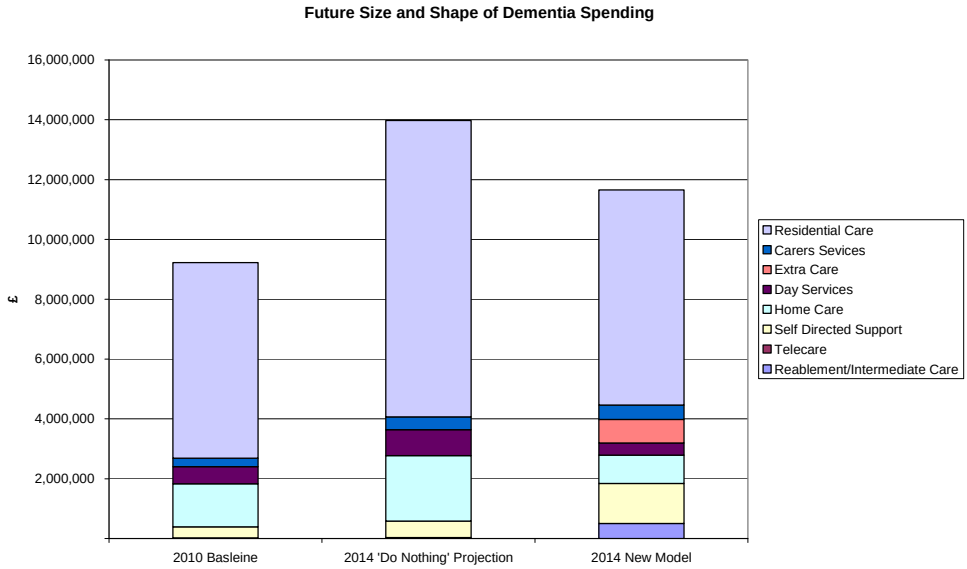
Estimated Total Dementia Expenditure

2010/11 Forecast	External Services - Older People Mental Health Client Group	Internal Services	LD Services - Customers Over 55	Total
Transport	26,771			26,771
Homecare	938,045			938,045
Daycare	670,630			670,630
Residential E.M.I	9,829,465			9,829,465
Respite E.M.I	137,364			137,364
Direct Payments Ongoing	416,058			416,058
Direct Payments One Off	11,520			11,520
Service Level Agreements				0
Internal Dementia Residential Care		711,750		711,750
Internal Dementia Residential Respite Care		162,655		162,655
Internal Care Home Dementia Day Care				
Internal Dementia Homecare		743,308		743,308
Sub Total - Gross Expenditure	**12,029,852**	**1,617,713**	**0**	**13,647,565**
Reimbursements	(118,662)			(118,662)
Residential Charges	(3,820,415)			(3,820,415)
Respite Charges	(15,123)			(15,123)
Estimated Charges for Community Care Services	(309,453)			(309,453)
Estimated Charges for Internal Services		(183,047)		(183,047)
Sub Total - Gross Income	**(4,263,654)**	**(183,047)**	**0**	**(4,446,701)**
Total Net Expenditure	**7,766,198**	**1,434,666**	**0**	**9,200,864**

6.3 Health financial data has not been included in these figures or the projections discussed below. But estimates received from health colleagues indicates a spend of approximately £12 million for continuing health care and home care.

6.4 In developing this strategy, we have, for the first time, explored the feasibility of combining demographic and inflation pressures (the push) against service re-engineering, so for example spending more on telecare to reduce spend on residential care to give an illustration of the potential impact on the financial envelope. Whilst this is indicative only, it provides a valuable demonstration of the potential benefits (or otherwise) of key commissioning and service redesign decisions.

The projections for 2011 – 2014 using this methodology illustrates that whilst there will be some good outcomes and financial benefits there remains a budget pressure for this client group.



6. Next Steps

6.1 A workshop has been design for the 1st March 2011. The purpose of this workshop is to a) consult on the overall direction of the strategy b) work collectively to agree the joint delivery plan and c) begin to form the basis of the government structure for the implementation process. The workshop is seen as a positive opportunity to pull all strands of the strategy together to seek overall endorsement and a collective ownership.

6.2 It is further proposed that the Dementia Strategy is presented to Cabinet in April for their consideration and approval.

6.3 Once agreed, it proposed to review the current governance structure to ensure that it aligns to the Health and Wellbeing Board who should be considered overall custodians of this strategy.

The following steps are offered as a way forward:

1. Stakeholder Consultation event – 1st March 2011
2. O & S Committee approval to progress to consult widely
3. Period of consultation with key stakeholders including service users and carers
4. Revised joint governance structure established that feeds into the forming Health and Wellbeing Board.
5. Leads identified within NHS Warwickshire and Adult Social Care.

WENDY FABBRO
Strategic Director of Adult,
Health and Community Services

Shire Hall
Warwick
27th January 2011

Living Well with Dementia in Warwickshire

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Contents

0 Dedication

This strategy is dedicated to the memory of Marion Grimwood 1929-2010, a founder member of the Warwickshire Older Peoples Partnership Board and the Dementia Task group. Marion was a relentless and passionate campaigner for quality older people's services in Warwickshire and a leading Dementia Champion locally.

1 Foreword

On behalf of the Dementia Task Group and Older Adults Policy Board we are pleased to present this first Dementia Strategy for Warwickshire.

This is the first time that agencies have come together to both consult and then produce a joint strategy and is further evidence of our intention to work together on an issue that matters in Warwickshire. Dementia is a complex and perplexing condition and includes a number of complex conditions the most common of which is Alzheimer's disease.

"We must not forget that people over the age of 55 fear dementia more than any other condition, including cancer. Yet public awareness about Dementia, its symptoms, the importance of getting a diagnosis and the help available for those with the condition has been very limited." Alzheimer's Society.

This strategy is Warwickshire County Council and NHS Warwickshire's response to the National Dementia Strategy. It sets out current initiatives designed to improve the lives of people with dementia, their carers and families, enabling them to have a more fulfilled life. It is the culmination of two years of work led by the Dementia Task Group. The Dementia Task Group comprises of a group of multi-agency professionals, carers and service users. It is anticipated that the commissioning process will take five years in total to deliver and is a whole system transformation supported by collaboration of all agencies working to improve both the experience and outcomes of people with dementia and their families.

Warwickshire believes that in taking forward this strategy that:

- People's experience of having Dementia and the services they receive will improve, for them personally and for those individuals and families caring.
- Levels of public awareness and understanding will improve and
- The stigma associated with Dementia will reduce as people become more aware of their diagnosis, what support and services are available to them, and how they can in turn keep well and live longer supported in the community of their choice.

We would like to thank all members of the Dementia Task Group, the Dementia Project team and the Phoenix Group - a North Warwickshire Peer support group for Dementia users and their carers - who gave and continue to give their time, energy and attention to the preparation of this strategy. Without their hard work this strategy would not exist.

Cllr Jose Compton
Dementia Champion
Warwickshire County Council

John Linnane
Director of Public Health
NHS Warwickshire

2 Purpose of Document

The purpose of this document is to inform all people living and working with dementia on how Warwickshire County Council and NHS Warwickshire, in partnership, are taking forward the National Dementia Strategy and other supporting papers locally. This document covers how we currently commission services and how we propose to commission in the future. Future commissioning is set in the context of well publicised financial restraints but with a focus on quality. In line with Personalisation, an emphasis on choice and control for service users and their carers will be paramount moving forward.

Overall Aim of the Strategy

By 2014, all people with dementia will have access to high quality integrated services across health and social care from highly skilled staff.

3 Introduction

3.1 What is Dementia?

Dementia is a long term condition with a high impact on a person's health, personal circumstances and family life. Alzheimer's disease is the most common form of Dementia and is generally diagnosed in people over 70 years of age. As well as having a profound impact on the individual, Dementia can also have high impact on family members and friends.

"Dementia results in a progressive decline in multiple areas of function, including memory, reasoning, communication skills, and those skills needed to carry out daily activities. Along side this decline, individuals may develop behavioural and psychological symptoms such as depression psychosis, aggression and wandering, which complicate care." *(National Dementia Strategy 2010)*

3.2 Why Do We Need a Dementia Strategy?

There is considerable evidence that supporting good practice for people with dementia and their carers can better the quality of their lives and reduce care costs. Some of the key research findings are summarised below:

- Providing people with a diagnosis decreases their level of anxiety and depression. *(carpenter et al 2008)* Only around 30% of people with dementia have a formal diagnosis made *(National Audit Office 2007)*
- Early diagnosis and intervention have a positive effect on the quality of life of people with dementia *(Mittelman et al 2007).* People often wait up to three years before reporting symptoms of dementia to their doctor *(Alzheimer's Society 2002)*
- Early provision of support at home for people with dementia can reduce institutionalisation by 22% *(Gaugler et al 2005).* A brief program of support and counselling diagnosis alone has been demonstrated to reduce care home placement by 28% (Mittelman et al 2007)
- People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation, but this is not widely appreciated by clinicians, managers, or commissioners. *(Royal College of Psychiatrists 2005)*

3.3 What people with dementia and their carers have told us

People in Warwickshire want to be well informed and to know where to go to; to get good quality information, advice and a timely diagnosis when they are ill. The same applies for those with Dementia.

Users and Carers tell us that services are different across the county, access to these services is not always timely and support, information and advice limited. You want confidence to know that any services provided to you or the person you care for are of the highest quality.

You have told us that once diagnosed with Dementia we needed to develop a range of services that fully meet your changing needs as both an individual and those of your carer/supporter.

Extra care housing, telecare and assistive technology are an integral part of services for people with dementia, if improving quality of care and maximising choice, independence and control are to be achieved. Housing should be based on need not the environment in which it is provided.

Users and Carers applauded the National Dementia Strategy recommendation for an informed and effective workforce.

For a full detail of what people with dementia and their carers have told us please go to Appendix 1

National And Local Context

4 National Policy Context

This strategy is informed by key national reports and policy documents:

The National Dementia Strategy, 'Living Well with Dementia' Dept of Health February 2009 overarching goal is for people with dementia and their carers to be helped to live well with dementia, no matter the stage of their illness or whether they are in the health and social care system. The vision to achieve this is divided in three parts:

- To encourage help-seeking and help-offering by changing public and professional attitudes, understanding and behaviour towards dementia.
- To make early diagnosis and dementia treatment the rule rather then the exception. This will be achieved by locating the responsibility for the diagnosis of mild and moderate dementia in a specifically commissioned part for the system that can make an accurate diagnosis, communicate the diagnosis sensitively to those affected and provide individuals with immediate treatment, care and peer and professional support as needed.
- To enable people with dementia and their carers to live well with dementia by the provision of good quality care for all with dementia from diagnosis to the end of life, in the community in hospital and in care homes.

The **Quality Outcomes for people with dementia: building on the work of the National Dementia Strategy. Dept of Health September 2010** reinforces and builds on the strategy above and states:

Good quality early diagnosis and intervention for all - Two thirds of people with dementia never receive a diagnosis; the UK is in the bottom third of countries in Europe for diagnosis and treatment of people with dementia; only a third of GPs feel they have adequate training in diagnosis of dementia.

Improved quality of care in general hospitals - 40% of people in hospital have dementia; the excess cost is estimated to be £6m per annum in the average General Hospital; co-morbidity with general medical conditions is high, people with dementia stay longer in hospital.

Living well with dementia in care homes - Two thirds of people in care homes have dementia; dependency is increasing; over half are poorly occupied; behavioural disturbances are highly prevalent and are often treated with antipsychotic drugs.

Reduced use of antipsychotic medication - There are an estimated 180,000 people with dementia on antipsychotic drugs. In only about one third of these cases are the drugs having a beneficial effect and there are 1800 excess deaths per year as a result of their prescription.

It is underpinned by **The Vision for Adult Social Care: *Capable Communities and Active Citizens*** sets out the Government's ambition for personalisation and states that:

' the Government's values of freedom, fairness and responsibility, shifting power from central to local, from state to citizen, from provider to people who use services. Our ambition is to foster the conditions in which communities… and others can develop a diverse range of preventative and other support that will help to reduce isolation, improve health and well-being and, by doing so, better manage the demand for formal health and care.'

The paper goes on to state that:
'Better use of existing community-based services, for example step-down reablement or home improvement and adaptations, can also reduce demand for nursing and residential care. We expect councils to look closely at how they can reduce the proportion of spending on residential care through such improvements to their community-based provision.'

The NHS Operating Framework 2010-2011(Revised)

The Dept of Health, in the Quality Outcomes for people with Dementia report, identified, through the Strategic Health Authority monitoring process, that dementia was not given sufficient attention by PCTs. In the revised NHS Operating Framework it now states:

'NHS organisations should be working with partners on implementing the National Dementia Strategy. People with dementia and their families need information that helps them understand their local services, and the level of quality and outcomes that they can expect. Localities should publish how they are implementing the National Dementia Strategy to increase local accountability for prioritisation.[1]*'*

NHS Warwickshire has identified Dementia as one of its key priorities for 2011/2012.

Combined, these national strategy documents confirm that because of the projected increase of dementia and its associated costs there needs to be better joint provision which enables people to prepare and plan for their care that supports them to live well with dementia.

It is also worth noting that this strategy will be implemented during a difficult and well documented financial climate. More than ever investments will need to demonstrate that key outcomes are being delivered in an effective and efficient manner.

[1] Quality outcome for people with dementia: building on the work of the National Dementia Strategy 2010.

6.1 Local Policy Context

The Adult Social Care Transformation Programme underpins the development of this strategy. This whole systems transformation incorporates:

- Self directed support to become mainstream ensuring people have maximum choice and control
- Less time spent on assessment and more on support planning and brokerage
- Access to universal information, advice and signposting for all people irrespective of their eligibility for public funding.
- Personal budget for everyone who is eligible for public funded support
- An increase in the take up of Direct Payments
- Family carers treated as experts through experience and support to mainstream their caring role and to have a life outside of caring.
- A skilled and informed workforce
- Commissioning that stimulated and incentivises high quality services that provides high quality services.

5 Population Profile and Future Demand

5.1 The prevalence of Dementia nationally

Dementia presents a huge challenge to society both now and increasingly in the future. The Alzheimer's Society statistics tells us there are currently 750,000 people living with dementia in the UK[2]. This represents one person in every 88 (1.1%) of the entire UK population. By 2021 there will be over 940,000 people living with dementia and this is predicted to soar to 1.7 million by 2050, this represents a 125% increase in the number of people living with dementia between 2010 and 2050, or 3% per year.
Oldest age is the largest risk factor for dementia. Around 68% of people with dementia are over 80 years of age, but there are over 16,000 people (2%) under the age of 65 who have the illness.

It is estimated that there are currently 735,000 people are currently living with late onset dementia in the UK. The table below show the prevalence rates for late onset dementia (aged 65 and over) per 100,000 of the population[3]. It shows that the prevalence of dementia rises substantially with increased age, on average almost doubling every 5 years between the ages of 65 and 94. There is a higher prevalence of late onset dementia for females aged over 75, population statistics tell us that the life expectancy of women is longer than men meaning there will be more women than men living with dementia. Overall The Alzheimer's Society estimates that approximately two women for every man living with dementia[4].

Prevalence of Late Onset Dementia – per 100,000 Population

		Female	Male	Total
Late Onset Dementia	65-69	1,000	1,500	1,300
	70-74	2,400	3,100	2,900
	75-79	6,500	5,100	5,900
	80-84	13,300	10,200	12,200
	85-89	22,200	16,700	20,300
	90-94	29,600	27,500	28,600
	95+	34,400	30,000	32,500

The table below show the prevalence rates for early onset dementia (aged between 30 and 64) per 100,000 of the population[5]. Young onset dementia is comparatively rare, accounting for 2.2% of all people with dementia in the UK, the Alzheimer's Society estimate that there are now 16,000 people with young onset dementia in the UK. However, given that data on the numbers of young onset cases are based on referrals to

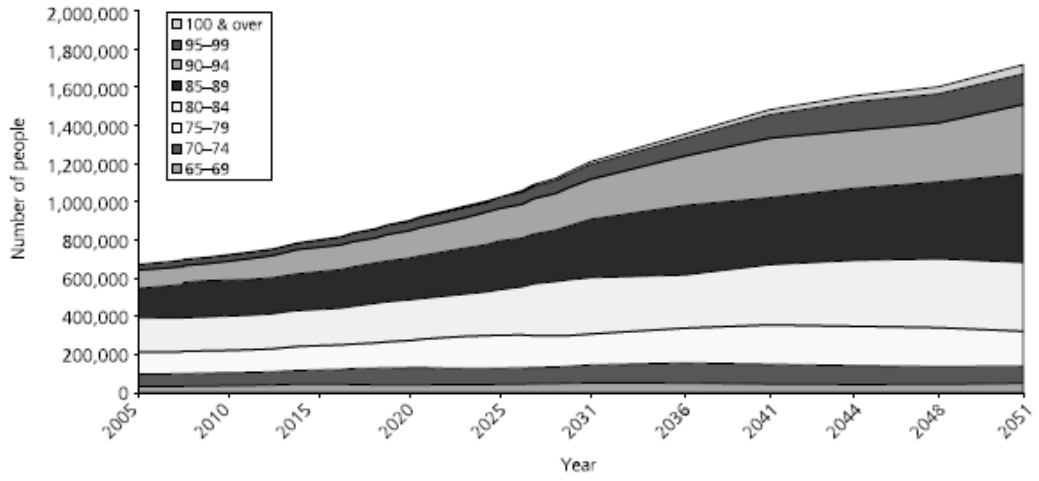
[2] Alzheimer's Society (http://www.alzheimers.org.uk)
[3] 'Dementia UK', 2007 - Alzheimer's Society
[4] Alzheimer's Society (http://www.alzheimers.org.uk)
[5] 'Dementia UK', 2007 - Alzheimer's Society

services, this number is likely to be an underestimate, the true figure may be up to three times higher. The prevalence of early onset dementia is higher in men than in women for those aged 50-65. There is a higher prevalence of early onset dementia for people from Black and Minority Ethnic (BME) groups. It is estimated that 6.1% of people from BME groups with dementia have early onset dementia, compared with 2.2% in the wider population of people living with dementia[6]. This means there is likely to be a demand for specialist early onset dementia services tailored to those from BME groups.

Prevalence of Early Onset Dementia – per 100,000 Population

		Female	Male	Total
Early Onset Dementia	30-34	9.5	8.9	9.4
	35-39	9.3	6.3	7.7
	40-44	19.6	8.1	14
	45-49	27.3	31.8	30.4
	50-54	55.1	62.7	58.3
	55-59	97.1	179.5	136.8
	60-64	118	198.9	155.7

This chart shows the projected increase in the number of people living with late onset dementia in the UK between 2005 and 2051.[7]



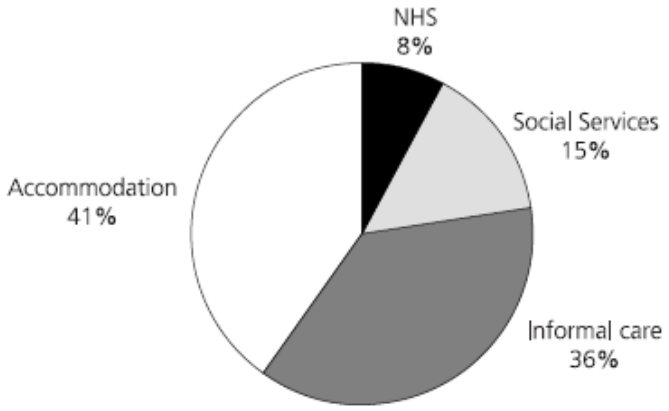
Projected number of people with late-onset dementia by age group (UK)

[6] 'Dementia UK', 2007 - Alzheimer's Society

[7] 'Dementia UK', 2007 - Alzheimer's Society

5.1.1 Economic burden of illness nationally

The Alzheimers Society estimate that in 2007 the total cost of dementia in the UK was £17 billion per annum or on average £25,472 per person with late onset dementia[8]. Accommodation accounted for 41% and informal care inputs from family members and unpaid carers accounted for 36% of this £17 billion. The chart below show the distribution of dementia service costs

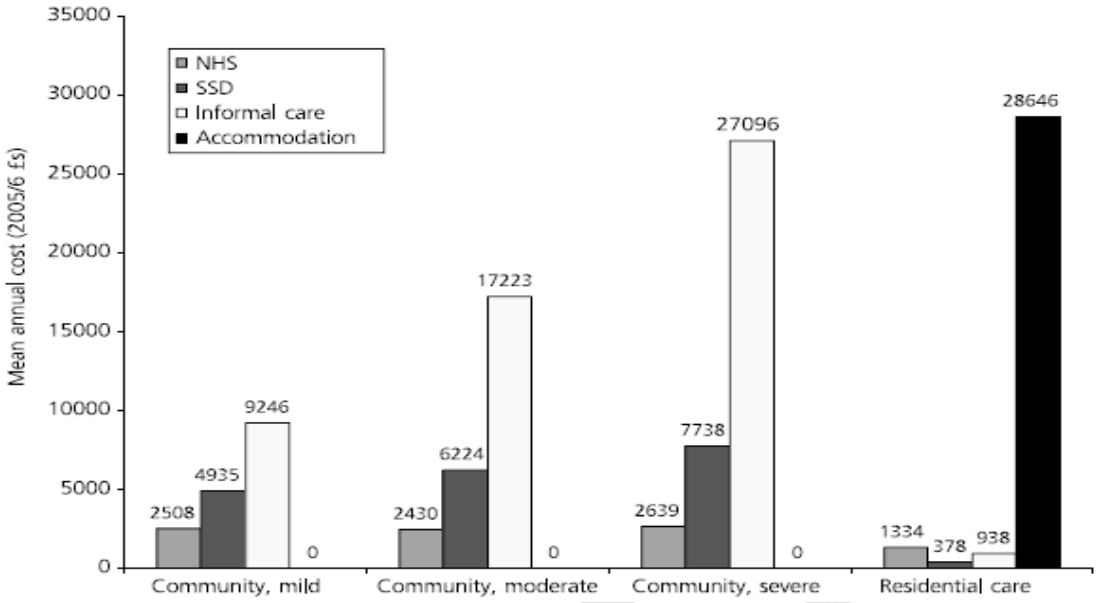


The table and chart below shows the average total annual cost per person based on the severity of their dementia and their setting and the breakdown of who is meeting those costs[9]. It shows that the most expensive scenario is a person with severe dementia living in the community, however 72% of this cost is the estimated value of unpaid informal care provided by family and friends. 28% of the cost (£10,500 per person per annum) is provided by Social Services or NHS. The largest single cost is accommodation costs in residential care, representing 92% of the cost of people with dementia in care homes and is the responsibility of Social Services or NHS to fund if the person cannot fund their own care.

Setting	Total Annual Cost Per Person
People in community with mild dementia	£16,689
People in the community with moderate dementia	£25,877
People in the community with severe dementia	£37,473
People in care homes	£31,296

[8] Dementia UK', 2007 - Alzheimer's Society

[9] 'Dementia UK', 2007 - Alzheimer's Society

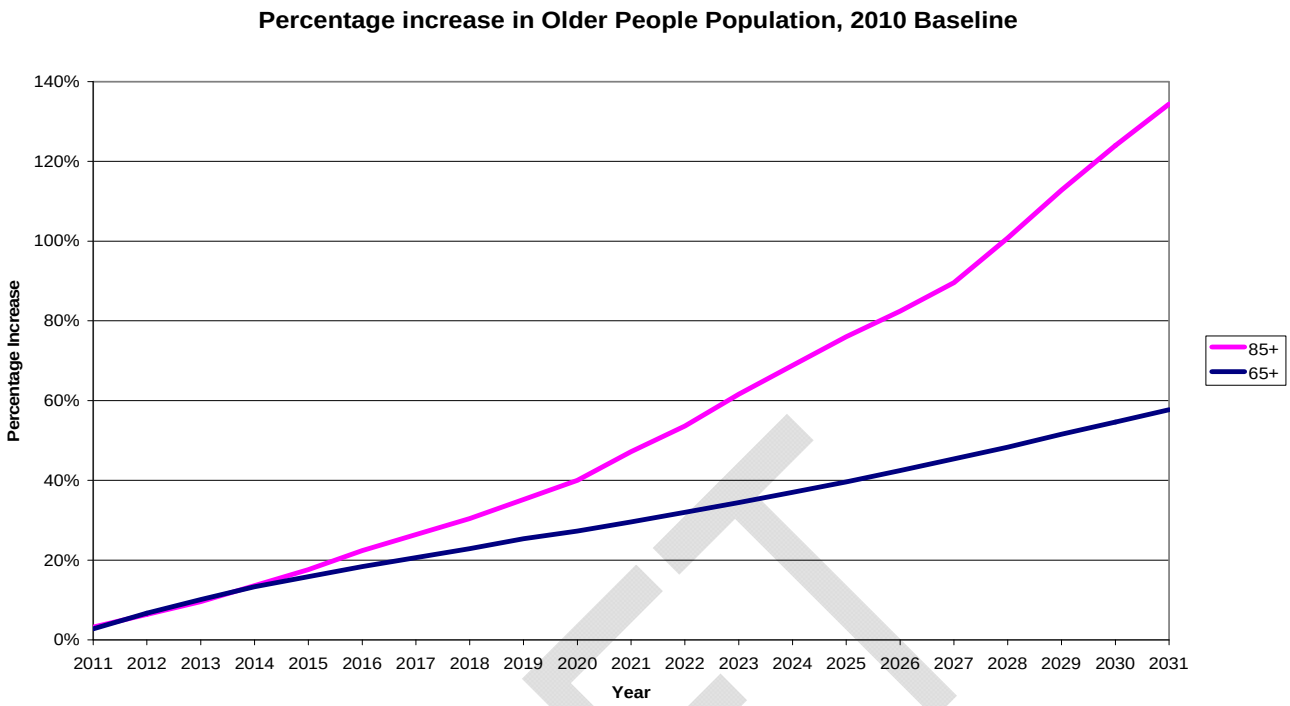


5.2 The prevalence of Dementia locally

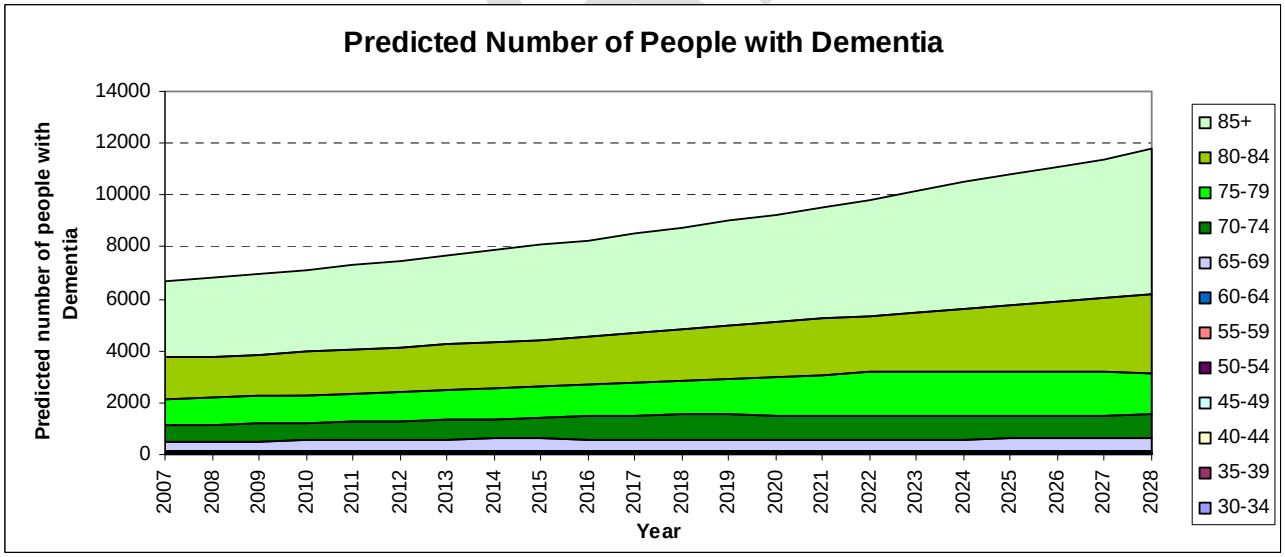
The total population of Warwickshire is 535,000 of which 95,000 people were aged 65 and over[10]. Taking into account Warwickshire population estimates and the Alzheimer's Society prevalence rates set out above it is estimated that there are currently 7,100 people in Warwickshire living with dementia. Using the population projections for Warwickshire it is estimated that by 2021 9,500 people in Warwickshire living with dementia, an increase of 34%. The projected increase in the number of people in Warwickshire living with dementia is a reflection of the projected 'demographic drift' where we will see people living longer and therefore more older people, particularly those living beyond the age of 85. As the prevalence rates showed the older a person becomes the more likely they will have dementia.

The graph below show the dramatic increase in older people's population compared to the 2011 baseline, especially in the 85 and over age group. The number of people aged over 85 is predicted to double between 2011 and 2028.

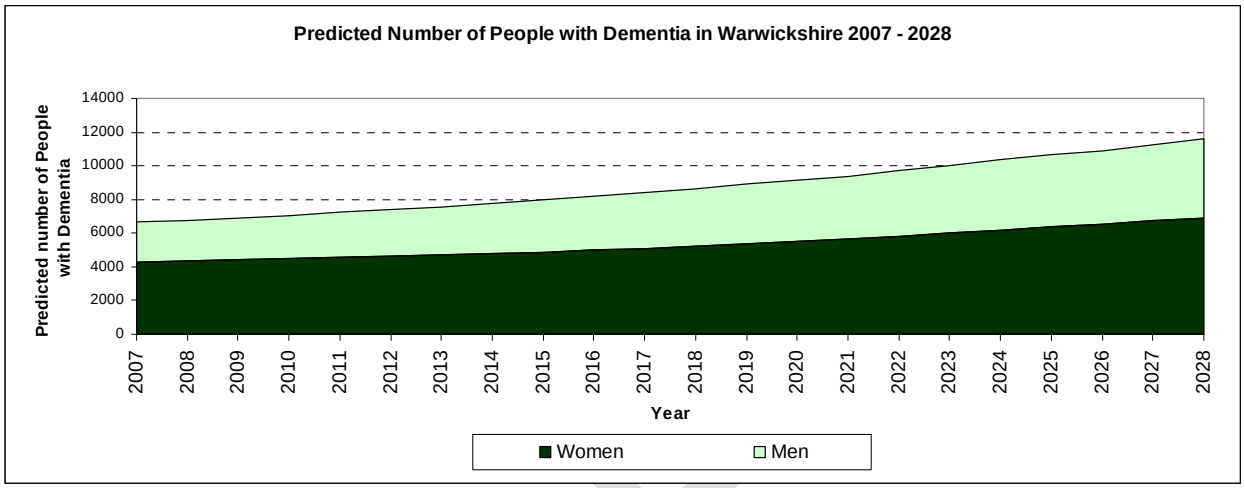
[10] 2009 Mid Year Population Estimate – Office of National Statistics



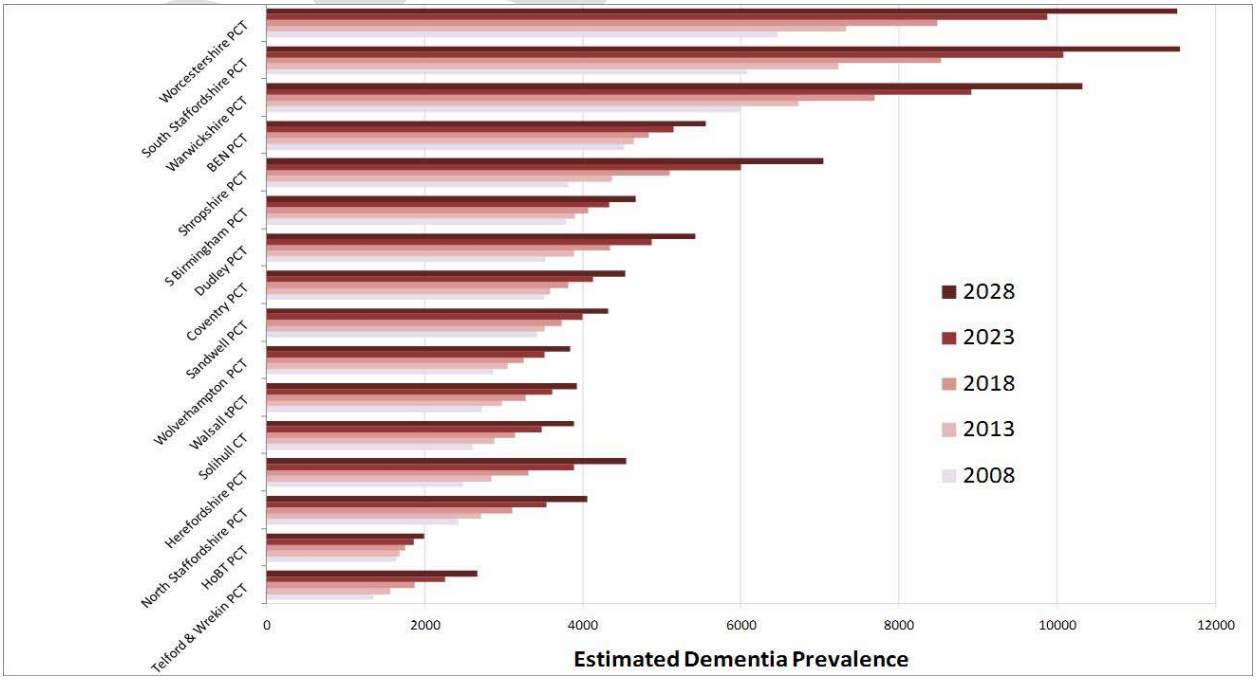
When the projected population increases are combined with the dementia prevalence rates it shows the large projected increase in the numbers of people in Warwickshire living with dementia in the next 20 years.



The chart bellows illustrates that based on prevalence rates and population projections there will be significantly more women than men living with dementia in Warwickshire. However the proportion of men and women with dementia will be changing over the next 20 years. Currently 63% of people with dementia in Warwickshire are women, this is predicted to fall to 59% by 2028.



The chart below shows that effect of the 'demographic drift' on the predicted numbers of people with dementia is a particular issue for Warwickshire. Warwickshire is predicted to have the 3rd highest number of people living with dementia by 2028 in comparison to the rest of the PCTs in the West Midlands. Additionally Warwickshire is predicted to be amongst the largest proportional rise, a trend that is prevalent in all rural areas (i.e. Worcestershire, Staffordshire, Shropshire and Herefordshire)

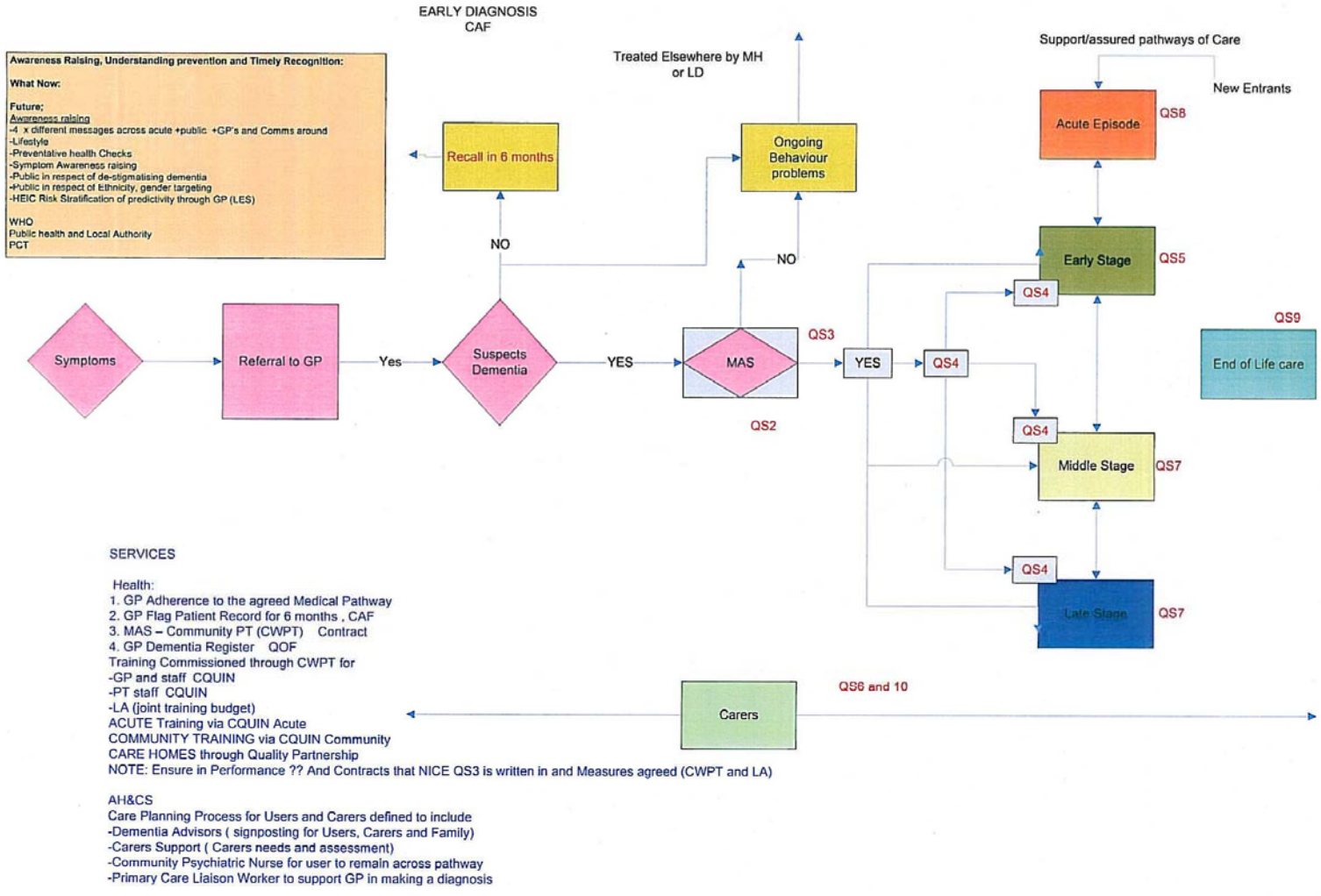


The following table shows the current numbers of patients registered as having dementia within the local population by District rather than by proposed GP Consortium, against the expected prevalence. This will enable local targets to be identified in order to narrow the gap by 25% between the recorded incidence and expected prevalence by 2013.

Area	Recorded Incidence	Expected Prevalence	Percentage	Difference
Warwick	522	1492	35%	970
Leamington	420	1440	29%	1020
Rugby	219	580	38%	361
North Warwickshire	726	2218	33%	1492
Nuneaton	286	1073	27%	787
Bedworth	333	852	39%	519
Stratford	207	414	50%	207
Grand Total	**3535**	**10747**	**33%**	**7212**

6. Having an Assured Care Pathway for people with dementia living in Warwickshire

Warwickshire County Council and NHS Warwickshire, have, over a period of time, developed the Warwickshire Assured Care Pathway for people with Dementia and their Carer. Attached as a separate paper entitled, 'Warwickshire Assured Care Pathway for people with Dementia and their Carer.' this document illustrates the journey a patient and any carers should take once a diagnosis of dementia has been confirmed across the health and social care economy. Summarised below, the pathway also



defines the type of services people should expect as their illness progresses. The Dementia has four key stages; Early Stage, Middle Stage, Later Stage and End of Life. Each stage is interdependent and requires transactional and transformational ownership across all partner organisations to ensure that the person with dementia and their carers receives high quality care.

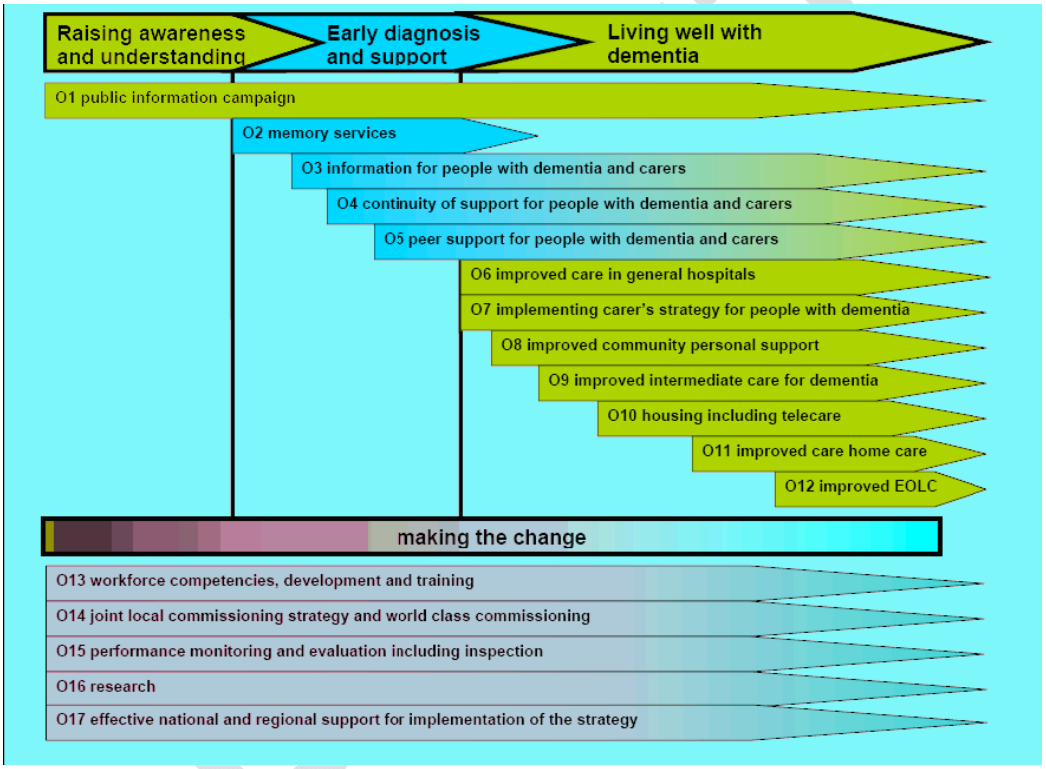
7 Market Analysis

The National Dementia Strategy, in its development, was clear that Local Authorities and Primary Care Trust's should take a radical approach to whole system transformation to meet the twin aims of better outcomes at lower cost.

The national strategy has set a clear direction of travel. Using 17 objectives set within 4 broad themes:

- Raising awareness and understanding
- Early diagnosis and support and
- Living well within dementia
- Making the change

And defined within the care pathway, as illustrated below:



Current Map of Services

A market analysis has been undertaken to assist in building a picture of existing local services as well as a wider picture of the market and an assessment of current gaps in services availability. Using these objectives to establish a baseline of current provision, it provides health and social care with an evidence base of gaps in provision which will inform the future joint commissioning intentions for Dementia services within Warwickshire.

7.1 Raising Awareness and Understanding

Objective 1 - Improved public and professional awareness and understanding of dementia. *Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.*

Dementia is increasingly becoming one of the most important causes of disability in older people. A key part of understanding mental ill health is to promote positive mental health and keeping a well 'mind and body', this includes people being aware of what they eat, drink and the exercise they take and how excess can contribute to long term conditions one of which is dementia.

As two-thirds of people with dementia live either in their own homes or with their carers, and as such, come into contact with the full range of universal services – e.g. housing, benefits agency staff and GP receptionists. A lack of understanding of dementia can lead to; a) symptoms not being recognised b) people not being encouraged to seek further information and support and c) care practices that can make the situation worse for both the person with dementia and their carer further creating an isolating and marginalised environment.

Wellbeing Exchanges, are currently provided to meet the need of general mental health adult and older adult with functional conditions but none for Organic (Dementia). These are jointly funded through the Local Authority and NHS Warwickshire. There at seven bases across the County (5 x Mental Health Services and 2 x Local Authority) at a value of £60,000 per service)

Services report that they have provided signposting to both Age Concern and Alzheimer's society services and some drop in services for functional mental health do attract working age /early onset dementia users who do not want to access older age services.

A more rigorous public health campaign to raise general awareness of the benefits of healthy lifestyles and links to dementia, together with a better universal understanding of the impact of dementia given its potential to touch everyone's life will underpin this strategy.

Joint training, across a range of providers and key stakeholders, including universal services, is discussed under objective 13.

7.2 Early Diagnosis and Support

Objective 2 - Good quality early diagnosis and intervention for all

All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

General Practice

Practices in Warwickshire currently record some 2000 patients with a diagnosis of Dementia against the national prevalence and research indicators.

GP Consortia	Recorded Incidence	Expected Prevalence	Percentage	Difference
Warwick	522	1492	35%	970
Leamington	420	1440	29%	1020
Rugby	219	580	38%	361
North Warwickshire	726	2218	33%	1492
Stratford	207	414	50%	207
Nuneaton	286	1073	27%	787

Currently Warwickshire has around 7,200 people with dementia which suggests registration is not representative of need. This is a key issue for individuals as Quality Outcome Framework registers do require individuals to be registered and their care reviewed every 15 months. For those individuals diagnosed early this ensures speedy referral to Memory Assessment Services (MAS) and pharmaceutical and therapeutic interventions that will help them live active lives longer. NHS Warwickshire has asked 15 low recording GP practices to specifically improve their Dementia QOF registration over the next year.

Memory Assessment Clinics

NHS Warwickshire currently commission Memory Assessment Services (MAS) through Coventry and Warwickshire Partnership Trust. There are currently three memory assessment clinics, each with their own consultants, in; Rugby, North Warwickshire and South Warwickshire. Access to these services is routinely through primary care. The clinics vary in approach due to legacy funding and the services currently commissioned vary across the county but will move to a more equitable model which is based on the outcome of a key stakeholder consultation in Sept 2009. Further focussed attention needs to be given to the referral process from GPs through to the Memory Assessment Services, part of

this will be to improve the; screening process and links between Coventry and Warwickshire Partnership Trust as the provider and GP practices.

This operates a two stage approach for more complex cases people will be referred to a consultant for less complex referral will be to a nurse led service to increase and improve throughput. Importantly referral routes needs to be established for vascular conditions that results in people acquiring dementia, such as stroke hypertension and coronary heart disease.

Community Mental Health Teams

The development of the Community Mental Health Teams for Older People in Coventry & Warwickshire was informed by the proposal to integrate Coventry and Warwickshire County Council and the Coventry and Warwickshire Partnership Trust resources to form integrated health and social care Community Mental Health Teams for Older People in Coventry & Warwickshire. This arrangement has been underpinned by a Section 75 agreement under the NHS Act 2006.

The aim of the integrated service is to provide seamless health and social care to older people with mental health needs and their carers and whose needs are complex and fall within the scope of the service.

The team provide comprehensive specialist assessments, appropriate therapeutic engagements and interventions to:-

- people over the age of 65 years with functional mental health problems and people with dementia
- service users previously known to working age CMHT who have now graduated into older adults psychiatry due to their presenting needs
- people under the age of sixty five who have a diagnosis of early onset dementia.

The main functions of the integrated Community Mental Health Teams for Older People are to provide:

- Co-ordinated delivery of secondary health and social care for service users who have complex and enduring mental health needs
- Appropriate assessment to diagnose, provide treatment and enable people to access support
- Assessment of carers needs and access to support
- Advice and assistance to GPs, primary care teams and others on request.
- Give individual support, advise and assistance to agencies which provide care to older people with mental health problems if the service user is already known to Community mental health teams older people
- Assessment and appropriate follow up to known service users in other hospital locations

The service is also available to support family and other informal carers, professionals and agencies seeking to meet the needs of people who meet the criteria (e.g. residential and nursing homes, acute and community hospitals, generic health and emergency services). In addition the service is also available to agencies whose role includes supporting older people with mental health conditions to live independently (i.e. primary care and social care in the statutory, voluntary and independent sectors) with advice and occasional intervention to overcome short-term difficulties.

Objective 3 - Good quality information for those diagnosed with dementia and their carers *Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.*

Warwickshire county council currently spends approximately £90,000 on commissioned information services. Primarily commissioned through the alzheimers society, the service provides information and advice to people with dementia and their carers.

Part of this expenditure is used to develop a dementia specific website that links several other sites including; NHS Choices, Guideposts, Alzheimer's, and Sterling University. The site development is part of the Dementia demonstrator site bid award and is supported by a range of organisations including; the Phoenix group, a post diagnostic support group in the North of the County. Adult Health and Community Services as part of the dementia demonstrator site work have commissioned the Phoenix group to research the type, format, source, accessibility and usefulness of advice and information available to newly diagnosed dementia users and carers.

In addition to the service provided by the Alzheimer's Society a number of other providers supply information and advice for both users of services and their carers/families. All of the material used by these providers is currently accessible through the WCC Dementia website. This is to ensure ease of access and a central gateway to services for both professionals and the public.

Community mental health teams have some publications and leaflets that are used in the assessment and care management process.

Advocacy

Warwickshire currently commissions its Advocacy services jointly with NHS Warwickshire from a singe voluntary sector provider.

In July 2010 NHS Warwickshire commissioned Independent Advocacy, the joint provider, to produce a report and recommendations in respect of the needs of people with dementia. The report indicated that some 197 contacts were made by service users for support ranging from; benefit advice, housing related support legal issues, debt, finances, and appeals. Recommendations have been made to NHS Warwickshire in respect of

converting part of the current service to a Dementia specific resource. There is also further work to scope future advocacy services for social care underway to ensure better commissioning of this form of support.

For those users who lack capacity to make decisions Warwickshire adult social care jointly commissions, with Coventry City council and Solihull care Trust, Independent Mental Capacity Act services. This is provided through a grant the valued £137k.

Objective 4 - Easy access to care, support and advice following diagnosis.
A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.

Dementia Advisor

Warwickshire was successful in securing 1 of 22 national Dementia Advisor Demonstrator sites in the North of the County. A Dementia advisor has been appointed. The purpose of this role is to provide information and support to newly diagnosed patients and to signpost the journey ahead and the services and support that will be available to people with dementia and their carers. Intervention at this stage when people are first diagnosed is seen as key to enabling people with dementia and their carers to come to terms with the disease and enable them to cope better throughout their journey with dementia. A key benefit of this role is the relationship with the memory assessment service and links to people at the point of diagnosis.

National evaluation of the Department of Health Demonstrator site pilot is inbuilt into the DH programme. Locally Warwickshire have commissioned TD4H, an independent provider to develop a programme of evaluation (IPOP) with the capabilities of measuring both qualitative and quantitative information produced through contact made by the dementia advisors. Long term the programme capabilities include outcome measurement and quality of life measures for the person with dementia, types of services accessed and impact on admissions to both residential and acute care settings. Lessons learned from the pilot will inform our future joint commissioning intentions. Early responses from users tell us that the service is valued, has enabled people with Dementia to have a choice in decisions made about their future and has secured for those users a voice.

The service currently is linking with the Admiral Nurse Service in the North of the County to ensure that carers are also fully supported and issues such as Advance Directives are discussed. Admiral Nurses provide support to carers of people with dementia. The Admiral Nurses are trained Community Psychiatric Nurses who:

- work with family carers as their prime focus
- provide practical advice, emotional support, information and skills
- deliver education and training in dementia care
- provide consultancy to professionals working with people with dementia
- promote best practice in person-centred dementia care

A full evaluation of this project will inform the commissioning intentions of this strategy in relation to developing future dementia advisors across the county.

Objective 5 – Structured Peer Support and Learning Networks
The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

Peer Support & Dementia Cafés

Peer support is key to living well with dementia. Peer support services have developed to give people with dementia an understanding of how other people with dementia perceive and cope with their own illness and the problems they may encounter every day. This includes the possibility of social isolation and difficulty in accepting the diagnosis, and what this means to them and their families. Peer support brings with it the emphasis that individuals with dementia and their carers are not alone in coping with the disease and encourages interaction with others who know, as far as is possible, what they are going through. The dementia cafes are designed to complement formal care and information services and are part of a wider range of psychosocial treatment, care and support, which is critical for an illness with limited medical treatment options.

The café are usually supported by a skilled facilitator and can be thought of as a type of guided self help peer support group. The service is provided for the person with dementia as the first priority. The service is available to people who have received a diagnosis of dementia who may attend either unaccompanied where appropriate, or with family, friends or carers. Cafés are generally directed at people in the earlier stages of dementia, although people at different stages of dementia are included.

Current Spend on Low-level dementia services

Service	Location	Annual contract value	Funding Source	Evaluation
Alzheimers Society Advice and Information	Rugby, South, North	42,000	AHCS (inc one-off grants)	Low-level services review
Alzheimers Society Café	South, Warwick	10,777	AHCS (one-off grant)	Low-Level services review
Peer Support/ Phoenix	North/ N+B	10,000	CWPT	Under review
Joes Cafe	North/ N+B	2,000	CWPT	-

Dementia website	Countywide	2,000	Dementia Demonstrator (DoH)	Ongoing review as part of Demonstrator site
Dementia Advisors Project	North	103,750	Dementia Demonstrator Site (DoH)	Full review being carried out by consultancy
	Gross Spend	**159,750**		

Service reviews for low-level services will be considered as a high priority to ensure commissioning intentions are delivering against Objective 5.

Discussions with members of the BME Phoenix group indicate that membership is low. It is perceived that some members are not seeing the benefit of peer support. It is essential that in taking forward information and promotion for Dementia services with the BME community that advice and support to people from different cultural backgrounds and with specialist needs are included in services commissioned. Further work needs to be commissioned to understand the specific needs of people with dementia from minority communities and their ability to access mainstream services.

6.3 Living Well with Dementia

Objective 6 - Community personal support services

Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.

Personal Budgets

SCIE define a personal budget as an allocation of money that is to be used to meet the individual's personal outcomes. Key to the personal budget approach is the need to give clear early understanding of the amount of money available, so that they can influence and control how it is spent, in a way that best meets their needs. Personal budgets must be implemented within the framework of self directed support which involves self directed assessment, up front allocation of money and support planning to promote choice and control.

Personal budgets are already being used across older people and physical disabilities services. Learning disability clients will begin using personal budgets from April 2011. For older people with mental health issues including people with dementia plans are at a formative stage and its anticipated that they will be implemented by April 2013.

Community Fast Response Team

NHS Warwickshire in partnership with CWPT recently de-commissioned ?? Acute specialist MH beds at Hawthorne ward in Rugby, diverting acute resources to a community based 'fast response team' for dementia/older adult mental health clients. Early evidence shows that the new service has successed in reducing/diverting admissions through its assertive outreach approach. Consideration now needs to be made in rolling our both this service and to expanding the current Crisis Resolution and Home Treatment services available to functional adult mental health to all older adult providion on a 24/7 basis. This will prevent inappropriate admissions, facilitating early discharge and providing specialist home support to users, families and carers.

Domiciliary Care

Specialist domiciliary care for people with dementia is a necessary component of support to enable people with dementia to be supported to live in their own homes. Not all people with dementia necessarily require specialist dementia domiciliary care as their needs follow a continuum and many people's needs are appropriately met through standard domiciliary care where staff are appropriately trained in dementia awareness. This is

the case where a persons needs are primarily for personal care rather than mental health care.

However, there are a small number of people who needs do require specialist care. A specialist dementia service is only likely to be required where the person with dementia may be presenting with challenging behaviours.

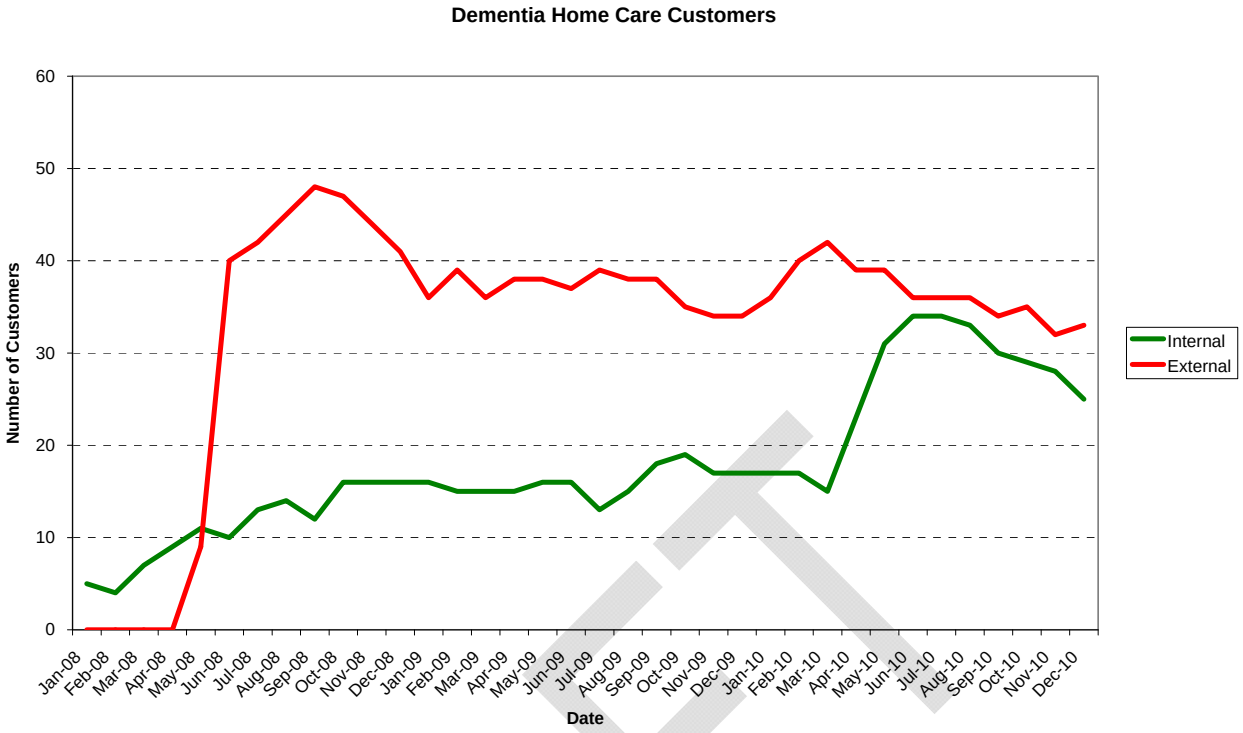
There are currently three models of domiciliary care that caters for people with dementia. These include:

- A countywide generic model of maintenance through a block contract with providers, valued at £304,333 per week with call off
- A specialist dementia spot purchase contract provided by Guideposts valued at £8988 per week, this covers 35 people per week totalling 432.32hrs.
- An in house specialist model operating in the North of the County and Stratford only, the value of this contract is £400,000 working with some 17 clients in total in 2009/10 clients with dementia.

Specialist Domiciliary Care

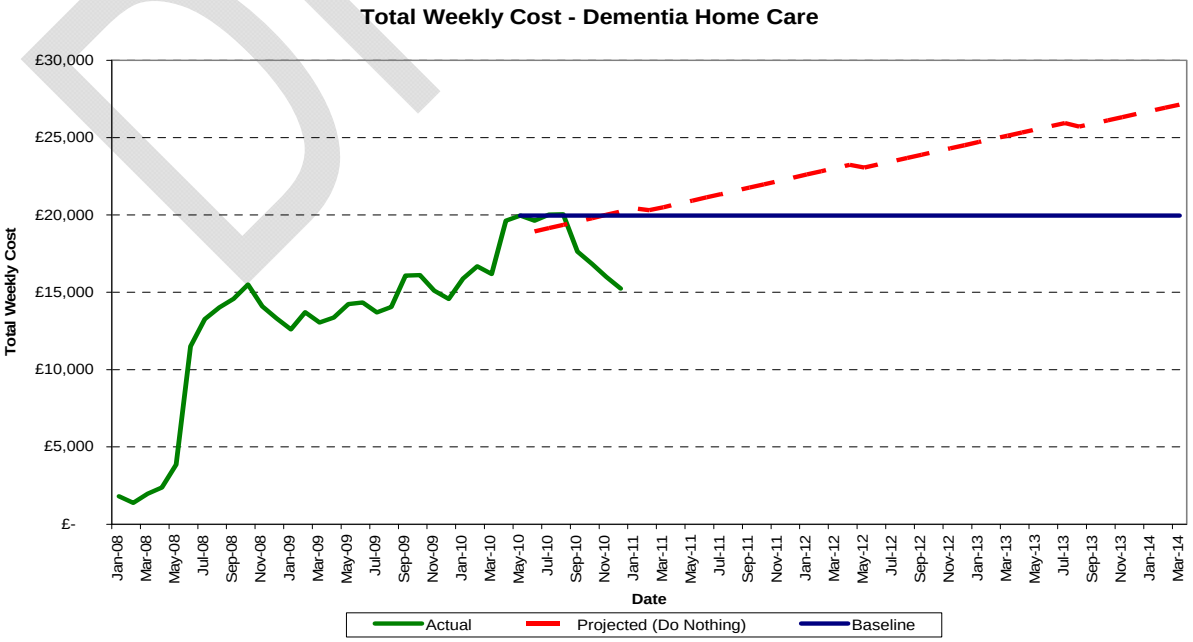
Warwickshire County Council currently operates an internal specialist dementia domiciliary care service and commission a service from a specialist external provider. The external provision has been in place since April 2008 and currently supports 33 having peaked at almost 50 customers in September 2008. In November 2009, elected members approved the establishment of a 2nd specialist dementia in house home care service in Nuneaton and Bedworth, to mirror the one that had been operating in Stratford since 2007. The internal service currently supports 25 customers, in June 2010 it was supporting 34.

The chart below show the trend in the number of customers receiving the internal and external services since January 2008. The reduction in the number of people receiving domiciliary care is mirrored in domiciliary care for personal care needs and is a result of the County Council's reablement service helping people to regain their independence and therefore not be reliant on council funded services, this is combined with a stricter application of Fair Access to Care eligibility criteria. At present reablement is for personal care needs only but the service will soon be rolled out to help people with dementia regain their independence which will likely see a reduction in demand for specialist dementia domiciliary care.

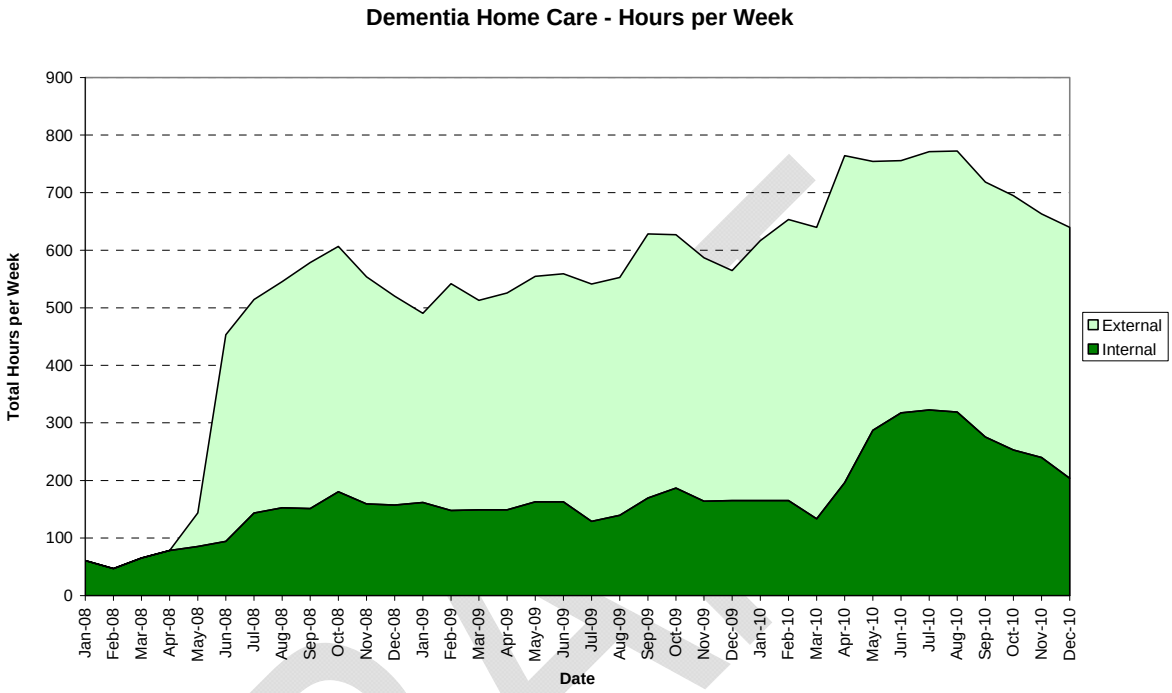


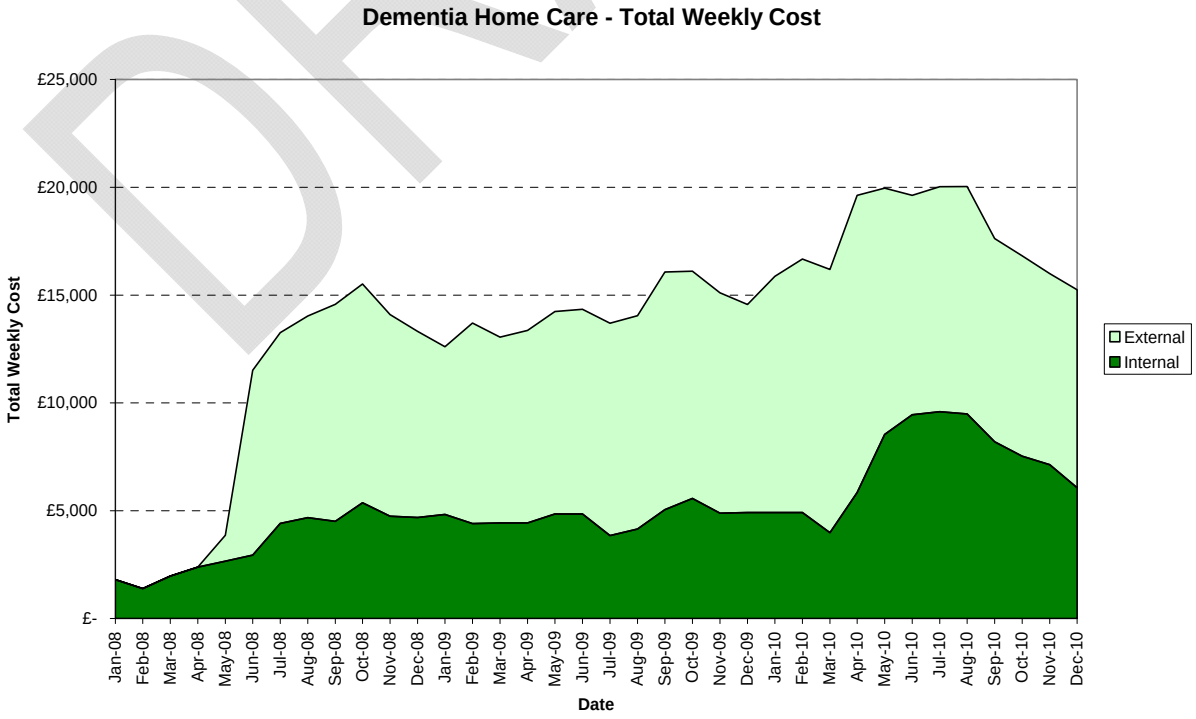
Source: WCC Carefirst

This chart is taken from Adult, Health and Community Services Transformation Monitoring. It shows the total weekly cost of specialist dementia domiciliary care since January 2008 and predicts (from April 2010) what demand would have been, based on trends and demographic changes, if the Directorate did not change the way it delivered its services. It shows that the weekly cost of specialist dementia domiciliary care is predicted to rise by 40% between April 2010 and March 2014.



The following 2 charts show the split between internal and external specialist dementia home care provision. They show that 68% of the total hours of care being provided are though external provision but this represents just 60% of the total cost. This is a reflection on internal services being more expensive to deliver than external provision. The cost per hour for external services is £21, compared to £30 for internal services.





Non-Specialist domiciliary care

In addition to the specialist dementia domiciliary care provided a number of people living with dementia have a predominant need of personal care that can be met with non-specialist domiciliary care. In November 2010 119 people identified with Dementia were receiving non-specialist domiciliary care totalling 1000 hours per week (8.4 hours per person per week on average)

Voluntary sector day services

Warwickshire county council also commission the voluntary sector to provide day services:

Name of Org	District	Value of Contract	Users/ wk	Cost per unit	Contract Type
Alzheimers Society	Stratford/ Warwick	115,351	61	36.3	Block
Age UK	North	122,361	60	35	Block
Rugby Mind	Rugby	52,275(+25K PCT)	75	20.6	Block
	TOTAL	**289,987**	**317**		

Independent day care

As at 2009/10 and through block and/or spot arrangements the following day care was provided specifically for people with dementia:

Name	Area	Annual Value	Sessions per wk	Spot or Block contract
Gildawood Court	Nuneaton & Bedworth	60,921	30	Block (voids)
Pinnacle Care	Rugby	137,473	105	Block (voids)
Bentley House	North W	37,606	13	Spot
Chasewood Lodge	Nuneaton & Bedworth	8,271	3	Spot
	Total Spend	**244,721**	**151**	

Day care block contracts with independent providers are currently underused with a large number of voids. It is vital that this is addressed given the financial pressures outlined on page 56 of this strategy.

All Day Care services were subject to a full Value for Money review in Sept 2009 and subsequent cabinet report in January 2010; this included dementia specific services. Day Care services are now subject to an

efficiency savings target across portfolios of Warwickshire's Transformation Programme. Mental Health specific day services, of which dementia specific services form a significant part, are expected to deliver efficiency savings totalling 25%. This is through a review of eligibility, a tightening of the eligibility criteria and a move towards a more personalised model of day opportunities, including a shift to Individual Budgets/ Direct Payments to fund day opportunities. We must remember that day care is one element of carer support and must be considered as part of the wider preventative strategy in dementia services.

NHS day services

A range of days services including day care and day treatment/assessment are offered across the county. Some of these incorporate memory clinic services. Coventry and Warwickshire Partnership Trust the provider of these services has developed and agreed with commissioners a pathway to these services to ensure clarity in future provision. Again there are issues of equity across the population. A review of these services is pending.

Nuneaton	Mira Peripatetic Day Hospital	Various functions: assessment, treatment and respite.
Warwick	Woodloes	
Stratford	Loxley	
Rugby	Maple* (due to move to the Railings)	

Each of the three services above are being independently reviewed. However, each part of these service are interdependent including those commissioned through adult social care. Economies of scale need to be explored to developing a joint approach to day opportunities.

Objective 7 - Services within the Carers strategy

Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

Warwickshire's strategic intentions with regard to services to support carers embody the core principles of the " Vision for Adult Social Care: Capable Communities & Active Citizens" for services to be more personalised, more preventive, more outcome focused. The revised Warwickshire Carers Strategy " Carers Support Services: Transformation and Savings Plan 2011-14" also incorporates the key priorities for carers support identified in the national refreshed Carers Strategy "Recognised, Valued & Supported: next steps for the Carers Strategy" which are:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages
- Enabling those with caring responsibilities to fulfill their educational and employment potential
- Personalised support both for carers and those they support, enabling them to have a family and community life
- Supporting carers to remain mentally and physically well

Currently, generic information, advice and support services are being provided by Guideposts Trust in the north of the county and the Carers Support service in the south. These services offer support to carers of people with dementia. Rethink also provides a countywide information and support service targeting carers of people with mental ill health.

In addition to the above services there is:

Local Authority Specialist Mental Health Carers Assessment Workers. Based in localities carers assessment workers provide specialist assessment and support to adult and functional older adults with a MH diagnosis.

Carers Education Specialist Programmes CESP (through Rethink) to new carers enabling them to understand specific mental health conditions, treatment, medication and signs of deterioration/relapse and referral routes into services. One module of the current 12 CESP modules is a dementia module.

Dementia UK Admiral Nurses: Warwickshire has 2 Admiral Nurses commissioned by CWPT. Admiral Nurses are specialist mental health nurses specialising in dementia. Admiral Nurses work with family carers and people with dementia, in the community and other settings. Working collaboratively with other professionals, Admiral Nurses seek to improve the quality of life for people with dementia and their carers. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships. Carers report that the support of these specialist nurses particularly at key changes in the cared for life, (admission to residential care, end of life/palliative care) is invaluable.

New strategic developments in carers services:

A new approach to carers' information, advice and support is being commissioned and is due to begin in July 2011. The new service will be offer a consistent, county-wide, frontline open door for all Adult carers and will reach out to identify carers earlier in their caring role. It will ensure that carers are better informed about their individual caring role and provide or enable access to specialist advice and support.

Respite care is a significant support service to people who use services and their carers and families. As the spending profile of internal and

external respite provision across the County, attached as appendix 2 illustrates, cost of bed based respite provision fluctuates. It is important to note that external provision costs vary with usage from £65 to £76 per day whilst internal provision is fixed at a rate of £92.86 per day whether it is used or not. A review of respite provision will form part of the delivery plan. This will provide the opportunity to look at more innovative cost beneficial types of respite, such as the use of assistive technology.

The provision of carer replacement services for people with Dementia in Warwickshire is small. Community based carer support is provided by Carers Short Break services. This is predominantly from Carers Short Break block contracts totalling £362K per year, provided through the carers grant. However, these contracts are not dementia specific. In addition, dementia Day Care and 1:1 community support can be considered as carers support services, as a dual purpose is providing the carer with a break.

Crucially and as partnership with NHS Warwickshire and Coventry and Warwickshire Partnership Trust we need to review the usage and type of future respite and Carer Support facilities."

Objective 8 - Good quality care within general hospitals

Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.

The Royal College of Psychiatrists report 'Who Carers Wins'(2005), on improving outcomes for older people with mental health needs in acute general hospitals estimates that up to a quarter of people in general hospitals at any one time have dementia. This they indicate places the responsibility on commissioners of acute services to commission high quality care for people with dementia.

The National Dementia Strategy suggests improving care for people with dementia in general hospitals by providing:

- a nominated senior clinician to provide leadership,
- developing a care pathway for people with dementia supported by a specialist liaison service.
- evidence based commissioning, this should include number of delayed transfers of care.
- ensuring the acute trust has a place on the locality commissioning board for Dementia
- ensuring staff are dementia trained
- ensuring the needs of users and carers are included in all commissioning contracts with acute trusts through adoption of the Dignity in Care campaign and Essence of Care standards.

NHS Warwickshire have already taken to steps to address some of these issues. Through the CQUINN, a quality initiative, the Acute hospitals within Warwickshire have been incentivised to reduce the use of anti psychotic drugs. In addition, a target of 50% of staff trained in the management of dementia was also used to improve the experience of people with dementia in an acute setting.

NHS Warwickshire confirm that avoiding or preventing admission is a key focus for the coming year. A joint approach is required to avoid admissions and to reduce discharge to residential care, both of which are significant financial pressure points that deliver poor outcomes for the person with dementia and their family. Part of this reduction in admissions, which generally become complex cases to discharge, is a better understanding within community services, including adult social care of the management of dementia. Creating an oversight of community teams by a psycho-geriatrician is being pursued as a model to reduce avoidable admissions of people with dementia and supporting discharge to home or intermediate care as a first option.

Objectives 9 – Intermediate Care for people with Dementia
Intermediate care which is accessible to people with dementia and which meets their needs.

In its review of Intermediate Care the Department of Health (DoH) anticipates that commissioners will ensure that people with dementia will have full access to intermediate care services.

To support commissioners the DH offer three models none of which are exclusive:

- expanding existing services to include dementia, this would require specialist input from mental health services/teams and a review of workforce skills.
- Commissioning a specialist MH intermediate care service that would cover all mental health needs, rather than just dementia.
- Commission specialist MH intermediate care beds

NHS Warwickshire currently commission a generic intermediate care service, this excludes people with a diagnosis of dementia although inevitably some individuals referred have subsequently been diagnosed. Discussions have begun to jointly commission these services in the future.

Objective 11 – Good housing, housing related and telecare support.

The needs of people with dementia and their carers should be included in the devlopement of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

Extra Care Housing

Although the national evidence base regarding people living in an extra catre housing is in its infancy, a recent review funded by the Joseph Rowntree Foundation suggests there is mounting evidence that people with dementia living in extra care housing generally have a good quality of life. The review suggests that older people moving into extra care housing have much less physical and mental impairment than those moving into the various models of residential care, including nursing homes, whilst research studies by market leaders, including housing21 - one of WCC's Framework partners - suggest that around 25% of extra care housing residents have some level of dementia.

Specialist programmes of work have now developed that shows more positive results through better engagement with individuals and their families, utilising what can be seen as a common sense approach to dealing with people with dementia. The support proposed through the 'Equal Opportunities programme' of working includes:

- **Specialist dementia expertise** embedded within the staff base of the Extra care housing team to work with individuals and the team to ensure residents reach their full potential for wellbeing.
- **Individual Assessment and case work** that is personalised to enable individuals to achieve their goals identify types of interventions, occupations and activities that are most likely to unlock to unlock the potential for wellbeing and help people to achieve goals. Case work interventions also enable issues to be dealt with promptly before problems arise.
- **Activity and Occupation**, the lead dementia worker introduces and implements a programme of variable, flexible and practical to provide opportunities for vulnerable individuals to experience optimum wellbeing. Programmes introduced are fully integrated within the 'village' or broader community with the lead worker working alongside mainstream services to ensure that any programmes include the needs of dementia (and MH) users too.
- **Staff Training**, any staff who have face to face contact with residents receive a 1 day training course (as a minimum) in person centred care and mental health awareness. For senior staff this should increase to a three day course in enabling residents specifically with MH issues to work within the 'Enriched Care Planning Approach', the dementia Lead mentoring these staff to ensure skills are utilised and retained.
- **Management and Leadership**, the site management team are in addition supported externally to ensure all of the above are in place and actively used to better the experience for the service user and their family.

There is a cost to this programme which will be embedded into contracts at the point of commissioning. The programme delivered does fit well with personalisation, person centred planning and recovery, re-ablement and retention of independent living skills.

Housing Related Support

A Strategic Review of Supporting People services for older people has been carried out with the recommendations being consulted upon. There are no Supporting People services specifically for people with dementia, however, it is recognised that current services do accommodate and provide support to people with low and sometimes medium level dementia. However, the review highlighted the predicted growth in the numbers of people with dementia in Warwickshire and recommends that housing related support services commissioned in the future for older people should ensure that those providing support should to receive appropriate training in safeguarding older people and awareness raising and basic training in dementia.

Housing Options

Warwickshire was awarded £193,000 funding from central government for 2 years to pilot a specialist housing and care options for older people. This service comprises a countywide telephone service through a national provider and a local visiting service for those who require it with a Warwickshire written guide for older people living in Warwickshire, their families and carers and professionals. The visiting service can also provide support to those older people who wish to move to more appropriate accommodation. The pilot service is a partnership between a telephone housing options provider, the County Council and District and Boroughs. The service will be evaluated and is due to end in March 2012.
The service provides information and advice about:

- Services which enable people to continue to live in their home. This can include handyperson services, home safety check schemes, community equipment, adaptations and equity release schemes
- Alternative housing options including: moving to more suitable, often smaller accommodation, moving to accommodation where care can be provided or moving to a care home.
- Advice to people who would like to buy or part buy a smaller, more manageable home.

A Housing Options service is a proactive approach to meet the prevention and early intervention agenda, for example through falls prevention, as well as improve hospital discharge. A Housing Options service also enables and support people to maintain their independence either through moving to more appropriate accommodation or remaining in their own home safely. The preventative outcomes anticipated from a Housing Options service are that:

- More people will live independently in their home through options that enables this or through support to move to more appropriate independent living.
- Falls reduction and improved hospital discharge.
- Reduced crime through making properties more secure.
- Improved health and reduced heating expenses with reduced numbers of older people with flu and pneumonia through making properties warmer or downsizing to more economical properties.
- Improved quality of life of older people.
- Improved housing and care options information available so enabling more people to make appropriate choices at the right time.
- Delayed transfer of older people to care to residential homes as they are enabled to live at home for longer safely or through finding a more appropriate accommodation option.
- Reduced concerns and burden for carers and family members.
- Prevention of future more costly home repairs which can result in an individual deciding to move to less independent accommodation or living in poor quality housing.
- Reach those people not linked in with any other services and provide preventative information.
- Release family homes by supporting those who make the choice to downsize their property so enabling districts to meet more family housing need.

Telecare

Telecare is a key element of both national and local strategies and cuts across health, social care and housing. The national vision in Lifetime Homes, Lifetime Neighbourhoods and the local vision for the transformation of housing support services in Warwickshire both see telecare and assistive technology as an integral part in the range of housing options as part of a wider and more joined up approach to meeting housing need in order to support people to live independently.

Assistive technology is defined by the Audit Commission as 'any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties.' It can help individuals maintain independence, increase safety and confidence and support carers alongside traditional healthcare, social care and housing initiatives.

Whilst the numbers of people using telecare in Warwickshire with a diagnosis of dementia was not available (due to the way Districts record data) the promotion of equipment and its use has progressed.

People, including those with dementia and their carers, will have access, through those community mental health teams, to a range of equipment including; discreet GPS watches, allowing users more freedom and mobility, memo minders, flood detectors, IPads to enable users to actively participate in their care planning and completing and compiling life story

work, carbon monoxide detectors, gas shut off valves, fire detectors, lamp modules and pill dispensers.

It is also our intention to utilise capital funding to develop 'Smart Suites' in each locality enabling users and their carers, with staff support to look at what this type of equipment and support can offer before they buy, ensuring familiarity with the product and effective usage to support independent living.

By supplying a range of equipment to the teams and training teams in its use we hope to ensure that telecare is an integral part of every assessment otherwise it is unlikely that the benefits, including the cost benefits, of using telecare will be realised.

Just Checking System

Just Checking is assistive technology and can be used to enable professionals to build a more detailed picture of how a person with dementia is going about their daily life, during the day and night. It is useful at times when the person themselves may not be able to provide or recall much information and is a valuable tool in demonstrating what skills remain to enable the person to stay at home for as long as possible. There is compelling national evidence that the system can:

- Reduce home care calls by 50%
- provide evidence to tailor packages of support more effectively
- give objective information to concerned relatives

Just checking is a simple web based activity monitoring system. Small wireless sensors in the home generate a chart of activity which is accessed via a secure website. Health and social care professionals and family members can see when the person:

- got up and went to bed and whether they has a disturbed night
- visited the kitchen to prepare meals and drinks
- left the house and for how long
- and generally, their daily patterns and how they are responding to care services

Understanding day and night time patterns of a person with dementia will allow care to be targeted to best effect and to gauge the effect of the services which are being provided.

2 of these systems are available to each community mental health team and there are plans to commission 6 more for wider use. An evaluation of the cost benefits of this approach (which has already been proven elsewhere) will be completed in the summer of 2011.

A care package of 2 home care visits a day, plus Just Checking instead of residential care saves £383.00 a week, an annual saving of £19,916 The cost of purchasing and running a Just Checking system for a year is covered if residential care is postponed for just 10 days.

Objective 11 - High quality services within care homes

Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.

The Council has direct control over 19 care homes (686 places) for older people, of which 9 are operated on its behalf by Warwickshire Care Services, an independent not-for-profit organisation. Approximately another 400 places are purchased from the independent care home market and approximately one quarter of these include a top-up payment from relatives in addition to the standard fee rate funded by WCC.

The split between ordinary (or 'higher dependency') residential care and specialist dementia care has shifted considerably over the last few years. A recent independent survey highlighted that in the proportion of dementia care in the residential care market had risen from 9% to 52% over the last 10 years (6% within WCC homes). In the independent sector, many homes are now dual-registered for both forms of care so that if demand for dementia placements was to increase proportionately then availability could adapt accordingly.

The council is planning to retender its block contract currently being provided by WCS for 11 care homes across the County and this will give us an opportunity to introduce some of the future plans for dementia. And although the details are exempt from public discussion it is clear that the proportion of dementia residential care beds will increase and the overall strategy will include the focusing of one care home in each of the 5 districts on specialist dementia provision before the end of 2012.

Nursing Care

The number of places provided by the county's 33 nursing homes for older people is over 1,600. Nursing care is commissioned jointly with the PCT but the level of dementia care within this provision is far more difficult to define than in residential care because of the range and interdependencies of health conditions. Although a number of local authorities offer a higher fee rate for dementia nursing care (as opposed to standard nursing care), The Care Quality Commission is not isolating this service as frequently as in the past and WCC have no plans to introduce this as a distinct category. However, the council is working closely with the PCT to improve overall provision and quality within nursing homes with particular attention to meeting customers' needs in relation to dementia care e.g. awareness and training

Sustaining Quality

Quality is a key issue for existing and potential residents and their families. To enable us to be proactive in provision of good quality of care we need to be aware of what quality means to older people:

- Keeping clean and comfortable

- Enjoying a clean and orderly environment
- Being safe
- Having company and social contact
- Being active, having something interesting to do.

Reference: Qureshi and Henwood 2001

These quality expectations will be built into our overall strategic vision and performance monitoring process. As identified in the recent report "Commissioning Driving up Performance" one of the key challenges facing the Directorate's ability to improve performance through the commissioning process will be the future needs of the people in Warwickshire set against the financial constraints over the next 3 years. The Directorate's vision of ensuring that people's choice and voice are accurately represented in the delivery of services through focussing more on outcomes (rather than outputs) will face a reduction of 9% in baseline resources during this period. At a time of major change in both commissioning and performance frameworks, the Directorate must therefore be able to forge much stronger links than ever before between commissioning and performance if it is to ensure continuous improvement.

One strategy being developed to tackle poorly functioning services is to apply differential fee rates that reflect contract performance particularly where dignity, safeguarding or overall quality standards are not being delivered. And Warwickshire County Council will provide assistance in the form of targeted training to help lift standards with poorly performing providers.

Objective 12 - Good end of life care

People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.

In the West Midlands deaths by condition relate to; 75% of renal patients die in hospital, 60% of dementia patients die in care homes and 55% of cancer and 55% of chronic bronchitis patients die in hospital. The vision for all future End of Life Care services developed and delivered by NHS Warwickshire are as follows:

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 end of life care and services. These will be person and family focused, promote choice, provide symptom control, respite, psychological, social and spiritual support. They

will be sensitive to the individual's needs and wishes and delivered in a timely, integrated and coordinated manner.

There is a Warwickshire wide End of Life strategy which has been developed after consultation and in partnership with varied stakeholders which included Coventry and Warwickshire Primary Care Trust's, Warwickshire County Council and providers of End of Life Care including acute trusts, hospices and community services and patients and carers.

Historically End of Life Care and palliative care services have been primarily focused on care and the needs of people with cancer. The needs of individuals with other conditions such as dementia, chronic heart disease, chronic obstructive pulmonary disease, progressive neurological conditions i.e. dementia and Huntington's disease, stroke, progressive organ failure and AIDS have often been overlooked. The End of Life strategy sets out a five-year plan for the development and implementation of End of Life Care services for the people of Warwickshire in their last 12 months of life, applying to people of all ages, states of health and clinical condition and diagnosis

There are a range of pathways and frameworks that are used to support people at the end of their life. These include:

End of Life Care Frameworks

Gold Standards Framework (GSF)	**Liverpool Care Pathway (LCP)**	**Preferred Place of Care (PPC)**
The GSF framework, aimed at both primary care and care home settings, seeks to improve the care provided to patients nearing the end of life by achieving the following goals: 1.Patients are as symptom controlled as possible 2.Place of care – patients are enabled to live well and die well in their preferred place of care 3.Security and support – better advanced care planning, information and less fear, hospital admissions , fewer crises 4.Carers are supported, enabled and empowered 5.Staff confidence, communication and co working are improved	The LCP framework is a clinical pathway that provides guidance to clinicians on how to improve care of the dying in the last hours/days of patient's life. It provides guidance on indications for comfort measures, prescribing and discontinuation of inappropriate interventions and meeting the personal wishes for the last days of life. Designed for hospital use for cancer patients, it can be used for people with any diagnosis, in nay setting, care home, hospice and community.	The PPC document is a patient record, designed to record and monitor patient and carers choices and services received by all terminally ill patients. The aim of the document is to give patients and carers choices and aid communication with and between professionals.

A substantial number of Warwickshire residents die in care homes. Those with specific conditions such as dementia are more likely to die in a home. Quality of end of life care in homes is reported as variable. Public health data highlights variation in care homes admitting to acute trusts for people at the very end of life.

A number of Warwickshire county council care homes have residents who have not had a formal diagnosis or may have mental health concerns, Warwickshire county councils own internal homes have produced a new End of life Policy and sensitively focussed practice guidance to cover the range of residents. Warwickshire County Council aim to be active participants in the Gold Standards Framework award by April 2011 and will begin to work closer with our health colleagues to achieve the same aims within the same period of time.

Residents therefore can expect to be involved in the assessment and planning for their end of life care, based on best practice which when required will involve their relatives, staff, friends or advocates. The aim will be to ensure that any care planning processes are undertaken with a clear outcome focus which will provide what the resident wishes for, gives a clear indication of the quality of care that the home can offer in preparing for and dealing with this major life event.

7.4 Managing the Change

Objective 13 - An informed and effective workforce across all services *Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.*

The Joint Dementia Workforce Strategy supports the care pathway from initial diagnosis through to its conclusion or to such a point where the service user enters an alternative care pathway such as End of Life. The scope of the strategy includes all those people working with, supporting and caring for people with dementia. The overarching aim is to have a skilled, competent and confident workforce aligned to the care pathway.

This is achieved by introducing 3 levels of competencies with each level designed to meet the needs of the user and care / supporter at different points of their journey.

In order to improve the understanding of dementia overall and more importantly provide support, help and understanding across the Warwickshire health economies by using both qualitative and quantitative data we have been able to develop a workforce strategy that supports both service & clinical pathways whilst at the same time improving the service user and carers experience by improving the knowledge and skills

of those health and social care workers involved directly on indirectly with service users and their families.

Objective 14 - Joint commissioning strategy

This joint commissioning strategy and delivery plan have been developed by NHS Warwickshire and Warwickshire County Council Adult Health and community Services Directorate working collaboratively over a number of months. Key contributors have been service users, carers and providers from across a wide range of partners. This collaborative approach will continue to drive this strategy forward.

7.5 Gap Analysis

In developing our commissioning intentions, the following gaps have been identified:

- There is a lack of awareness generally amongst the public of some of causes of dementia, its affect on individuals their families and the stigma it holds. This, in itself can reduce people's willingness to come forward for diagnosis. For example, people will wait up to 3 years before reporting symptoms of dementia to their doctor.[11]
- Community based provision is not geographically aligned to the demographic change predicted across the County.
- There is a disproportionate investment in specialist resources compared to investment in more generic support, such as domiciliary care.
- The referral route to memory assessment clinics is unclear causing a bottleneck and delay in people with dementia being diagnosed early
- There is limited use of assistive technology/telecare for people with dementia. This needs to begin early in their diagnosis.
- Day services are variable in quality, access and focus. Plans are already underway to review these services.
- There is a high proportion of peer support and cafes in the North of the County.
- There is no information advice and signposting service across the whole County
- There is currently no reablement service for people with dementia.
- There is currently no intermediate care service that supports people to avoid admission to residential care
- There is a need to develop extra care housing to reduce admissions to residential care
- There is a lack of capability to meet the needs of those with early onset dementia

[11] Alzheimers Society (2002). Feeling the Pulse. London.

- There is limited access to these services for people with learning disability or from minority communities.
- Respite care, breaks from caring and emotional counselling support is limited
- A more co-ordinated approach to workforce planning needs to be adopted

8 Market Management

Positive and effective partnerships between commissioners and providers are the cornerstone of any strategy and are essential to build a strong health and social care economy that can meet and compete in the current market. In taking this strategy forward it will be important to establish the relationship on which future partnerships will be built. These include:

- Engaging early with the market
- Providing clarity around commissioning intentions
- Take the markets own needs into account and support them through training and development where necessary
- Stimulate a competitive supply market, where none exists
- Facilitate consortium/co-operative arrangements
- Monitor effectively and take action to develop or manage supply as needed

Relationships with the market need to be built on trust. To do this, regular provider forums will be established, where none exist so that these relationships can be formed.

Importantly for this client group and the particular specialist knowledge that will be required when working with some clients, such as those displaying complex and challenging behaviours, consideration will be given to a framework of enhanced fees.

Through a redesign of services, for example by improving community based services, both the rates of inappropriate admissions and delayed transfer of care will reduce. This is our ultimately aim because this will enable a reduced reliance on a bed based model and re-investment to ensure more effective community based services reach more people, equipping Warwickshire with the necessary scarce resources to meet demand in the future.

9 Commissioning Intentions

Based on the information above and by shifting resources from the point of crisis to prevention and early intervention and within available resources Warwickshire County Council and NHS Warwickshire have together agreed the following commissioning intentions:

Key Theme 1: Awareness and Understanding

- Address the understanding of some of the causal affects of dementia and promote healthier lifestyles through the prevention strategy.
- Provide universal information and advice for everyone about dementia.
- Have available advocacy services, including IMCA and access to support to develop living wills.
- Include dementia awareness in induction training for employees within the NHS, Council and partner organisations.
- Ensure any awareness campaign is coordinated with the development of services to ensure that any additional demand that is created through improved awareness is able to be responded to.

Key Theme 2: Early Diagnosis and Support

- Improve referral to the Memory Assessment Services to increase the number of people diagnosed early with dementia.
- Implement the agreed Dementia Care Pathway for Warwickshire.
- Work with GPs to review/remove/decrease the inappropriate use of medication which is a particular issue in care homes and which poses medical risk in older people by xxx
- Review the Dementia Advisor service in the North of the county and the role of the Admiral Nurses including cost effectiveness, to agree model for future provision.
- Commission specialist carer education and support programmes to ensure Carers are equipped with the skills and confidence to manage at home.
- Have access to effective peer support including Alz's/Joe's cafes countywide.
- Establish a referral route to the IAPT services for people newly diagnosed with dementia.
- Improve the awareness and use of advance directives and advance care planning for people with a diagnosis of dementia.

Key Theme 3: Living Well with Dementia

- Utilise personal budgets (and personal health budgets) for people with dementia and carers, to develop innovative and flexible services to support individual needs.
- Increase the take up of Direct Payments by 25% by 2014.
- Increase the use of reablement by 15% for people with dementia.

- Increase the use of intermediate care at point of discharge by 20% by 2014 for people with dementia.???
- Promote referral route to aids and adaptations, in particular continence care.
- Jointly review the use of building based day provision and reduce by 30% by 2014.
- Increase the use of intermediate care at point of discharge by 20% by 2014.
- Move to a model of flexible day care support for people with dementia, this will include day and night (24hr) options for support.
- Review respite provision to increase the range and type available
- Commission a range of community based general services that have appropriately trained staff able to respond to people with dementia and promote recovery and continue to enable independence.
- Commission residential and nursing care contracts that reflect the commissioning intentions laid down in the NDS, i.e. an identified Dementia Champion in the home, jointly commissioned in reach services to care homes through CMHT OP services, reduction and adherence to protocols for use of anti-psychotic drugs use.
- Dementia appropriate End of Life services that support individuals to have a 'Good Death'.

In commissioning housing related support we will work with housing partners, supporting people, housing associations, extra care providers and independent care homes to;

- Through service re-design and within existing resources commission specialist dementia residential care units within key areas of the County each incorporating the provision of respite.
- Decrease the use of residential care by 20% over the next three years at the point of discharge.
- Make available at least 25% of extra care units to people with dementia within the Care & Choice Accommodation Programme.
- Commission a range of housing options that better meet the specialist needs of people with dementia. Include offering people the option (early) of living in Extra care ensuring that families see Extra Care housing as a viable option for people with Dementia.
- Ensure that the supporting people programme offers appropriate housing related support to people with dementia.
- Increase the use of assistive technology to support people to live at home by 10%

Key Theme 4: Managing the Change

- Developing a joint health and social care Workforce Development Strategy train 30% of staff to ensure a competent and confident workforce underpinned by the findings from the recent Dementia Education Projects research and outcomes of other regional projects e.g. Strategic Health Authority initiatives
- Including people and their carers in the delivery and evaluation of learning programmes where *appropriate/possible.*
- Ensuring all relevant workers complete a level one development programme

- Commission and deliver the second or intermediate level development programme by *Sept 2011*. This programme is for workers who are most likely to come into contact with patients who may undergoing treatments or interventions that may not be related to dementia, for example within A&E or a planned elective intervention. A significant part of this programme will be focused upon communication, managing difficult behaviour and support
- Commission and deliver an advanced / specialist programme for those workers whose involvement is likely to be at the original diagnosis of the disease and then later on as they move towards the end of life pathway.

10 Financial Envelope

10.1. Current Financial Climate

Because of the significant financial savings that Warwickshire County Council have to make during a time of transformation, it is important to state that currently, dementia services have not been set a savings target unlike other client groups. However, with the significant financial pressures faced by NHS Warwickshire, Warwickshire County Council combined, coupled with demographic pressures that are well known and documented any changes in services must ensure the best use of resources to place the health and social care economy in a good position to meet growing demand.

Given the complex nature of funding arrangements within the council, it is difficult to determine the precise amount of funding available and used for people with dementia. This is primarily because of the difficulties in diagnosing someone with dementia and the fact that the expertise to meet individual needs are based within older people mental health teams. Whilst the prevalence of dementia continues to grow and will become a significant factor in future years, it is not economically viable to separate out the needs of people with dementia from other older people with mental health issues, such as depression. The financial envelope below must therefore be taken with some degree of caution. It is fair to estimate that the spend on people with dementia and their carers, within adult social care, is likely to be in the region of between £8 million to £11 million as shown below.

Estimated Total Dementia Expenditure

2010/11 Forecast	External Services - Older People Mental Health Client Group	Internal Services	LD Services - Customers Over 55	Total
Transport	26,771			26,
Homecare	938,045			938,
Daycare	670,630			670,
Residential E.M.I	9,829,465			9,829,
Respite E.M.I	137,364			137,
Direct Payments Ongoing	416,058			416,
Direct Payments One Off	11,520			11,
Service Level Agreements				
Internal Dementia Residential Care		711,750		711,
Internal Dementia Residential Respite Care		162,655		162,
Internal Care Home Dementia Day Care				
Internal Dementia Homecare		743,308		743,
Sub Total - Gross Expenditure	**12,029,852**	**1,617,713**	**0**	**13,647,**
Reimbursements	(118,662)			(118,6
Residential Charges	(3,820,415)			(3,820,4
Respite Charges	(15,123)			(15,1
Estimated Charges for Community Care Services	(309,453)			(309,4
Estimated Charges for Internal Services		(183,047)		(183,0
Sub Total - Gross Income	**(4,263,654)**	**(183,047)**	**0**	**(4,446,7**
Total Net Expenditure	**7,766,198**	**1,434,666**	**0**	**9,200,**

10.2 Financial Projections for 2011-2014

Given the financial and demographic pressures considerable work has been completed to identify the 'push / pull' factors that will impact on the financial viability of this strategy over the next three years.

'Push / Pull Factors

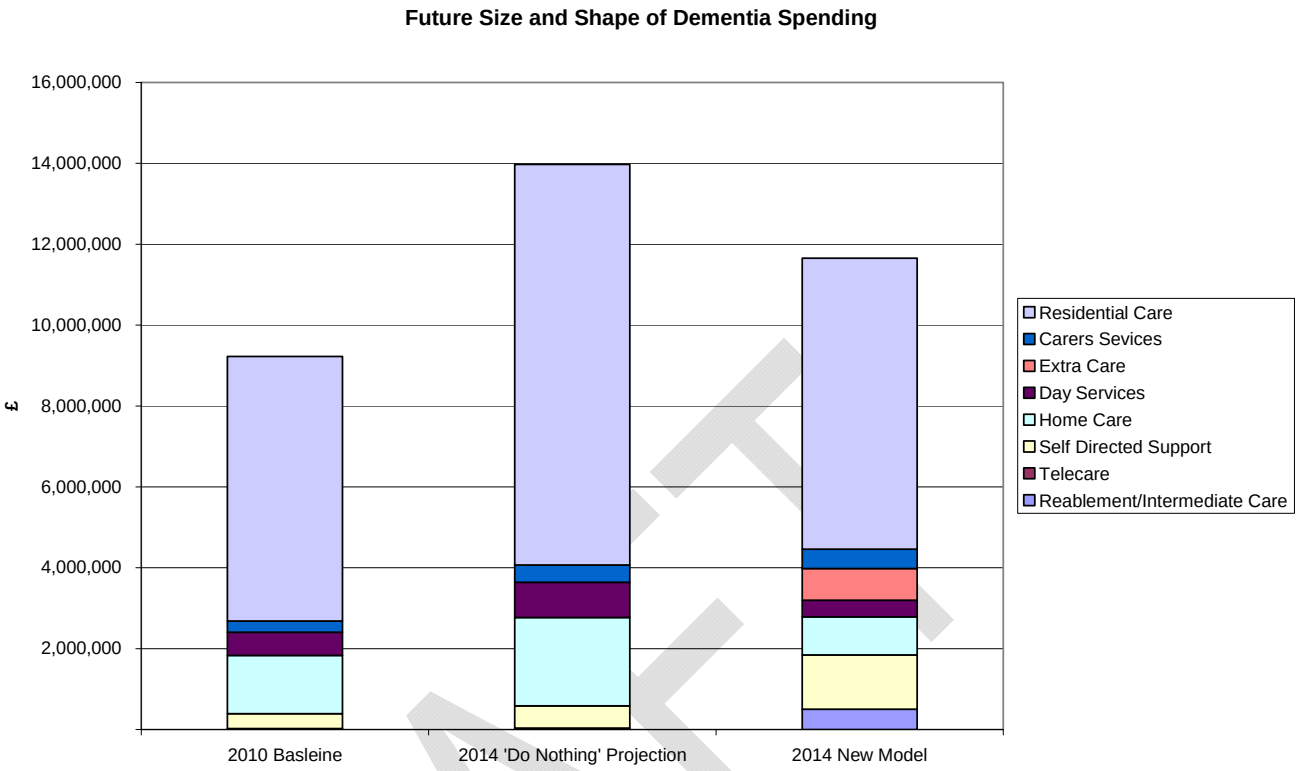
There are a variety of different factors that will 'push and/or pull the funding for services, for example; residential care – price inflation and demographics will push the price but at the same time Improvements to Public Health, Telecare, Prevention, will all pull expenditure on residential care down. And for each type of expenditure there are all these factors pushing and pulling.

As discussed earlier we will shift resources from the point of crisis to prevention and early intervention. The graph below illustrates, over the next three years the impact of making these changes and how through service re-engineering Warwickshire County Council and NHS Warwickshire will be in a good position to meet demand. All of the proposed commissioning intentions and the impact of service re-engineering, together with the anticipated 'push / pull factors' result in a shift in how the financial envelope will be used. The graph and financial table below illustrates the impact of these forces and the net result for 2014. Importantly several assumptions have been made including:

Assumptions:

- Inflation of approximately 2.5% per year
- Demography increasing costs by approximately 9% per year
- Significant switching from traditional services to direct payments under self directed support, with new services costing less than traditional services (the illustration shows day services 50% saving, homecare 10% saving, residential care 5% saving)
- Reablement and telecare investment generating net savings on homecare and residential care (illustration shows 2% saving on homecare and SDS, and 1% on residential care)
- Carers – (illustration shows a 20% increase in Carers spending offset by savings on package costs)
- Early intervention and diagnosis – this would significantly mitigate demographic pressure.
- Extra care will provide a cheaper alternative to residential care.

Overall, service transformation has the potential to significantly mitigate increases in spending


Future Size and Shape of Dementia Spending
16,000,000
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
£
2010 Basleine
2014 'Do Nothing' Projection
2014 New Model
Residential Care
Carers Sevices
Extra Care
Day Services
Home Care
Self Directed Support
Telecare
Reablement/Intermediate Care

Impact of the Push / Pull Effect and the projected re-engineering to meet commissioning intentions.

	2010 Basleine	Inflation	Demography	2014 'Do Nothing' Projection	SDS	Reablement	Telecare	Carers Services	Early Intervention and Diagnosis	Extra Care	2014 New Model
Reablement/Intermediate Care						500,000					500,000
Telecare	20,000	2,076	8,232	30,308			40,000				
Self Directed Support	366,568	38,054	150,873	555,495	1,081,595	(163,709)		(29,468)	(72,196)		1,371,717
Home Care	1,441,444	149,640	593,272	2,184,356	(436,871)	(674,749)	(61,455)	(21,455)	(49,491)		940,336
Day Services	574,939	59,686	236,634	871,259	(435,630)				(21,781)		413,848
Extra Care										780,000	780,000
Carers Sevices	280,161	29,084	115,309	424,554				84,911	(25,473)		483,992
Residential Care	6,537,753	678,703	2,690,819	9,907,275	(495,364)	(188,238)	(92,237)	(184,473)	(447,348)	(1,310,400)	7,189,215
Total	**9,220,865**	**957,245**	**3,795,138**	**13,973,248**	**(286,270)**	**(526,696)**	**(113,691)**	**(150,485)**	**(616,290)**	**(530,400)**	**11,679,108**

11. Priority Actions and Implementation

11.1 Our actions in taking forward the Strategy will be:

- Explore with Warwickshire Observatory the development of a systematic approach to capture and report intelligence including accurate local prevalence and demographic information.
- AH&CS to develop with Warwickshire PCT a robust performance dashboard to include primary care QOF data, secondary, acute and community based services to improve commissioning intelligence.
- To utilise and develop national and local research and benchmarking information to enhance performance of services locally.

11.2 Measuring for Success

The Dept of Health Quality outcomes for people with dementia, in consultation with people with dementia and their carers have developed a series of outcome measures:

By 2014, all people with dementia living in England should be able to say:

I was diagnosed early	I understand, so I make good decisions and provide for future decisions making	I get the treatment and support which are best for my dementia and my life
Those around me and looking after me are well supported	I am treated with dignity and respect	I know what I can do to help myself and who else can help me
I enjoy life	I feel part of a community and I'm inspired to give something back	I am confident my end of life wishes will be respected. I can expect a good death

We will also identify a number of the following outcome measure for adult social care and use to measure progress over the lifetime of this strategy.

Enhancing independence and control over own support

• The proportion of those using social care who have control over their daily life

Enhancing quality of life for carers

• Carer-reported quality of life

Ensuring people feel supported to manage their condition

• Proportion of people with long-term conditions feeling supported to be independent and manage their condition*

Helping older people to recover their independence

• Proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into reablement/rehabilitation services

Preventing deterioration and emergency admissions

• Emergency bed days associated with multiple (two or more in a year) acute hospital admissions for over 75s*

Improving recovery from falls and falls injuries

• The proportion of people suffering fragility fractures who recover to their previous levels of mobility / walking ability at 120 days*

Supporting recovery in the most appropriate place

• Delayed transfers of care*

Delivering efficient services which prevent dependency

Improving access to information about care and support

• The proportion of people using social care and carers who express difficulty in finding information and advice about local services

Treating carers as equal partners

• The proportion of carers who report that they have been included or consulted in discussions about the person they care for

Providing effective safeguarding services

• The proportion of referrals to adult safeguarding services which are repeat referrals

12 Appendices

Appendix 1

Below are the outcomes that people with Dementia and their family carers have told us are important to them in order to live well with dementia.

This information has been gathered through a variety of workshops, conferences, visits to services and clubs and events held locally.

What people with dementia and their carers have told us

Key Theme; Raising Awareness and Understanding

People in Warwickshire want to be well informed and to know where to go to, to get good quality information, advice and a timely diagnosis when they are ill. The same applies for those with Dementia. To support individuals to keep well or seek timely advice and referral on for diagnosis you have told us that you want to see:

- Joined up local campaigns providing evidence based information and advice about how to keep well and reduce the likelihood of acquiring early onset of Dementia.
- Advice and information about who to see and what to do if you suspect you have dementia and where to go to get help.
- Local media campaigns include advertising and specific web links to be made available to the general public and to specific agencies who deal with advice and information for the public, this should include local education facilities, i.e. both schools and colleges to ensure young people hear the message and act wisely.
- That campaigns include and link with other campaigns and information, i.e. stroke, alcohol, healthy eating.
- That information published should be clear and easy to understand, readily available on request and distributed through a range of resources i.e. supermarkets, libraries and is suitable for all abilities and cultures.
- That you would want to have the relevant tests and treatments to confirm diagnosis early, enabling you to plan your life and adjust where appropriate to life changes produced by the condition.
- If you do not have a clear diagnosis you want to be advised as to what to do to improve your memory and be supported in this through Primary care or memory services.
- You would not want to wait a long time to be seen because more people are being referred to services earlier. This may mean services opening more frequently or being better staffed and more flexible.

Key Theme 2; Early Diagnosis and Support

Users and Carers tell us that services are different across the county, access to these services is not always timely and support, information and

advice limited. You want confidence to know that any services provided to you or the person you care for are of the highest quality.

You have particularly stated that you would want to see;

- Model the impact of increasing early diagnosis on other services. People diagnosed early are more likely to receive pharmaceutical and therapeutic interventions that will help them live active lives for longer therefore reducing hospital admissions and delaying the need for long term care. Establish formal processes to ensure that people who are admitted to hospital with a diagnosis of dementia are notified to the appropriate GP practice to ensure that the patient is placed on the dementia register.
- A single Dementia pathway for Warwickshire that is publicised and accessible is measured for quality and is staffed with competent, capable practitioners throughout.
- Eligibility throughout the pathway that is published and accessible to all.
- A 'navigator' to assist you, and stay with you throughout your journey (Dementia Advisor).
- Key health and social care support staff at specific intervals across the pathway, i.e. in Primary Care, Memory Assessment services and End of Life care that offer specialist support, reviews if your conditions changes and advice in change of circumstances.
- Support to remain at home and a care plan that reflects this that you have control of and contribute to.
- Support for carers to include information (including on line information and forums), education, and peer support. If you do not know how to deal with issues they become Crisis, this is something you have told us you wish to avoid therefore to be better able to meet the presenting symptoms and issues.
- A care pathway between Acute services, Learning Disability and Dementia services need to be part of the services developed, they also need to be robust and be performance managed.

Key Theme 3; Living Well with Dementia.

You have told us that once diagnosed with Dementia we needed to develop a range of services that fully meet your changing needs as both an individual and those of your carer/supporter. Things you told us included:

- The need for a person GP to work with mental health services and learning Disability services to support the whole person's health throughout.
- The need to have a dedicated person in acute care settings responsible for dementia, this should include a lead clinician and a liaison service.
- Help to stay at home for as long as possible.
- Avoidance of repeat admissions to hospital and once there frequent moves that continue to confuse and disorientate people
- To learn from best practice in other authorities and PCT's.

- Equal access to MH services, this includes Crisis Resolution and Home Treatment teams and Assertive Outreach support for people with challenging behaviour or hard to engage/support.
- Not being transferred from Hospital straight to residential care
- More appropriate age related services for Early Onset dementia.
- Access for both users and carers to IAPT services.
- Short breaks for carers which include:
    - Domiciliary care
    - Day services
    - Peer support groups
    - Voluntary sector support services
    - Expanding direct payments to carers
    - Expanding individual budgets for people with dementia
- The need for people to be treated with Dignity and Respect
- A diagnosis no matter where you are. Ie in a care home and an appropriately adjusted care plan to reflect your needs

Extra care housing, telecare and assistive technology are an integral part of services for people with dementia, if improving quality of care and maximising choice, independence and control are to be achieved. Housing should be based on need not the environment in which it is provided. To do this you tell us we must:

- Promote and commission extra care housing options that are able to support long term users with a diagnosis of Dementia or who are diagnosed with dementia whilst in an extra care housing setting.
- Make available assistive technology, enabling users and carers to experience the technology within a specialist support package which will assist them to live at home.
- Offer flexible day care support options that are available at home (to include short breaks), or in the community.
- Ensure housing staff are trained in Dementia
- Flexible use of individual budgets.
- Establish a research and evidence base for services offered and technology made available to ensure it is fit for purpose.

Key Theme 4; Making the Change

Users and Carers applauded the National Dementia Strategy recommendation for an informed and effective workforce. Locally their views included the need for:

- Awareness raising/training for staff working within the general health, housing, social care and community sectors, including GP's, Police and Fire, Probation and Education to both ensure early recognition of dementia onset and progression/deterioration in those with a diagnosis necessitating referral to specialist services.
- Mandatory training for staff in primary and secondary care from GP to receptionist, from consultant to porter / cook; from management to students.

- Accredited training for the whole Dementia workforce, in particular contractual requirements necessitating accredited training for staff at all levels.
- Specific training for risk and risk management that supports service users to stay at home and that takes account of carers concern within the framework of the personalisation agenda.
- Ensure that all commissioned service include service specifications that specify dementia training and core competencies that include, but are not limited to, the national minimum standards.
- All community based health and social care staff will receive core training in dementia.
- Home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia training.
- Profile the capacity and skills of the workforce to that training and support can be targeted and work with a number of joint projects with Universities and GP training through online programmes.

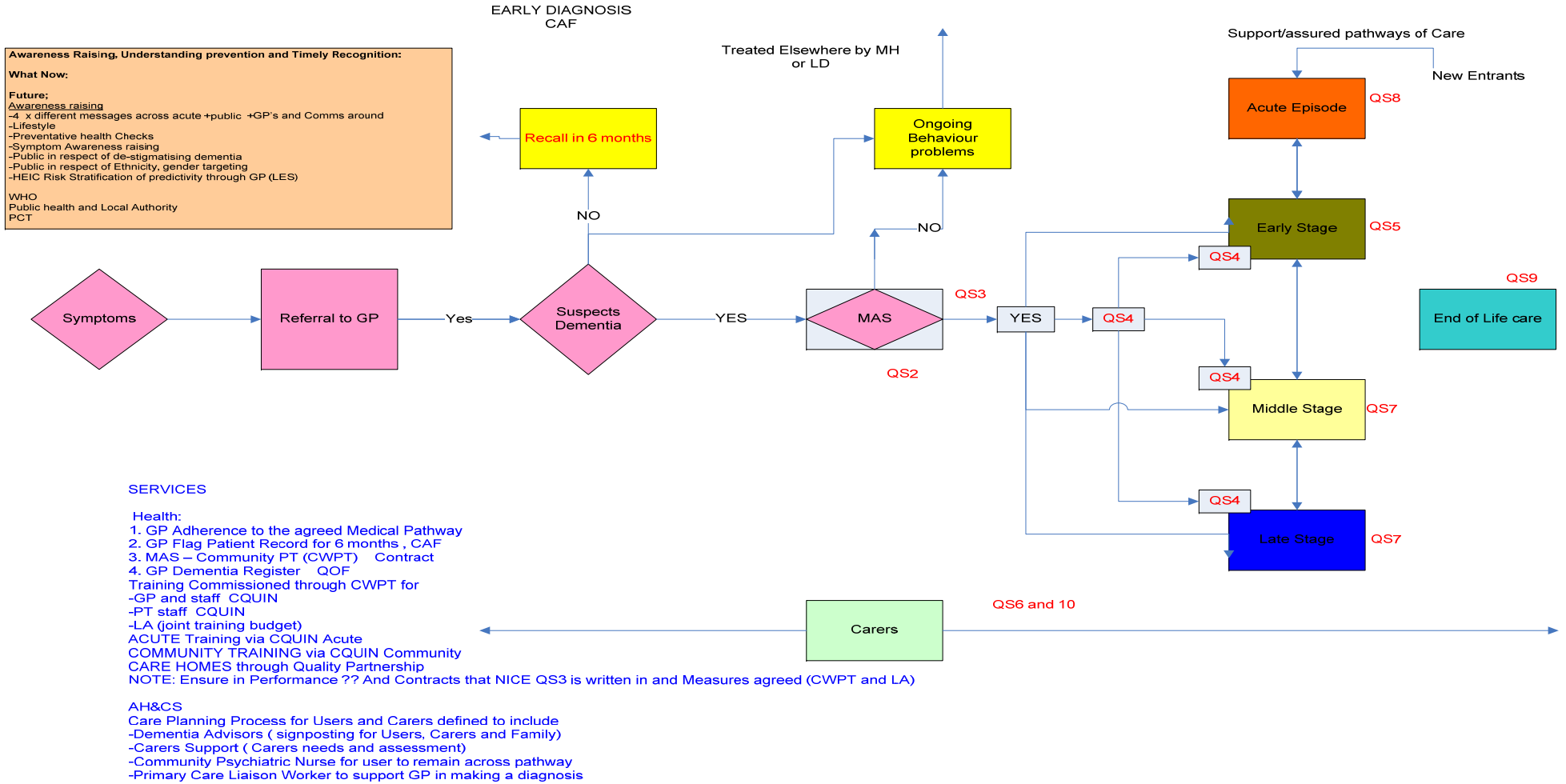
Appendix 2

Dementia Respite services - Financial year 2010/11

Specialist Dementia respite services

	External			Internal			Total		
District	**Externally Provided Respite Nights**	**External Costs £**	**External Unit Cost Per Night**	**Internally Provided Respite Nights**	**Estimated Internal Costs £**	**Internal Unit Cost Per Night**	**Total Respite Nights**	**Total Costs £**	**Overall Unit Cost Per Night**
Stratford	37	2,829	76.46	258	23,957	92.86	295	26,786	90.80
North Warks	367	24,126	65.74	59	5,479	92.86	426	29,605	69.49
N and B	708	52,783	74.55	7	650	92.86	715	53,433	74.73
Rugby	473	33,577	70.99	65	6,036	92.86	538	39,613	73.63
Warwick/ L	44	3,293	74.84	107	9,936	92.86	151	13,229	87.61
Total	**1,629**	**116,608**	**71.58**	**496**	**46,057**	**92.86**	**2,125**	**162,665**	**76.55**

Warwickshire Assured Care Pathway for People with Dementia and their Carer



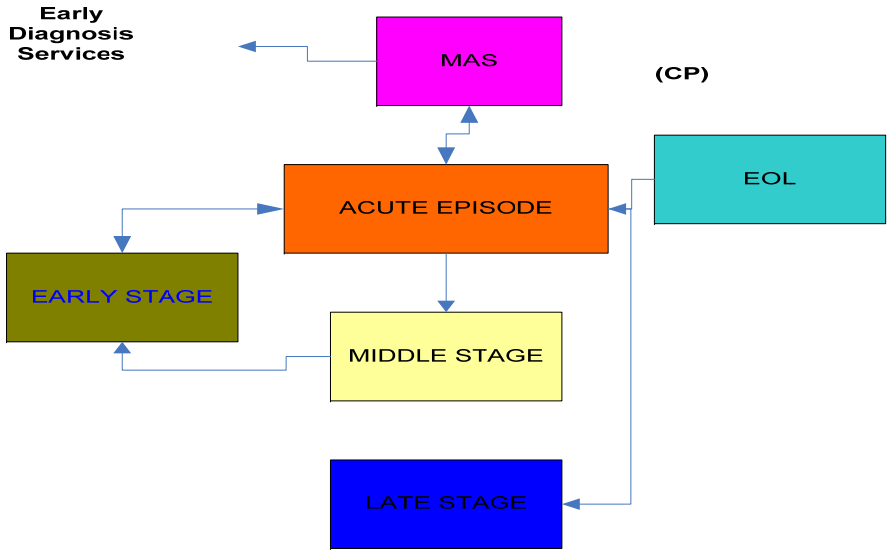
SERVICES

Health:
1. GP Adherence to the agreed Medical Pathway
2. GP Flag Patient Record for 6 months , CAF
3. MAS – Community PT (CWPT) Contract
4. GP Dementia Register QOF

Training Commissioned through CWPT for
-GP and staff CQUIN
-PT staff CQUIN
-LA (joint training budget)
ACUTE Training via CQUIN Acute
COMMUNITY TRAINING via CQUIN Community
CARE HOMES through Quality Partnership
NOTE: Ensure in Performance ?? And Contracts that NICE QS3 is written in and Measures agreed (CWPT and LA)

AH&CS
Care Planning Process for Users and Carers defined to include
-Dementia Advisors (signposting for Users, Carers and Family)
-Carers Support (Carers needs and assessment)
-Community Psychiatric Nurse for user to remain across pathway
-Primary Care Liaison Worker to support GP in making a diagnosis

Early Stage



Workforce Links

General Services
Training to educate in Dementia Awareness and ability to refer on to the Dementia Care Pathway to include cultural diversity

Services

-
1. Advice and Information/Range of Low level Services or Life Choices QS5
2. Carers Support and Assessment/Interventions/ Education
3. Peer Support
4. Assistive Technology
5. Generic Home Assessment
-Housing/SP
-Specialist Adaptations
-Domiciliary Care
-MOW
-Continence services
-Falls
6. 1st stage advance care Planning (Admiral Nurse for specific intervention then away) QS5
7. Voluntary Sector Community based services
8. Community Alarm
9. General Aids to Daily Living- Phyllis, walking sticks, grab rails
10. General Wellbeing services.

IAPT links to MH and to CWPT (Specification)

Dementia Care C0-ordinators

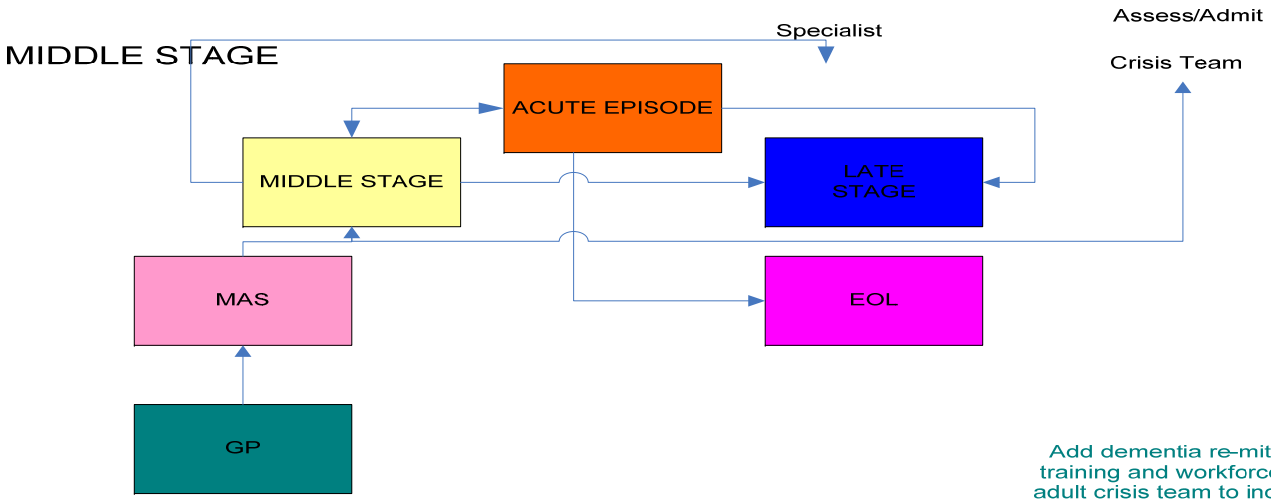
Ongoing Medicines from Diagnosis stage

Review by Consultant/GP Medical Condition urgent

Watching Brief- who owns the progression

Pastoral Care

Medicines management



SERVICES

Add dementia re-mit for training and workforce for adult crisis team to include Dementia

same for Assertive Outreach

Transitional Care Arrangements

Falls

Health (CWPT) And Social Care (JC) CHC QS1

- Assessment in Community
- Specialist Dom Care
- MOW

QS2
- One to One support services
  - -Carer relief
  - -Carer respite
- Dementia Advisor QS6
- General Wellbeing Services
- Residential Care ?? Nursing care and CHC) services
- Adaptations and Housing related support
- Extra Care

Residential Care Liaison in reach worker posts…….
Hospital in Reach liaison

Specialist carers support

Wandering

Medicines Management

Need to carry on services if entering straight on to Care Pathway

Who owns progression and medical support for life in the community

QS7 IAPT Psychological Interventions

Crisis resolution and Home Treatment

Day Hospitals (functional)
%care CMHT OPMH

Step Up/Down Team specifically for dementia

Continence Care
Pastoral Care
SALT

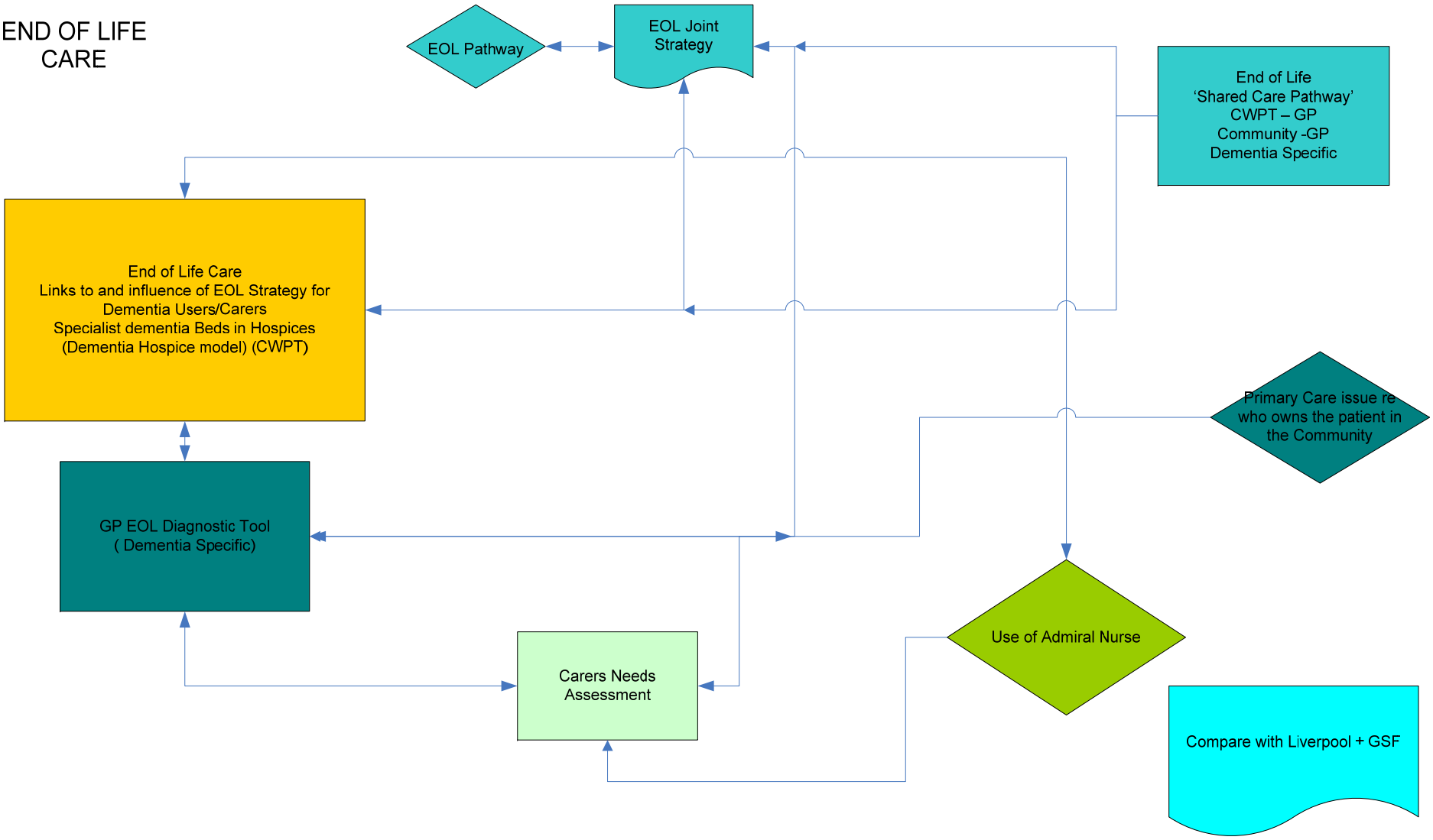
Re-ablement
Intermediate Care

ADVOCACY

Cert for Dementia

QS4 Reviewing Packages of Care

END OF LIFE CARE



Living Well with Dementia

Delivery Plan for 2011 – 2014

Awareness and Understanding

Dementia Strategy Delivery Plan 2011 - 2014

	Lead and Supporting officers
People in Warwickshire want to be well informed and to know where to go to; get good quality information, advice and a timely diagnosis when they are ill. The same applies for people the with dementia. T	**John Linnane. Director of Public Health** **Emily Smith. Health Inequalities Officer.**
Lead Organisation	

Action	Start Date	End Date	Activity	Deliverable	Responsible officer and organisation
Address the understanding of some of the causal affects of dementia and promote healthier lifestyles through the prevention strategy.	commenced	March 2012	1. Develop a risk stratification tool the focus of which is to identify those factors that best predict patients developing early dementia.	1. Publicity campaign about the effects of alcohol, stroke and other conditions on dementia.	**John Linnane** **Sandra Ward** **NHS Warwickshire**
Provide universal information and advice	Feb 2011	Sept 2011	1. Identify responsible officer for collection and collation of information relevant to	1. Resource Directory that is up to date and	**Marcus Herron**

for everyone about dementia.			people with dementia. 2. Input data into Directorate resource directory 3. Agree joint approach using the care pathway to establish key information giving points with NHS Warwickshire and CWPT. 4. Update WCC and NHSW websites.	public facing 2. Identified officer responsible for monitoring and updating information	**NHSW?**
Have available advocacy services, including IMCA and access to support to develop living wills			1. Review current contracts with advocacy services. 2. Set up focus group of users/carers to determine need. 3. Agree joint commissioning intentions for future advocacy services 4. Tender new contract	1. Co-production group of users/carer and staff 2. Revised specification for advocacy services. 3. Re-tendered advocacy services	**Lorna Ferguson/Sally Eason**
Include dementia awareness in induction training for employees within the NHS, Council	April 2012	March 2014	1. Establish agreed joint learning outcomes for dementia awareness 2. Incorporate into induction programme for NHSW,	1. An agreed learning outcome for dementia awareness training.	**Rachel Faulkner** **?? NHSW**

and partner organisations.			WCC and WWPT. 3. Explore links with Skills for Care (dementia) programme. 4. Identify funding stream, including any external funds. 5. Delivery training (using a range of media)	2. Agreement across WCC and NHSW and key partner organisations 3. 30% of frontline staff trained in dementia awareness across NHSW and WCC and key partners.	
Ensure any awareness campaign is coordinated with the development of services to ensure that any additional demand that is created through improved awareness is able to be responded to.	April 2011	March 2014	1. Establish communication/engagement group and produce communication and stakeholder engagement plan for lifetime of strategy 2. Produce Plan across health and social care economy including partners 3. Agree strategy for implementation throughout strategy programme	1. Communication and Engagement Plan 2. Stakeholder Analysis document 3. Effective Communication and engagement with user/carers/staff and key stakeholders	**Rebecca Davidson/Comms person from NHS Warwickshire**

Key Outputs/Targets	Key Outcomes
By March 2012, people with dementia and their carers are more knowledgeable about dementia.	
By September 2011, a resource directory is available for people with dementia and their carers	
By April 2011, agree a joint care pathway for people with dementia and their carers.	
By September 2011, clients and their carers are more knowledgeable and informed about Personalisation.	
By September 2011 information on the range of local service will be readily available.	
By September 2011, service users, carers frontline staff and key stakeholders and partners are well informed about the Dementia Strategy and its commissioning intentions	

Early Diagnosis and Support

Dementia Strategy Delivery Plan 2011 - 2014

	Lead and Supporting officers
User and carers tell us that services are different across the County, access to these services is not always timely and support, information and advice limited. You want confidence to know that any services provided to you or the person you care for are of the highest quality.	**Maria Fennell – Coventry & Warwickshire Partnership Trust (CWPT)**
Lead Organisation	

Action	Start Date	End Date	Activity	Deliverable	Responsible officer and organisation
Improve referral to the Memory Assessment Services to increase the number of people diagnosed early with dementia by xxx	April 2011	March 2012	1. Set up focus group between CWPT and GPs to agree improved referral route to Memory Assessment Services to improve referral to MAS 2. Agree a more targeted approach to those	1. Revised targeted referral route to memory assessment service. 2. Improved relationships between	**Sally Eason NHS Warwickshire** **Maria Fennell – CWPT**

			referred to MAS 3. Communicate revised referral approach to all GPs in Warwickshire. 4. Re-negotiate contract with CWPT to include nurse led memory assessment service.	GPs and MAS. 3. Increase in the number of people appropriately referred who go on to be diagnosed early.	
Implement the agreed Dementia Care Pathway for Warwickshire	April 2011	March 2014	1. Within consultation process include consultation on the Care Pathway for Dementia. 2. consult with wide range of staff across health and social care 3. Revised Care Pathway and communicate widely 4. Monitor implementation.	1. Care Pathway revised and agreed at DLT and CEC 2. Staff fully informed of revised Care Pathway 3. Leaflet for service users and carers widely distributed	
Work with GPs to review/remove/decrease the inappropriate use of medication which is a particular issue in care homes and which poses					

medical risks in older people by xxx					
Review the Dementia Advisor service in the North of the County and the role of the admiral nurses including cost effectiveness to agree future model	Sept 2011	August 2012	1. Set up review group ensuring links to demonstrator site for dementia advisor 2. Complete evaluation of the dementia advisor role. 3. complete review of Admiral nurse role. 4. Agree future commissioning intentions for this type of role across the county. 5. Secure funding and implement revised model based on better outcomes and lower costs.	1. Evaluation report for Demonstrator Site Dementia Advisors 2. Review report of Admiral Nurses 3. Revised model for Warwickshire including cost benefits 4. Funding sourced and secured	**Lorna Ferguson/Sally Eason.**
Commission specialist carer education and support programmes to ensure carers are equipped with the skills and confidence to manage at home.	March 2012	Sept 2012	1. Set up co-production review group 2. Complete desk top review. 3. Agree revised model ensuring cost benefits and better outcomes that sustained the	1. Co-production group – users and carers willing to act as trainers/facilitators 2. Revised	**Rachel Faulkner**

			caring role 4. Agree model and implement	programme for CESP. 3. Increase in the number of carers able to continue caring for longer.	
Have access to effective peer support including Alz/Joe's cafes countywide.	tbc	tbc	1. Map existing prevalence statistics and current peer support services – identify gaps 2. Review current provision for benefits – financial and individual outcomes 3. Agree future model based on better outcomes at lower costs	1. Increased access to peer support or cafes 2. Universal spread of services across the County 3. Improved outcomes for people with dementia and their carers	**Lorna Ferguson**
Establish a referral route to the IAPT services for people newly diagnosed with dementia.	April 2012	Sept 2012	1. Set up task and finish group across partner agencies 2. Agree referral protocols and routes	1. Referral protocols and routes jointly agreed 2. Business process	**Amanda Gatherer - IAPT Lead** **GPs**

			3. Establish business process and communicate widely 4. Review approach within 6 and/or 12 months for effectiveness. 5. Include survey review of services received and the effect on mental health quantified.	mapped 3. Communications plan implemented 4. survey of user satisfaction completed and overall performance improved.	
Improve the awareness and use of advance directives and advance care planning for people with a diagnosis of dementia.	April 2011	March 2014	1. Confirm legal perspective on the use of advance directives 2. Provide frontline staff with updated protocols for advance directives. 3. Ensure voluntary and community sector understand the value of advance directives and use in their information giving processes.	1. Clear protocols on the use of advance directives 2. Knowledge and expert voluntary and community sector in advance care planning.	**David Solely/Linda Fleming**
Key Outputs/Targets				Key Outcomes	

Living Well with Dementia (1)

Dementia Strategy Delivery Plan 2011 - 2014	
	Lead and Supporting officers
Users and carers have told us that once diagnosed with dementia we needed to develop a range of services that fully meet your changing needs as both an individual and those of your carers/supporter. Things you told us included:	
Lead Organisation	

Action	Start Date	End Date	Activity	Deliverable	Responsible officer and organisation
Utilise personal budgets (and personal health budgets) for people with dementia and carers, to develop innovative and flexible services to support individual needs.	Sept 11	Mar 2014	1. Train frontline staff in self directed support and personal budgets/ health budgets 2. Agree business processes to be used within older people mental health teams. 3. Champions in each team	1. Integrated teams informed and knowledgeable about personal budgets/health budgets 2. Business process in	**Jenny Wood/David Solely – WCC** **Sally Eason - NHSW**

			established 4. Performance indicators defined 5. Small pilot completed and evaluated for personal health budgets	place 3. All eligible people for social care in receipt of a personal budget 4. xxx people in receipt of a personal health budget	
Increase the take up of Direct Payments by 25% by 2014.	April 2011	Mar 2014	1. Ensure that all staff within integrated teams understand the benefits of Direct Payment. 2. Set performance targets for each team and monitor progress 3. Communicate the benefits of Direct Payments with people with dementia and their carers. 4. Complete a survey of users and carers utilising Direct Payments and share good practice and learning	1. Increased number of people with dementia in receipt of Direct Payments 2. Improved confidence in services delivered.	**David Solely** **Lesley Kendall**

Mainstream and externalise domiciliary care including specialist provision.	April 2011	Dec 2011	1. Tender mainstream domiciliary care provision ensuring the needs of people with dementia are included. 2. Tender specialist dementia domiciliary care service to external market for people with complex behavioural needs associated with later stages of dementia.	Mainstream domiciliary care contract that incorporates support to people with moderate dementia. External specialist cost effective domiciliary care for people at later stages.	**Rob Wilkes – WCC** **Steve Smith - WCC**
Increase the use of reablement by 15% for people with dementia.	Sept 2011	March 2014			
Promote referral route to aids and adaptations, in particular continence care.					
Jointly review the use of building based day provision and reduce by 30% by 2014.	April 2011	March 2012	1. Jointly review with health the provision of day opportunities. 2. Include people with dementia and their carers 3. Agree revised model of day hospitals and day care ensuring that the needs of	1. Day opportunities revised.	**Lorna Ferguson – WCC** **Sally Eason NHSW**

			carers are fully considered.		
Increase the use of intermediate care at point of discharge by 20% by 2014 for people with dementia.???	April 2011	March 2014			
Move to a model of flexible day care support for people with dementia, this will include day and night (24hr) options for support.					
Review respite provision to increase the range and type available	April 2012	March 2013	1. Complete detailed mapping of existing provision. 2. Agree revised model incorporated new ways of support carers, eg through technology.	1. Provision of respite increased and improved. 2. New models introduced. 3. Carers ability to continue to care for longer increased	**Christine Lewington - WCC**

Commission a range of community based general services that have appropriately trained staff able to respond to people with dementia and promote recovery and continue to enable independence.			Explore cost benefits of extending the crisis resolution and home treatment service to people with dementia.		
Review respite provision to increase the range and type available					
Commission residential and nursing care contracts that reflect the commissioning intentions laid down in the NDS, i.e. an identified Dementia Champion in the home, jointly commissioned in reach services to care					

homes through CMHT OP services, reduction and adherence to protocols for use of anti-psychotic drugs use.					
Dementia appropriate End of Life services that support individuals to have a 'Good Death'.					

Key Outputs/Targets	Key Outcomes
By March 2013 all people with dementia and their carers will have a personal budget. .	
By March 2012 at least 25% of people with dementia will have a direct payment.	
By April 2011, an agreed care pathway for people with dementia is in place and well understood by staff across health, social care and partner agencies.	
By April 2012, clients and their carers are more knowledgeable and informed about Personalisation.	

Living Well with Dementia (2)

Dementia Strategy Delivery Plan 2011 - 2014	
	Lead and Supporting officers
In commissioning housing related support we will work with housing partners, supporting people, housing associations, extra care providers and independent care homes to;	**Rob Wilkes.** **Tim Willis. Lead for Extra Care Housing** **Rachel Norwood. Housing Related Support Lead.**
Lead Organisation	

Action	Start Date	End Date	Activity	Deliverable	Responsible officer and organisation
Through service re-design and within existing resources commission specialist dementia residential care units within key areas of the County each incorporating the					

provision of respite.					
Decrease the use of residential care by 20% over the next three years at the point of discharge.					
Make available at least 25% of extra care units to people with dementia within the Care & Choice Accommodation Programme.					
Commission a range of housing options that better meet the specialist needs of people with dementia. Include offering people the option (early) of living in Extra care ensuring that families see Extra Care housing as a viable option for people with Dementia.					

Ensure that the supporting people programme offers appropriate housing related support to people with dementia.					
Increase the use of assistive technology to support people to live at home by 5%.	April 2011	Oct 2011	1. Commission a 24 hour support to customer using assistive technology including where an actual physical response is required.		**Rob Wilkes**

Comment [WCC1]: Needs to be more targeted.

Key Outputs/Targets	Key Outcomes

Making the Change

Dementia Strategy Delivery Plan 2011 - 2014	
	Lead and Supporting officers
Users and carers applauded the Nation Dementia Strategy recommendation for an informed and effective workforce.	**Rachel Faulkner. WCC**
Lead Organisation	

Action	**Start Date**	**End Date**	**Activity**	**Deliverable**	**Responsible officer and organisation**
Develop a joint health and social care workforce development strategy ensuring a competent and confident workforce.			1. Set up Joint Workforce sub group 2. Produce workforce training programme for levels1 to 3. 3. Identify targeted groups for yr1, yr2 and yr3. 4. Establish an evaluation process.	Joint Dementia Workforce Strategy Training Programme for: New staff, targeted existing staff, joint posts, stakeholders delivered over three years. Training evaluation programme produced.	**Rachel Faulkner – WCC** **Xxx - NHSW**
Include people and their carers in the delivery and			1. set up co-production group and train in the art of	Co-production group	**Rachel Faulkner**

evaluation of learning programmes			facilitation. 2. Agree how facilitators will be engaged in the training programmes. 3. Ensure all out of pocket expenses are reimbursed and include recompense for training delivered. 4. Evaluate the support, training and participation achieved.	identified Training for facilitators delivered Training programmes delivered and satisfaction feedback evaluation report produced.	**Amanda Burn**
Ensure all relevant workers complete a level one development programme as part of their induction and/or continuing professional development.	April 2011	March 2014	1. Agree induction level one training programme. 2. Target and map delivery of training for yrs 1, 2 and 3. with a view to have 100% of all staff trained in dementia awareness 3. Identify and target training to key stakeholder staff.	Level one induction training programme completed. 100% of staff receive dementia awareness 25% of stakeholder staff trained	**Rachel Faulkner**
Commission and begin delivering the second or	April 2011	Sept 2011	1. Agreed intermediate training programme.	Intermediate training	**Rachel Faulkner**

intermediate level development programme.			2. Target and map training to key professionals; A & E staff, general acute staff, Practice Nurses, external res care staff.	programme defined. Targetted staff trained Levels of confidence improved.	
Commission and deliver an advanced/specialist programme for staff likely to be working directly with people who have been diagnosed with dementia and their carers.	April 2011	March 2014	1. Agree the advanced training programme. 2. Target and map training to key professionals; specialist res/nursing home staff, hospices, palliative care staff. 3. Include refresher courses for frontline specialist staff eg; acute staff, social work teams	Advanced programme delivered to at least 50% of specialist staff.	**Rachel Faulkner**
Deliver a Dementia Awareness training programme to carers of people with dementia.	April 2011	March 2014		Training programme adapted to support delivery to carers. Carers more aware of the management of dementia	**David Williams - WCC**

Key Outputs/Targets	Key Outcomes

Warwickshire County Council

NHS Warwickshire

Agenda No 7

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult and Community Services Overview and Scrutiny Committee**
Date of Committee	**23 February 2011**
Report Title	Adult Social Care Prevention Strategy
Summary	This Briefing Note sets out the purpose of the prevention strategy, which is to clearly set out the vision, direction and principles of the approach to delaying the need for those with moderate needs entering the social care system and reducing dependency and need for those already in the system through recovery, rehabilitation and reablement
For further information please contact:	Kim Harlock, Head of Strategic Commissioning Tel: 01926 745101 ***kimharlock@warwickshire.gov.uk*** or Andrew Sharp, Service Manager, Older People, Physical Disability, Intelligence & Market Facilitation Tel: 01926 745610 ***andrewsharp@warwickshire.gov.uk***
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☐	
Other Elected Members	☐	
Cabinet Member	☐	
Chief Executive	☐	.....
Legal	☐	
Finance	☒	Chris Norton, Strategic Finance Manager

Other Chief Officers	☐	.....
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	☐	.....

Adult Social Care and Health Overview and Scrutiny Committee

Briefing Note – Adult Social Care Prevention Strategy

23rd February 2011

1. Background

1.1 Developing a strategic response to the Department of Health expectations around prevention as underpinned by the Putting People First agenda is a key component of the current transformation programme within adult social care. The purpose of the prevention strategy will be to clearly set out the vision, direction and principles of the approach to delaying the need for those with moderate needs entering the social care system and reducing dependency and need for those already in the system through recovery, rehabilitation and reablement. Delivering against this strategy will ensure that we are well placed to respond to the needs of our customers and improve their outcomes, whilst also supporting changes in our service model, which respond to the need to reduce costs in both the short and long-term.

2. Information and Advice

2.1 Our strategic approach to prevention will set out the way in which we will promote and protect people's health and wellbeing through recovery, rehabilitation and reablement to support independence and improve quality of life. The wider prevention agenda beyond those in contact with social care is delivered on a cross partnership basis and although we will continue to play a role in this work, our focus is upon working with health colleagues to deal with issues related to our direct customer base. To do this we recognise that our services need to change; they need to be more responsive and focused on new models of provision, particularly in adult social care. This strategy is intrinsically linked to the transformation of adult social care and the move away from traditional services to a more personalised approach and the development of community based alternatives to care. Our work through this strategy will be person centred and provide people with choice and control in the types of care and support that they access, alongside a recognition of the contribution that carers make to the health and social care economy and the support that they require to help them to maintain their caring role for as long as they choose.

2.2 In developing the prevention strategy the Directorate is seeking to build upon approaches and activity which is already in place across the County and to respond to the findings of the "Review of Adult Social Care Prevention Services" reported to Cabinet in January 2011. In addition the strategy will confirm and express our commitment to a continued focus on supporting those with "critical" or "substantial" needs through the services that we provide and commission, alongside a tightening of our interpretation of the Fair Access to Care (FACs) criteria in line with decisions taken by Cabinet in July 2010.

We have also taken account of changes in the way that health and social care will be delivered on a national level and the local response to the white paper "Liberating the NHS" is central to the development of our strategic approach to prevention.

2.3 The prevention strategy is now in the final stages of its development and will be reported in full to the Adult Social Care & Health Overview and Scrutiny Committee and Cabinet in April and May respectively. The purpose of this briefing note is to identify the principles contained within the strategy and to express the way in which this development work will contribute to the delivery of services across adult social care in the future linked to the transformation agenda.

2.4 The current model of adult social care provision in Warwickshire is mainly based upon provision of support when problems arise and this can lead to the creation of a dependency based approach. There is a clear need to strike a balance between delivery of support in a crisis through the use of short term interventions and on-going mechanisms to maintain independence. As part of the transformation programme for adult social care we have recognised the need to provide reactive services where appropriate but to shift our focus more towards services and signposting to community based alternatives which promote health and wellbeing, prevent or limit deterioration and support recovery following a period of crisis. By shifting our approach in this way we can begin to address the key challenges presented by issues associated with an aging population and changes in the social structure which has resulted in reductions in support provided through extended family carer roles.

2.5 Clearly the development of this strategy is set against the context of reducing resources and reduction in central government funding for the provision of social care and health services, alongside demographic challenges through the aging population. However, public sector partners within Warwickshire recognise that by changing our model of delivery we will not only be able to respond to this financial pressure but also improve outcomes for customers and carers, by moving towards more personalised approaches to service delivery. Inverting the triangle of care to move away from treatment as the first point of interaction, responds positively to national policy drivers linked to the Putting People First agenda.

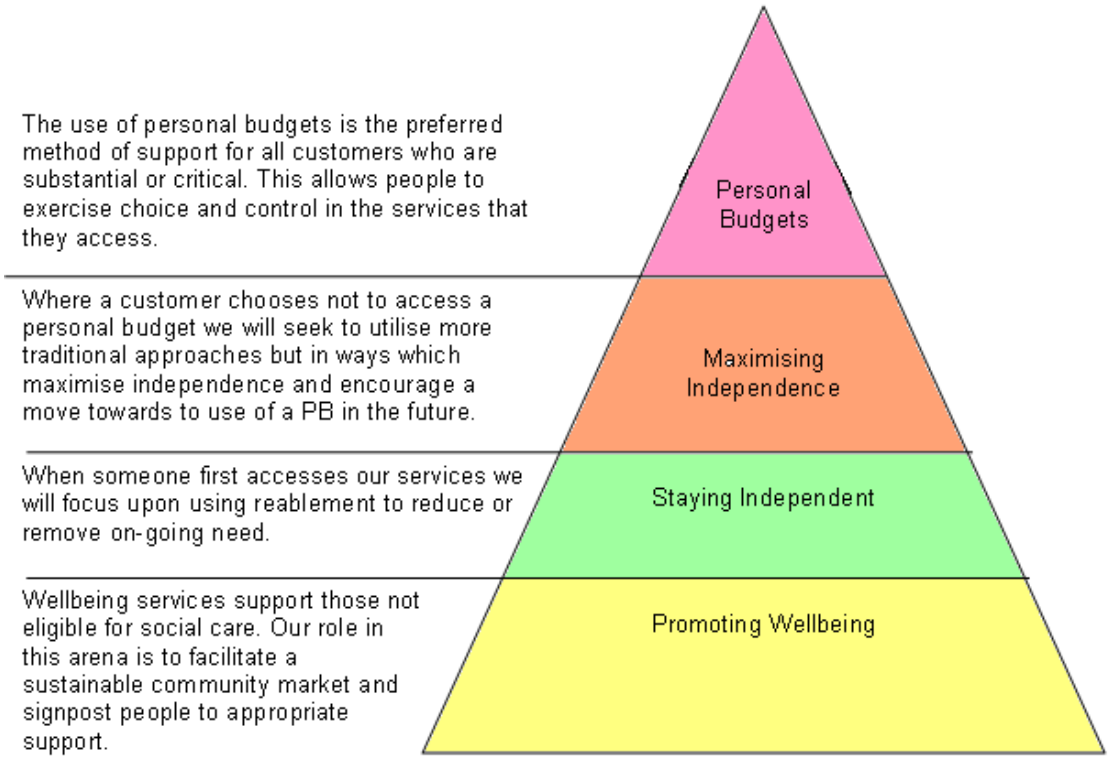
2.6 In order to focus activity, the strategy is being designed to address services for all adults in Warwickshire supported through adult social care and across health where arrangements overlap. The strategy is designed to cut across all of the client groups within which adult social care hold responsibilities, namely older people, learning disability, physical disability (including sensory impairment), mental health and their carers who:

- Require or will require access to information, advice and advocacy services
- Require or are at risk of requiring intensive health or social care support
- Require or will require low level non social care based support to maximise their independence

Although therefore the range of customers to be supported through this approach is broad, interventions will be targeted and managed in such a way as to ensure that impact is maximised.

2.7 From a delivery perspective the strategy seeks to set out our approach to address support across all levels of need but clearly defines responsibilities which rest directly with adult social care (critical and substantial need), those services which are designed for those on the cusp of accessing social care services (upper moderate needs) and those who would benefit from support outside of the social care arena (moderate and low needs). The following diagram expresses the principles behind this and the way in which our activity is aligned to our strategic approach to the transformation and development of adult social care services.

Balancing our approach against need



2.8 In terms of activity delivered and commissioned by the Directorate the strategy will seek to express headline directions against each core area of development, these being:

- Services to promote wellbeing (community based not social care)
- Information, advice and signposting
- Reablement
- Intermediate care
- Long term conditions
- Specialist residential and extra care housing
- Falls prevention
- Telecare and telehealth
- Aids, adaptations and equipment

2.9 The diagram below expresses the impact of activity across the FACs need continuum and the interaction across the four levels of FACs:

<table>
<tr><th colspan="2">Promoting Wellbeing & Staying Independent</th><th colspan="2">Maximising Independence</th></tr>
<tr><th>Low</th><th>Moderate</th><th>Substantial</th><th>Critical</th></tr>
<tr><td>Healthy Lifestyles</td><td></td><td></td><td></td></tr>
<tr><td>Vaccination</td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Screening</td></tr>
<tr><td colspan="4">Falls Prevention</td></tr>
<tr><td colspan="4">Aids, Adaptations and practical support</td></tr>
<tr><td colspan="2">Information, Advice & Signposting</td><td></td><td></td></tr>
<tr><td></td><td colspan="3">Telecare</td></tr>
<tr><td></td><td colspan="3">Intermediate Care</td></tr>
<tr><td colspan="2">Low Level Reablement (hospital discharge)</td><td colspan="2">Social Care Reablement</td></tr>
<tr><td colspan="2"></td><td colspan="2">Extra Care Housing</td></tr>
<tr><td colspan="2"></td><td colspan="2">Long term conditions</td></tr>
</table>

2.10 The approach of the strategy is aligned to and supportive of the ambitions for adult social care expressed within the Corporate Business Plan which is currently being developed through the Partnerships & Performance Unit. As a result delivery against the strategy will be measured and managed through a range of formal channels linked to the corporate performance framework and as part of the governance structure of the adult social care transformation programme.

3. Next Steps

3.1 The development of the draft version of the prevention strategy is almost complete. To support the production of a final version the Institute of Public Care (IPC) have been asked to consider the document and the information it contains in the role of a critical friend. A final draft version of the strategy will be developed following consideration of their comments and feedback, which will be made available to the Directorate Leadership Team (DLT) within Adult, Health & Community Services for comment. Following consideration of the document by DLT a final strategy will be presented to Overview & Scrutiny in April for comment and Cabinet in May for consideration and approval.

Contact Officers:

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Head of Strategic Commissioning

Tel: 01926 745101

Andrew Sharp, Service Manager, Older People, Physical Disability, Intelligence & Market Facilitation

Tel: 01926 745610

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview and Scrutiny Committee**
Date of Committee	**23rd February 2011**
Report Title	**Learning Disability Strategy**
Summary	The attached consultation and communications plan sets out a programme of activity over three months to inform and consult a wide range of stakeholders on the Learning Disability Strategy. Through the use of material taken from the original consultation workshops with service users and carers, we will demonstrate a positive response to the outcomes people have defined as important to them. This lends itself to the personalisation agenda and supports the concept of individual choice and control. Using a range of mediums and techniques including the use of easy material, a robust programme of consultation and communication is detailed in the attached documents. It is proposed that a final report, detailing the analysis of the consultation process, is prepared and presented to Cabinet in June 2011.
For further information please contact:	Chris Lewington Service Manager Tel: 01926 743259
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	Valuing People Now, DH 2009 Valuing Employment Now Putting People First Concordat Think Personal Act Local Using person centred information in commissioning, DH

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees ☐ .....

Local Member(s) ☒ Not Applicable

Warwickshire County Council

Other Elected Members	☒	Councillor L Caborn, Councillor D Shilton, Councillor S Tooth, Councillor C Watson, Councillor C Rolfe, Councillor R Dodd
Cabinet Member	☒	Councillor I Seccombe
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 NO

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☒	16th June 2011
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Further Consultation	☐	.....

Adult Social Care and Health Overview and Scrutiny Committee – 23rd February 2011

Learning Disability Strategy

Report of the Strategic Director of Adult, Health and Community Services

Recommendations
The committee are asked to consider the draft joint commissioning strategy for adults with a learning disability 2011-14, and make recommendations to Cabinet as appropriate.

1. Introduction

1.1 This Learning Disability Joint Commissioning Strategy refresh has been developed in recognition that there needs to be a significant cultural shift in the way services are commissioned and delivered if the vision and principles set out in Valuing People Now, Valuing Employment Now and Putting People First are to be become a reality for people with a learning disability living in Warwickshire.

1.2 The strategy focuses on creating a more coherent strategic direction to the way services for people with a learning disability and their families are delivered to ensure the best use of limiting resources.

1.3 It will create a more enabling and individualised approach, reduce dependency on high cost solutions and give people more choice and control to make informed decisions about how they live their life.

2. Commissioning Intentions

This strategy aims to change the traditional pattern of commissioning and states that:

In future we will commission less:

- residential care and more individual housing including support arrangements.
- residential respite care and more short breaks
- residential care out of Warwickshire and spend more on local services to develop local capacity.
- building based services and more community based daytime opportunities.

We will increase:

- the number of people with a Personal Budget

- the number of Direct Payments
- the use of Telecare and Telehealth

We will also:

- Through better commissioning, reduce the use and need of social care support
- Develop the use of individual service funds, person centred contracting and framework agreements
- Work with providers to develop more creative solutions that reduce the use for paid support.
- Work with the social work team to introduce self directed support as part of a new pathway for learning disability services.
- Improve availability of information advice and support brokerage developing the role and working with the voluntary and independent sector.

Model of Engagement

It will be important to create a comprehensive programme of informing and consulting service users, carers and key stakeholders. Importantly, we will need to establish the areas where we are providing information only and where formal consultation begins and ends. In addition, we want to continue in the spirit of co-production which has already firmly underpinned the development of this strategy. Below is an abbreviated version of the 'ladder of participation'.

1. Levels	2. Description
Level 1 - Informing	At this level you are telling people about the decisions that have already been made. They cannot influence the decisions at this level.
Level 2 - Consulting	At this level you are asking users, carers and the wider public for their views and opinions so that they can influence the decisions made.
Level 3 – Working Together	At this level you are asking users, carers and the wider public to work with you and be an equal partner in all aspects of planning and decisions making.
Level 4 – Users Leading	At this level you are asking users, carers and the wider public to take a leading role and control key decisions about how the services will be planned and delivered.

In using these levels we will be clear with people about what they can and cannot influence.

There are three areas for consideration which form this engagement process. They are:

1. **Informing and consulting** on the learning disability in particular the five commissioning areas; choice and control, a fulfilled life, a place to live,

supporting family carers and good health.
2. **Consulting** on the move away from building based day time support
3. **Informing and working together** on raising awareness around personalisation and self directed support

For each of these groups, we will continue to use the Dept of Health's 'Working Together for Change – using person centred information for commissioning' to engage and consult.

Range of materials to be used

A range of material, including the use of a DVD of the key messages, and an easy read questionnaire (attached as appendix 1) will be the primary medium for informing and consulting service users. The use of the DVD is to capture the key messages contained in the strategy in a format that can be used repetitively with service users. This will be important for people who need time to assimilate information and/or who may need to hear the messages several times. An online questionnaire will also be developed for each of the key groups, service users, carers and stakeholders. Advocacy support will be commissioned through New Ideas.

For carers, a series of workshops will be planned where a DVD of the original messages that service users gave will be used as a scene setting tool. An on line questionnaire will be available as well as the opportunity to become actively engaged in the implementation through the co-production group.

Providers will also play a significant part in the consultation process. A wide range of partners, including; health, district and borough councils, the independent and private sector, the voluntary and community sector as well as the public will be invited to express their views, again primarily through the use of an on line questionnaire. For key stakeholders 2 workshops will be held.

3. Implications and Impact

Implementation of the learning disability strategy includes radical change to the way services are organised and delivered. The most contentious area is likely to be the reduced use and possible closure of the large day centres that are currently used within learning disabilities. A separate report is being progressed about the co-location of some reduced services for people with profound and complex needs and people with complex physical disabilities. It is anticipated that a joint venture with health will be pursued. Importantly the use of community resources needs to underpin the future shape of day time activities.

Evidence suggests that the impact of any proposed closures will adversely affect family carers. This raises concerns as some of this anxiety may transfer to service users themselves.

The consultation will need to ensure that it properly records the impact of any possible closures hence the need to create a 2 staged process to the consultation itself.

A risk matrix will be completed prior to consultation.

4. Consultation and Communication Plan

Attached, as appendix 2, is the consultation programme. It is proposed that the consultation process is held over a three month period because of the complexities of a) sharing the key messages and b) working with people with a range of communication needs. It is proposed to commence in March and complete early June.

Also attached, as appendix 3, is the communication plan.

A detailed analytical report of the outcomes of the consultation will be presented to Cabinet in June 2011.

WENDY FABBRO
Strategic Director of Adult,
Health and Community Services

Shire Hall
Warwick

January 2011

‘A Good Life for Everyone’

Warwickshire’s Joint Commissioning Strategy for Adults with a Learning Disability 2011-2014

Warwickshire Health and Social Care Commissioning Strategy
Refresh for 2011-2014

PART ONE
Our Vision And Commissioning Intentions

Introduction

Valuing People states that "Like other people, people with a learning disability want a real say in where they live, what work they should do and who looks after them…"

This Learning Disability Strategy refresh has been developed in recognition that there needs to be a significant shift in the way services are organised and delivered if the vision and principles set out in Valuing People Now, Valuing Employment Now and Putting People First are to be realised here in Warwickshire.

We know that services in Warwickshire remain traditional in their approach. As an example at the moment, there is a higher than average use of residential care, too few people with a learning disability are supported to find and keep a job. We also know that we need to move away from large building based day services to community based support.

This strategy will focus on creating a more coherent direction to the way services for people with a learning disability and their families are delivered to ensure the best use of limited resources. It will create a more enabling and individualised approach which reduces the dependency on high cost solutions that do not deliver the choices and preferences individuals with a learning disability should be empowered to take.

This Strategy will make clear the commissioning priorities for the next four years. It will be based on what we know about the needs of the local learning disability population and their families and what people with learning disabilities and their families have told us they need.

The Strategy must be delivered using the Directorates 'Principles for Change' which are:

- We must look to deliver quality services at the lowest possible costs.
- We must look to help people regain or attain independence outside of social care services, wherever this is possible.
- We must aim to share services with local partners either neighbouring local authorities or with health partners or both together, where this offers the best solutions.
- We will help people to use their own resources where this is feasible. We will no longer offer subsidies for services for those who through a means test can demonstrate they can afford to pay for those services.

Our Vision

We will change how we do things. Starting with the person at the centre, thinking about what they do well, what they like to do, what their hopes and dreams are.

We will support them and help them look at ways to have control and make good choices about getting a 'good life' for themselves.

Our Aim

Our aim is to promote the rights of adults with a learning disability to live locally as equal citizens, to maximise their independence through the provision of a range of services including, good information and advice, access to employment, leisure and learning opportunities.

Our Objectives

1. We will help people with a learning disability to direct their own support, offering a personal budget so that they have maximum control and through self directed support ensure everyone who is eligible for social care has real choice and control over their lives and the services they use.

2. Through better commissioning, ensure people with a learning disability and their carers have access to a range of housing and support options which promote independence and wellbeing,.

3. By promoting active citizenship and community connections ensure people have access to valued opportunities such as getting a job, being included in their local communities, accessing leisure and learning opportunities and engaging in meaningful activities during the day, evenings and at weekends.

4. Ensure people have access to good health, through better health promotion, timely access to primary and secondary care including access to professional and skilled staff in peoples own homes, preventing admission to institutional care, where this is possible.

5. An emphasis will be placed on supporting people who are least heard, for example, people with profound and complex needs, people with autism and/or people from minority communities to make decisions and choices for themselves.

6. Support family carers, particularly older family carers, to enable them to continue in their caring role where they are able, and to plan for the future of the person they care for when this is needed.

7. To have an effective governance structure that promotes joint working and ensures delivery of this strategy, including an effective and efficient learning disability partnership board.

This strategy is the local response to national policy initiatives and to what people with a learning disability have told us in Warwickshire about what they need and want in order to have a good life and improve the outcomes that matter to them the most. It also describes what we need to do to help make this happen.

It is based on information that has been gathered in 3 different ways:

- Information from talking to adults with a learning disability, parents and carers and other stakeholders about what outcomes they want and what action needs to be taken.

- Information from the Joint Strategic Needs Assessment and other local data.

- Information in Government policies and strategies that describe what we need to do for people with a learning disability and their carers.

COMMISSIONING INTENTIONS FOR 2011-2014

The report **Getting to grips with commissioning for people with learning disabilities** (Care Services Improvement Partnership, 2007) found that despite a doubling of spending by Local Authorities on adults with a learning disability in the last ten years, the *proportion* spent on enabling people to live in the community as opposed to residential or nursing care remains relatively low. The report concluded that receiving support in community settings had better quality of life outcomes and better value services for public money.

As illustrated earlier, the budget spend for people with a learning disability in Warwickshire is dominated by traditional residential support which serves 28% of people receiving a social care service. There is an urgent need to look at how we commission more flexible and individual service options to ensure that the services commissioned are good value for money, serve more people and produce better quality of life outcomes for people with a learning disability and their carers.

This strategy aims to change the traditional pattern of commissioning.

In future we will commission less:

- residential care and more individual support arrangements.
- residential respite care and more short breaks
- residential care out of Warwickshire and spend more on local services to develop local capacity.
- building based services and more community based leisure and daytime opportunities.

We will make sure that:

- everyone has a Personal Budget
- more people will use Direct Payments
- and more people will use Telecare and Telehealth

We will also:

- Through better commissioning, reduce the use and need of social care support
- Develop the use of individual service funds, person centred contracting and framework agreements
- Work with providers to develop more creative solutions that reduce the use for paid support.
- Work with the social work team to introduce self directed support as part of a new pathway for learning disability services.

- Improve availability of information advice and support brokerage developing the role and working with the voluntary and independent sector

Below are the outcomes that people with a learning disability and their family carers have told us are important to them in order to have a good life. Through workshops with people with a learning disability, carers and providers these outcomes have been agreed and will be used to inform all of our commissioning intentions. These outcomes were also agreed at the Learning Disability Partnership Board..

1. More Choice and Control

Outcomes

People with a learning disability want to have choice and control over how they live their life. In particular, they want to have choice and control over:

- How their money is spent.
- Who supports them in the day time and at night.
- Any changes made to the way they are supported.
- What college courses or work they do.
- What they eat and when they eat it.
- What household jobs they take part in, for example, cooking, cleaning and shopping.
- How they travel and spend their leisure time.
- Where they go on holiday and who with.
- Who they spend their time with.
- What relationships they develop and decisions about marriage, civil partnership and children.
- Having a pet to look after.
- When to have a bath, what time to get up and what time to go to bed.
- Taking risks

Commissioning Intentions

We will support people and their carers by:

- Making sure everyone can take up self directed support so that they can be in control of their own support.

We will:

- Provide good information and advice so people can make better and more informed decisions.
- Introduce self directed support.
- Over time give everyone a Personal Budget

- Support lots of different people, including people with a learning disability and carers, to do support planning and brokerage.
- Introduce different ways of managing a Personal Budget, such as through a Direct Payment, a council managed account or an Individual Service Fund.

2. A Fulfilled Life

Outcomes

People with a learning disability want to live a fulfilled life. In particular, they want to:

- Enjoy their leisure time and get involved in a range of activities.
- Have and keep a job they want and enjoy and be able to take acceptable risks in the workplace.
- Be able to travel independently.
- Undertake voluntary work.
- Learn new skills at college.
- Have relationships and make friends.
- Be free from harassment and discrimination.
- Have opportunities to set up social enterprises
- Get the right benefit entitlement.

Commissioning Intentions

People with a learning disability want a fulfilled life; they want to have more independence, get a job if they want and have access to other opportunities outside of social services.

We will support this by:

- Looking at how we can help people to get paid jobs in public services,
- Plan how in house day opportunities services can be re designed to focus on meeting individual outcomes
- Help people to travel more independently so that they can access work, learning and social opportunities.
- Develop information, advice and brokerage to help people to access other opportunities that do not rely on day centres and other social services.

3. A Place to Live

Outcomes

People with a learning disability want a safe and secure place to live where their needs can be met. In particular they want to:

- Decide where they live and to make it homely in the way they choose.
- Decide how they live and what they do.
- Decide who they live with.
- Be close to local shops and services.
- Be as independent as possible.
- Be able to have a pet to share their home with.
- Have options about where they live.
- Live in a safe and inclusive community free from anti-social behaviour.
- Long term security in their home.

Commissioning Intentions

To support people with a learning disability to have their own home we will commission future models of accommodation and support based on robust needs assessment, supply and gaps analysis and sound financial information. We will also:

- Look at lots of ways we can support people to get a home of their own with support if needed such as:
  - Renting or buying instead of residential care for new people
  - Living with friends or alone
  - Living closer to family and friends locally
  - Moving from hospital or residential accommodation
  - Promote assistive technology as an means of enabling people to be more independent and safe within their home

We will support a mixed market of housing options and invest resources in the development of new supported living options, so we will:

- Work more closely with the community and independent sector to develop more housing options.
- Promote shared ownership as a model of good practice
- Develop the use of family capital to develop housing options (including home extensions).
- Enable people to take over the tenancy or ownership of parental homes.
- Invest in shared lives schemes (adult placement)
- Review the services of people currently living out of county with the aim of building local capacity so that they can return if they wish
- Reduce residential care provision to refocus on supported living options which give housing rights and provide better quality outcomes in terms of independence, choice and inclusion

4. Good Health

Outcomes

People with a learning disability want to be healthy and well. In particular, they want to:

- Learn about healthy eating and have a balanced diet.
- Prepare food and drink when and where they want to.
- Be a healthy weight.
- Have a positive experience when going to the GP or hospital.
- Get advice about men's and women's health and well-being issues, including sexual health.
- Have healthy eyes, teeth and gums.
- Be active and get exercise.
- Engage in social and leisure activities to improve their well-being.

Commissioning Intentions

Everyone has a right to good health and to feel healthy and safe. To support people with a learning disability to have good health and well-being we will:

- Commission the Health Access Team to:
  - Support GP's to undertake annual health checks for all people with learning disabilities, including young people in transition.
  - Improve the patient experience in a hospital setting.
  - Provide training to staff within primary and secondary care on effective communication with people with a learning disability.
  - Collect health data for future service planning and development.
- Respond to the findings of the Six Lives survey jointly with Solihull & Coventry and ensure that improvements are made to performance across health and social care.
- Develop a new approach to the provision of assessment and treatment services in Warwickshire to ensure they are more community based to prevent crisis, hospital and residential care admissions. This will include 24-hr outreach support which enables people to keep living with their families and own homes.
- Ensure the Health Access Team identify people who are autistic or have Asperger's syndrome.

5. Support to Family Carers

Outcomes

Carers want a more fulfilled life of their own. They want confidence to know that any services provided to the person they care for are of the highest quality. Carers of people with a learning disability want to:

- Get support and advice as and when they need it.
- Have piece of mind that adults with a learning disability are well cared for.
- Have breaks from caring.
- Be respected and listened to by professionals, especially in hospitals.
- Know and be happy with the plans for their cared for should anything happen to them.
- Have opportunities to socialise and share experiences with other carers.
- Be able to work.
- Be able to contribute to the work of the Learning Disability Partnership Board in a meaningful way.

Commissioning Intentions

To support this we will:

- Give all carers good information and advice about the range of universal services available to support them throughout their caring role.
- Increase the overall numbers of carers who have a Direct Payment
- Look at other different ways of supporting carers, including creating more innovative ways that carers can access short break.
- Work with older carers to plan for support in the future.
- Ask carers to work with us to develop better ways of providing respite, such as; shared lives schemes and/or assistive technology.

PART TWO

Financial Framework
Needs analysis
and
Creating a sustainable market

FINANCIAL FRAMEWORK

In Learning Disability services costs have increased nationally by approximately 7% per year in recent years and the cost pressure associated with Learning Disability is considered to be a bigger risk to local authority budgets than the cost relating to the increasing elderly population. This is reflected in the fact that expenditure on LD services as a proportion of total local authority expenditure has been increasing. In Warwickshire, net spending on LD service packages increased by 7.9% from 2008/09 to 2009/10 (7.0% the year previously), which roughly reflects the national average.

LD Transfer

In 2010/11 a transfer of £13.8m was made from Warwickshire PCT to Warwickshire County Council to cover the transfer of commissioning responsibility for approximately 300 customers with learning disabilities. This figure has now been reduced to £11.4m.

The gross budget for LD services before the transfer totalled £30m in 2009/10. However, with the learning disability transfer of services from health, the spending base for LD services has increased to £41m for 2010/2011, excluding the cost of local provider services day care. There was also a transfer of property, predominately used for residential care services valued at £8m which will be transferred with the rest of property to Resources.

It should be noted that there are opportunities to save as a result of the LD transfer where local authorities apply better commissioning practice but at the same time there will be offsetting cost pressures. For example if a package of care has not been appropriately reviewed for years a revised package might cost less because of better commissioning, but it could also end up costing more because needs have increased over many years but have not been met, or are now being met by the provider but not charged or paid for because neither provider or commissioner has reviewed the service or its costs. Therefore the intrinsic potential for further costs or savings from the LD transfer are not yet clear, but it is a fact that customer base has increased by £11.4m and the pressure from demand for LD services now applies across a wider base.

Real Terms Price Increases

Real terms price inflation within the LD market is a significant issue nationally. Estimated increases relating to need and headcount fall far short of the 7% per year increase in LD spending that has been occurring in recent years. The additional elements which make up the difference are general price inflation plus real terms cost increases driven by the LD care market. Key pressures on the LD care market are how changes in demand impact upon it combined with the very specialist nature of some of the services which increase provider power over prices.

This pressure is estimated to amount to 2.45%. Appendix 3 sets out a method of estimating this pressure for LD that puts together information known about headcount, need, general inflation, and overall cost increases which enables an approximate cost of real terms price increases to be estimated.

Use of Resources

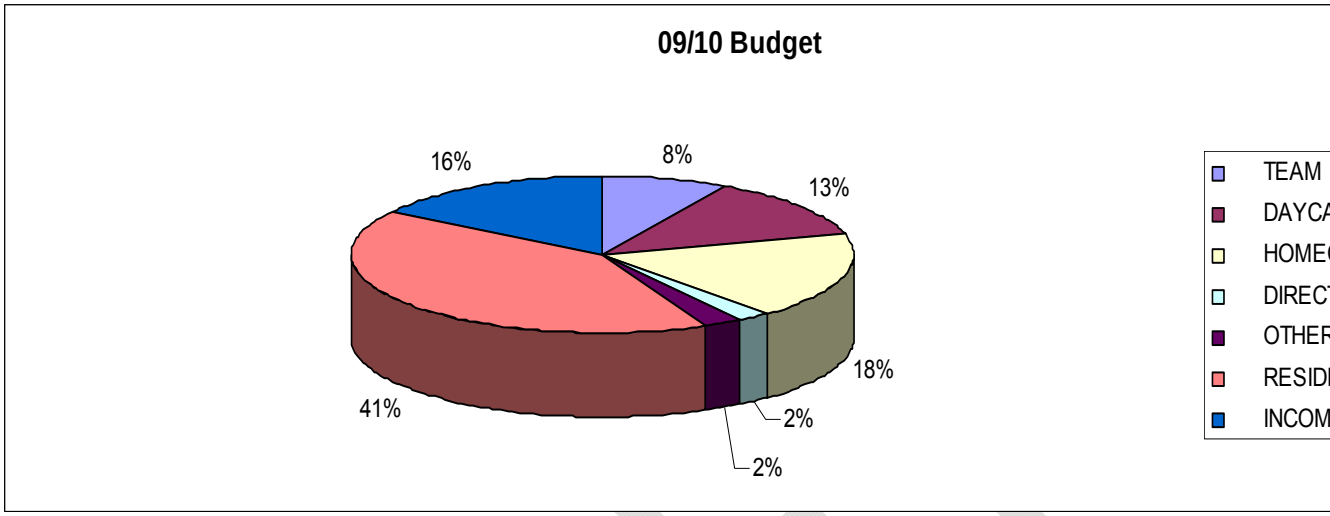
Analysis of expenditure for 2008/09 for Adults with learning disabilities aged 18-64 years.

This analysis looks at how activity and costs in Warwickshire compare with England. The analysis uses data published by the Information Centre for health and social care. The most recent national data is for 2008-09. The conclusions need to be used with care, because the spending figures are for adult social care, and exclude spending by the NHS and through the Supporting People budget. The overall picture this shows is that Warwickshire spends less than other councils, but supports fewer people at a higher cost per person. Compared to other councils, more money is spent supporting people to live in residential care, on home care and on day care. But fewer people are supported to live with their families or in their own homes. Fewer people have paid jobs or take part in voluntary work. Key findings for the year 2008-09 include:

- Warwickshire spent 7% less than average on social care for adults with learning disabilities, but supported 20% fewer people in residential care and 25% fewer people in the community.
- 47% of the budget was spent on residential care, compared with an average for England of 43% and best in class of 15%.
- The share of the budget spent on residential care has reduced more slowly in Warwickshire than in England as whole.
- Less than 1% was spent on supported accommodation, compared with the average of 9%.
- 6 % was spent on assessment and care management, just below the average of 7%.
- 3% was spent through direct payments, compared to an average of 4%, although the number of people with direct payments was increasing.
- Spending on equipment, home care and day services were above average.
- Unit costs of residential care were above average.
- 25% of people known to the council were in settled accommodation, compared to the average of 33%.
- 2% of people known to the council were in any form of work, compared with an average of 3%.

The actual spend for learning disability services for 2009/2010 generally continues to reflect this pattern of spend. However further work needs to be

completed to ensure that better financial analysis including modelling can support and underpin this strategy.



Through this strategy Warwickshire is committed to:

- Reducing the spend on residential care to under 20% of its overall learning disability services budget.
- Increasing the number of people with a direct payment
- Ensuring that everyone eligible for social care support has a personal budget by 2013.

National Priorities

Since 2001, national policy has consistently emphasised the need for people with a learning disability and their families to achieve meaningful social inclusion, choice and control. It expects learning disability services to be local, non institutional, personalised, and user led. The current policy outlined in 'Valuing People Now' (2009) and 'Putting People First' (2008) emphasises early intervention and prevention together with self-directed support via personal budgets or direct payments.

The coalition agreement confirms that this policy direction will continue:

"The Government will ... accelerate the pace of reform... Ensuring:

- Services are personalised to individual needs, with personal budgets offered by all councils ..;
- Preventative support is given to people when they most need it..
- Carers are helped .. with direct payments and other support".
- (Queen's Speech May 2010)

Valuing People Now has four guiding principles;

- Rights
- Independent Living
- Control
- Inclusion

'Valuing People Now' is also strengthened to ensure that it **includes everyone**, in particular those who are least heard or marginalised for example people with profound and complex needs, people with autism and people from black and ethic minority communities. Additionally there is a **commitment to personalisation,** empowering people to shape their own lives and the support they receive allowing for flexible use of resources to respond to lifestyle.

'A good life for everyone' is about getting to do the things that most people take for granted and getting access to good:

- ***Health***
- ***Housing***
- ***Work & education***
- ***Relationships and family***

To support this people need the right level of support, information and advice so that they can be active citizens in their local communities.

NEEDS ANALYSIS

National Projections

Research in 2008 by the Centre for Disability Research suggested an outlook of a 1.04% increase in headcount annually for LD people with critical and substantial needs. It is also noted that if moderate needs are included the rate of increase in headcount would be 7.9% per year.

According to the DH PANSI dataset, Warwickshire's overall learning disability population 18 + is projected to increase cumulitatively by 3.61% over the next five years.

Projected number of Clients with moderate to severe learning disabilities.						% increase of projected number of clients from 2010				
2010 Baseline	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
2,077.0	2,089.0	2,105.0	2,120.0	2,157.0	2,152.0	0.58%	1.35%	2.07%	3.85%	3.61%

Source: PANSI.

Whilst not all of these people will need adult social care, due to the moderate nature of their disability, it is important that we are aware of potential future demand on services as their needs change over time.

Comparing this overall national projection with current users of adult social care services (those with substantial and critical needs only), the table below illustrates a pattern of growth by district, who may be eligible for social care support over the next five years.

Table 2: Snapshot data from 31 March 2010 - population projections of people with LD from 2010 Baseline

	2010 Snapshot Data			2015 Projection				
District	**18-64**	**65+**	**Total LD Clients**	**18-64 % Change**	**65+ % Change**	**18-64**	**65+**	**Total LD Clients**
Out Of County	*70*	*4*	*74*					
North Warwickshire	125	14	139	0%	18%	125	17	141
Nuneaton and Bedworth	258	23	281	1%	16%	259	27	286
Rugby	135	10	145	3%	16%	139	12	151
Stratford	179	20	199	2%	18%	183	24	207
Warwick	204	34	238	11%	12%	226	38	264
Grand Total	**971**	**105**	**1076**	**4%**	**16%**	**1010**	**122**	**1131**

Warwick District has the highest predicted growth for 18-64 years age group with an average increase of 11%. But the most significant rise is in the 65+ years age group showing 16% across the County.

Scrutinising this further and comparing PANSI data for the number of people predicted to have a severe learning disability in 2010 and 2015, across England and the West Midlands with Warwickshire shows a higher number of older clients with learning disabilities in 2015. The population of people aged over 65 year with a Learning Disability is predicted to increase in Warwickshire at a greater rate than in the West Midlands and England generally. Conversely Warwickshire is predicted to see smaller increases in the number of people with a Learning Disability in the younger age brackets, particularly those in the 18-24 and 25-34 age brackets. The predictions strongly suggest that the number of older people with Learning Disabilities will increase at a greater rate than the average across the country and region, and the number of younger people with LD will increase at a slower rate. Given that this data was based on a report written in 2004, there is a note of caution about the robustness of these projections. However, it does correlate with local data based on existing clients.

	% Change between 2010-2015			Biggest Increase	Smallest In
	England	West Mids	Warks		
18-24	-3	-4	-3.0	WM	Warks/E
25-34	14	15	13.5	WM	WARK
35-44	-8	-13	-9.7	WM	ENG
45-54	7	7	8.0	WARKS	WM
55-64	1	-1	-1.5	ENG	WARK
65-74	14	11	15.5	WARKS	WM
75-84	8	9	11.8	WARKS	ENG
85 and over	13	14	14.8	WARKS	ENG
Total population aged 18 and over	4	2	3.5	ENG	WM

Current Client Profile

As at 31st March 2010 there were 1,076 people with a learning disability who were eligible and using adult social care services, including 75 people placed out of the county. Combining health and social care data this figure rises to 1686. However, the note of caution here relates to the lack of robust information about the definition used by health, for example, this figure is likely to include any person they have seen via their services e.g. could be people having allied professional services (OT , speech therapy, psychology,) or input from a Community Learning Disability Nurse, psychiatrist etc.

The table below confirms that the majority of people entering into adult social care are those aged between 18 and 24 years. It also shows that the numbers of people coming into the service for the first time at later stages in their life are not as significant as anecdotal evidence would suggest. However it does illustrate a peak around 45 – 55 years suggesting possible break down of caring roles as the health of both the service user and the carer begin to diminish.

Table 6: Age group of clients with LD at the start date of their first adult package

	Financial Year					
Age group at start of first package	**2005/6**	**2006/7**	**2007/8**	**2008/9**	**2009/10**	**Grand Total**
Under 18	3	3	4	1		**11**
18-24	28	28	39	19	21	**135**
25-34	3	5	7	3	3	**21**
35-44	6		4	3	4	**17**
45-54	5	3	3	6	6	**23**
55-64	3	1	4	5	1	**14**
65-74	2			2	2	**6**
Over 74		1	1			**2**
Grand Total	**50**	**41**	**62**	**39**	**37**	**229**

This data relates to service users with LD starting their first adult package between 2005/6 and 2009/10.

There are 115 older people with a Learning disability aged over 65 years in the county.

20% of the learning disability population known to us have Downs syndrome[1]. In this population there is a higher risk of early dementia, which as the population ages may reflect the need for specialist services for the 50 -65 year group.

Headcount

Research in 2008 by the Centre For Disability Research suggested an outlook of a 1.04% increase in headcount annually for Learning Disability people with critical and substantial needs. It is also noted that if moderate needs are included the rate of increase in headcount would be 7.9% per year.

The external information relating to Learning Disability often considers adults aged 18-64 only, whereas in Warwickshire Learning Disability services supports customers beyond the age of 64. Therefore some of the increase in levels of Learning Disability is contained within the higher figures relating to older people.

The average of the Department of Health PANSI projections and Planning 4 Care data suggests an increase of 0.96% in 2011/12 for Learning Disability aged 18-64. PANSI figures understate the increases because they do not account for the over 65 Learning Disability population, but Planning 4 Care information appears to be higher than the majority of other sources, suggesting it is overstating.

More detailed analysis of PANSI age profiled projections indicates that the increases in Learning Disability customers will be occurring as follows:

- Increases in the young age groups, i.e. young people with more complex needs to some degree compounded by an increasing proportion of working adults which reduces capacity for informal care, and;

[1] Warwickshire JSAN 2009.

- The most significant proportionate increases in the 65+ age groups (i.e. Learning Disability customers developing age related needs in addition to underlying Learning Disability needs, and also people with Learning Disability cared for by ageing carers/parents who become unable to continue to care).
- PANSI projects a fairly stable middle aged population of Learning Disability customers over the next few years.

In any one year there are approximately 40 children with disabilities on the transition list to transition to adulthood. However only a proportion of these will be eligible for adult social care services. In recent years approximately 25 new customers per year are reported to transition to adult social care, which is approximately 2.5% of the total customer base. However if this is reduced to reflect leavers (which will mostly be transition to health services and deceased customers) then the net increase is significantly lower than 2.5%.

An estimate of headcount changes has therefore been taken as an average of the various different sources of projection, simply because they all have various strengths and no one statistic stands out as more sensible than the rest.

Based on the information available the net headcount increase in 2011/12 is estimated to be 0.96%.

Average Need

Internal information about levels of need suggests a pressure of 1.00% from 2009 to 2010. Average need increases for two main reasons (1) because new customers transitioning in have on average more complex needs than the customers who leave, therefore increasing the average need per customer and (2) because the remainder of the customer base that did not change from year to year increase in average age and with age can come higher levels of need, particularly in the higher age brackets.

Autism

Autistic Spectrum Disorders are developmental disorders in three areas referred to as the triad of impairments which are social interaction, social communication and imagination. Aspergers Syndrome is the term usually used to describe people within the Autistic Spectrum who have relatively good expressive skills and average or above average IQ. They can also be labelled as mildly autistic or ‘high functioning’ but they are a group of people who can have significant impairments in social, occupational and other functional areas of life.

There are varying estimates of prevalence of Aspergers Syndrome. Conservative estimates put the prevalence at 10 per 10,000, whilst another study suggests prevalence is approximately 1 in 300 people.

It is to be noted that some people with Aspergers Syndrome will not require any statutory services, however, the majority of adults need understanding and

support from the wide range of agencies that they come into contact with. There is clearly a need in some cases for specialist interventions whilst also acknowledging the need for existing services to develop a workforce which can demonstrate the skills, knowledge and capacity to respond to the needs of the local population with Aspergers Syndrome.

Adults with Aspergers Syndrome continue to be excluded from accessing statutory health and social care because they do not 'fit' the current ways of thinking about disability or, even if they meet eligibility as defined under Fair Access to Care Services, they may not fit within the defined service user group for a given service and therefore experience difficulties in accessing appropriate services**.** In addition 65% of adults with Aspergers Syndrome have not received a Community care assessment (Barnard et al, 2001). The government does not consider Aspergers Syndrome a Learning Disability in its truest sense because individuals with this diagnosis usually have average or above average IQ scores (i.e. above 70). A quote from Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001, says, "This definition [of Learning Disability] covers adults with autism…..but not those who may be of average or even above average intelligence, such as people with Aspergers Syndrome".

A separate strategy has been developed for people with autism. Through the delivery plan, we will ensure that key outcomes are achieved and reported through the learning disability partnership board governance.

Profound and Multiple Learning Disabilities (PMLD).

People with PMLD are frequently excluded and remain some of the most disadvantaged people within our society. For this to change there needs to be better understanding of their distinctive needs. People with PMLD have specific communication needs and many have complex health needs. Nationally there is very little data on the population of people with PMLD. However figures that do exist demonstrate a rise in the numbers of people with PMLD, and show that their needs are becoming more complex. Better data is crucial to inform planning to ensure that all people with PMLD and their families are able to access appropriate support and services.

Warwickshire continues to use peer advocacy as a way of ensuring that people with profound and complex needs have a voice. In addition people with profound and complex needs are also supported to be involved in the learning disability partnership board ensuring that there continues to be a focus on this marginalised group of people. Further work however does need to be done with health colleagues to make sure that the right services are being commissioned.

Transitions

In any one year there are approximately 40 children with disabilities on the transition list to transition to adulthood. However only a proportion of these will be eligible for adult social care services.

In recent years approximately 25 new customers per year are reported to transition to adult social care, which is approximately 2.5% of the total customer base. However if this is reduced to reflect leavers (which will mostly be transition to health services and deceased customers) then the net increase is significantly lower than 2.5% suggesting that on the whole learning disability services are a static group.

Family Carers

The vision for social care states that: '*Carers are the first line of prevention. Their support often stops problems from escalating to the point where more intensive packages of support become necessary. But carers need to be properly identified and supported. Councils should recognise the value of offering a range of personalised support for carers to help prevent the escalation of needs that fall on statutory services.'* The guide to emerging evidence: Carers and Personalisation – improving outcomes 2010, reinforces this and states that*: If we are to achieve this, there is a need to:*

- *recognise the expertise of, and work in genuine partnership with, carers at all levels of service design and delivery;*
- *enable carers to design and direct their own support, have access to direct payments and be engaged in the support plan of the person they care for and the assessment where appropriate;*
- *wherever possible, establish whole family approaches that ensure there is integrated support planning that benefits everyone involved;*
- *develop a range of support options and opportunities to match the diverse needs of carers*

Many carers of people with a learning disabilty experience a lifetime of caring. Negotiating the health, education and social care systems through infancy, childhood and adulthood is a daunting task but can also mean that family carers may have decades of experience. For carers of people with learning disabilities, having a break, finding support and getting the best and most appropriate services must be seen in the context of this lifetime of caring. Carers who have a learning disability themselves also have their own specific needs.

As at December 2010, 517 carers of people with a learning disability were recorded on Care First.

Over half of these carers live in the North of the County.

Carers Age Groups spilt by District

Carers Age Group split by District

		Carer Age				
Client Address District	**Carer Recorded**	**18-64**	**65-74**	**75-84**	**85+**	**Not Recorded**
North Warwickshire	80	47	15	8	3	7
Nuneaton and Bedworth	157	94	28	18	7	10
Rugby	93	47	21	12	5	8
Stratford	85	50	13	7	5	10
Warwick	86	49	10	7	4	16
Out of County	15	11		2		2
Unknown	1	1				
Total	**517**	**299**	**87**	**54**	**24**	**53**

A significant proportion of these are elderly carers, 218 over the age of 65 years and 24 over 85 years old. Specific attention needs to be given to elderly carers so that better commissioning decisions and improved outcomes can be achieved for both the service user and their carer.

Another of our commissioning intentions will be to review current respite provision with a view to move from traditional forms to more creative ways of providing respite to carers, such as the use of shared lives schemes and/or the use of assistive technology.

Conclusion

Significantly against this backdrop, there is no local information source, for example a Learning Disability Register or database, which captures the range of needs information and the housing choices people may make, required for planning now. This will become more significant as we move towards personalisation and people become commissioners of their own support. There is no mechanism to capture unmet need or increases in demand.

Currently there is a dependency on Care First and information directly from local teams. There are gaps in the information available and some local information may not be reliable or may not scope the Learning Disability population adequately.

There are no joint data systems between housing, health and social care and information is so dispersed the only method of capture is to gather data from a range of sources including providers.

There is a need to improve the needs analysis information in particular housing and health needs of people with a learning disability, older carers, people with autistic spectrum disorders and people with low to moderate needs and people with complex or profound and multiple disabilities.

A more thorough strategic needs assessment would help us develop a better understanding of need in our local population. The next and subsequent iterations of the Joint Stragtegic Needs Analysis will provide the framework to deliver this. But current data collection systems need to be more robust and include a wider range of people than those who are FACS eligible for social care services to ensure confidence in the data.

It is clear that there are gaps in needs and supply data and that some local information may not be reliable or may not scope the Learning Disability population adequately. There is a need to improve the needs analysis information in particular relating to housing and support needs, the health needs of people with Learning Disability, employment, older carers, people with autistic spectrum disorders and people with low to moderate needs.

MARKET INTELLIGENCE AND MANAGEMENT

Managing the Market

With the introduction of personalisation and in particular the growing shift from public sector commissioning to a more individual approach to purchasing services the government has stimulated a change in the way services will be procured. It states that: *Traditional councils have purchased services on behalf of their communities, tendering out contracts for provider to bud to deliver services or spot purchasing services already available in the local market. The transformation of social care demands that councils now ensure the supply of the types of services support that people need and want to buy, without the same degree of comfort from contractual arrangements.*

For some providers this may well be a welcome shift but for others, perhaps smaller organisations, this creates some fragility to their sustainability, particularly at this economic time, when they will now have to compete for individual business.

Commissioning within this framework will be a challenge and calls for greater partnership between providers, requiring councils to be more transparent about their commissioning intentions and providers more willing to work together with councils to create a vibrant innovative market for people with a learning disability and their carers. A more ambitious approach needs to be taken in the commissioning and procurement of services if a sustained and vibrant market is to be achieved that will support people to live independently and to have a fulfilled life.

Most services provided to people with a learning disability are commissioned through the independent and voluntary sector, using either ; a block or spot contracts or the more recently introduced framework agreements.

We acknowledge that the framework is not working well in Warwickshire so one of our immediate actions will be to review this. In addition, we will introduce Individual Service Funds (*ISF is the term used to describe a personal budget that is held and managed by a service provider at the request of the person needing support.*) which will enable providers to work much more flexibility with service users, turning contracted hours into flexible funds that will be used to meet peoples individual outcomes.

ISFs Explained

ISF is the term used to describe a personal budget that is held and managed by a service provider at the request of the person needing support. It is a way of enabling someone who does not want to or cannot manage their own funds.

Individual Service Funds will have the following characteristics:

- The budget is held by the provider on behalf of the service user
- The support plan is the key document between the service user and the provider

- The service user remains in control of how the money is spent

This means that an individual's personal budget (or proportion of that budget) will be lodged with the chosen provider. The service users support plan will dictate how the money is used, the outcomes they want to achieve and the way that the provider is to support them to achieve these outcomes.

Commissioned Services

Currently there are three areas of commissioned services with the external market;

1. Residential Care
2. Community Support
3. Voluntary Support

Residential Care

The LD provider market is characterised by Residential Care and Supported Living Services. Regional benchmarking indicates a disproportionately high amount of residential care. Supported Living commissioning is below average. This has lead to an underdeveloped Supported Living provider market with variances in quality.

Regional benchmarking indicates that Warwickshire are currently paying a higher than average price per unit for LD Residential Care services.

Residential Care

Provider	Number of Placements	Number of providers	Average weekly cost per client
In- County	263	18	c. £1029
Out of County	72	50	c. £1279
Top 10 (by number of clients)	236	10	c. £929

There is some evidence that the top 10 res-care providers (who are all in-county) are already responding competitively in terms of cost, with a number of CFC reviews pointing to a fair price being delivered.

In contrast, early indicators from price management work point to a wide disparity in prices amongst complex needs providers, with varying overhead costs and profit margins. Prices for autism services vary widely; whilst there is a range of providers, competition is limited. This could be improved by:-

- Continuing scrutiny of pricing structures (CFC)
- Improved systems to monitor outcomes.

Improvements have already been evidenced by the willingness of a number of these providers to reduce costs, in acknowledgement of increased scrutiny across the demand market, including other authorities and health trusts.

Prices could be driven down further by:-

- Demand management- Rigid application of FACS to determine the level of support within packages.
- Improved long-term planning and transitioning

Supported Living

In terms of Supported Living services, the above points are crucial; current framework agreed rates limit the capacity to renegotiate pricing structures; cost-effective supported living services are dependent on sustainable housing options which require effective long-term planning.

Market-rate historical increases

Whilst market rates may have risen above inflation in recent years due to increases in statutory quality requirements, finding evidence linking this rise to improvements in the delivery of client's outcomes is difficult.

It can be evidenced that in some instances costs incurred by providers haven't necessarily risen above inflation whilst profit margins have increased.

One element of market management activity will be developing and improving systems which link provider performance (and costs) to delivery of outcomes. The aim will be two-fold;

- tie our demand for services more closely to delivery of outcomes
- tie price control activity more closely to delivery of outcomes.

As at December 2010 adult social care supports 412 people in residential and/or nursing care spending in excess of £15 million.

Geographical Area	**Numbers**
Nuneaton and Bedworth	**98**
Kenilworth/Warwick/Leamington	**63**
North Warwickshire	**61**
Rugby	**72**
Stratford upon Avon	**70**
Plus people recently transferred from health	**48**
TOTAL	**412**

Below is an analysis of the age range of existing clients. The largest proportion of people currently in residential care are under the age of 60 years and living in the Nuneaton and Bedworth area.

Clients with LD in Residential/Nursing Care

	18-59			60+		
NORTH WARWICKSHIRE DISTRICT	22	16		8	8	
NUNEATON & BEDWORTH DISTRICT	38	28	1	13	6	
RUGBY DISTRICT	24	26		11	6	1
STRATFORD DISTRICT	35	6		13	7	
WARWICK DISTRICT	32	9		9		
NO ALLOCATED DISTRICT	8	4	1		4	
Total	**159**	**89**	**2**	**54**	**31**	**1**

As stated earlier Warwickshire spends over 44% of its total learning disability budget on residential care. Comparing this to the best in class which is in the region of 10-15% confirms that Warwickshire needs to urgently review how it commissions support in the future.

One of the key commissioning intentions will be to increase the range and availability of housing options including related support and for those people who are currently in residential care support them to move to more independent living.

In addition, Warwickshire will continue to use the recently introduced Care Fund Calculator as a means of securing a fair equitable price for residential care costs.

Care Fund Calculator explained
The Care Fund Calculator supports local authorities in managing costs of residential care and supported living for adults with learning disabilities. It also helps providers to understand the process of negotiation. The CFC is helping local authorities to tailor packages more closely to the needs of clients

Respite Care

As at December 2010 learning disability services were providing respite support to 247 people costing in the region of £675,000.00

Respite is a significant support service to people who use services and their carers and families. Warwickshire has recently tried to recruit more respite providers to the County through a framework agreement. Currently four providers are registered with the council but further work needs to be done to stimulate a more vibrant and diverse market for respite provision.

One of our key commissioning intentions is to review the current respite provision and stimulate alternative more innovative services that respond to individual situations and circumstances.

Community Services Framework

There are currently 44 providers of community support in Warwickshire. The framework includes a wide range of providers offering a mixture of; domiciliary care, day time activities, one to one support.

Commissioned Voluntary Sector Services

Advocacy Support .

Two organisations provide advocacy support for people with a learning disability. New Ideas provides a valuable focus on self advocacy and peer support. One of its key roles is to support people with a learning disability to be active members of the partnership board. In addition, Independent Advocacy provides citizens advocacy to both service users and carers. Independent Advocacy also provide some element of appointeeship but further work needs to be done to ensure sufficient support is available across the County.

Both services focus on people who are FACS eligible. Therefore there is no access to advocacy for people with health needs or people falling below the FACS eligibility threshold.

Carer Support Services

Warwickshire has a higher than average elderly population of carers. Whilst significant support is given by providers of services, concerns have been expressed at the lack of support and work with families and carers to let go and move on.

The voluntary and independent sector provide valuable support. For example Guidepost in the North and Carers Support in the South provide a range of low level support through information, support groups, training, emotional support and access to organised activities, Other independent providers, such as Mencap also provide support to carers, through group activities or through one to one relationships. These relationships have been cited as very valuable to most carers.

There are also two specialist carers support workers appointed in each of the frontline teams who are responsible for the assessment and support to eligible carers. Each worker is seen as a resource for the teams and have in depth knowledge of the range of services available locally to support carers.

Through the assessment process, eligible carers are also supported to access more formal forms of support, such as Take a Break which enables carers to have some time off from caring.

Internally Provided Services

Warwickshire Adult Social Care currently spends in the region of £5.5 million on day time support. I has a number of large traditional day centres across the County. Over recent years and as part of its modernisation programme some of these services have migrated to small satellite units within local community settings. However the larger buildings remain.
Currently over 590 people access internal day time support, 460 of which are paid for by the local authority. This assumes that the remaining 130 are people who pay for their own care or is paid for by another local authority.

Currently internal day provision comprises of:

Service	Base2	Managers	Deputises	DCOs	Support workers	Admin	Customers
North Warks	3	1 (1)	1 (1)	4 (3.5)	18 (11.8)	1 (0.8)	58
Nun & Bed	10	2 (2)	4 (3.8)	16 (13.3)	36 (24.2)	3 (1.1)	136
Rugby	5	1 (0.9)	3 (2.6)	8 (6.2)	24 (18.4)	3 (1.5)	113
Warwick	5	1 (0.75)	3 (2.9)	11 (8.3)	51 (37.3)	2 (1.6)	104
Stratford	4	1 (1)	3 (2.5)	6 (6)	32 (24.7)	1 (0.4)	100
WEST	2	1 (1)	0	6 (5.6)	2 (0.6)	1 (0.7)	79
TOTAL	**29**	**7 (6.65)**	**14 (12.8)**	**51 (42.9)**	**163 (117)**	**11 (5.7)**	**590**

121 of these people are also currently living in residential care. There are also a number of people who use day time support who are also living in supported accommodation who should be better supported to access mainstream services.

From our commissioning intelligence, including transitions information, it is likely that there will be two pressure points over the next five years; firstly from elderly carers, Warwickshire has a higher than average growth of elderly carers – 16% over the next five years and secondly a growth of younger people with more complex needs which is around 11% growth over the same period.

Through visioning days and workshops, service users and carers have said they want:

Opportunities to do more things, fishing, shopping, eating out, go on holiday.

choice and the ability, to say for themselves, what they want to do.

Do more things in their own local communities and integrate better including having access to better transport arrangements.

Have a range of opportunities to socialise, meet their friends, make new friends.

The right to access employment and education just like everyone else.

All of the things people with a learning disability have told us confirms that the best way of achieving this is through personal budgets. Therefore a key outcome of these changes will be the introduction of personal budgets for everyone ensuring that people with a learning disability have access to a range of alternative opportunities, for leisure, occupation, educational and social activity. Some may be provided by mainstream services but others may need to be developed in the market place provided in the future by the voluntary and independent sector.

To do this means that everyone needs to be confident in working in a personalised way. Part of these changes will require service users, carers and staff to understand the values and principles of the personalisation agenda which is at the core of what adult social care delivers.

To deliver these changes we must:

- Give people better information about personalisation
- Put in place ways of enabling people with a learning disability and their families to use self directed support which includes support planning and brokering services for themselves.
- We need to give people information about all of the different things that they could use their personal budget on
- We need to have high standards in place to make sure that all of these services are of the highest quality and work in a person centred way

It will be important that throughout these changes and into the future that we continue to support people with a learning disability and their families to live a fulfilled life. Knowing that the 'outcomes' achieved, through personals budgets, are those of the person with a learning disability (individual outcomes) will be a key to this. This information will also be important for any future commissioning that adult social care does on behalf of people with a learning disability and their families.

Warwickshire Employment Support Team (W.E.S.T.)
A key component of day time activities is getting and keeping a job. For people with a learning disability this is no different to everyone who aspires to find a job that fills their time positively and provides a wage.

WEST is part of adult social care learning disability provider services. It is a small specialist team who support people with a learning disabilities to access and keep paid employment. It is a countywide service for people with a learning disability who want to work, **and who** meet the criteria for Fair Access to Care Services. We help them to find employment:

- In the public sector
- In the private sector
- Full – time or part – time

- In some cases support to explore employment / education / having options where appropriate support is not available elsewhere

W.E.S.T. is currently supporting up to 79 people in finding and keeping a job.

Personal Budgets and Direct Payments

What is a Personal Budget?

SCIE define a personal budget as an allocation of money that is to be used to meet the individual's personal outcomes. Key to the personal budget approach is the need to give clear early understanding of the amount of money available, so that they can influence and control how it is spent, in a way that best meets their needs. Personal budgets must be implemented within the framework of self directed support which involves self directed assessment, up front allocation of money and support planning to promote choice and control.

Warwickshire learning disability service is embarking on the introduction of personal budgets including being part of the third wave of In Control for health budgets.

Between April 2009 and March 2010, 148 people with a learning disability had a Direct Payment. The figure below is higher than the actual numbers of people who receive a direct payment (126 clients) as people use a direct payment to purchase more than one service.

DP Subtype	Number of Services	Percentage
Daycare	11	7%
Homecare	46	31%
Other	88	59%
Respite	3	2%
Total	148	100%

Based on data extracted from 1 April 2009 to March 2010

At the moment there is no systematic way of analysing exactly what all Direct Payments are spent on. As reflected above 59% of people spend their direct payment in other ways. Evidence from the evaluation of the Individual budget pilots in 2009 reflected an increased spend on personal assistants, leisure, social and educational services. More information is needed locally to enable us to predict changes in demand for services. We know, for example, from the data that the districts where direct payment users live are Warwick (28%) and Nuneaton and Bedworth (26%), reflective of the higher populations of people with a learning disability in those areas.

Housing and Housing Related Support

Too few people with Learning Disabilities have the choice and control over where they live and who they live with. This has been recognised in the recently produced strategic housing and housing related support strategy for people with a learning disability which sets out an ambitious programme of change for future housing options for people with a learning disability that underpins and strengthens this strategy

Warwickshire currently places too many people into residential care. At the moment over 40% of people who are eligible for social care support live in residential care. This is too many so over the next four years there will be real focus to firstly stop placing people into residential care and secondly work with people currently in residential care who wish to have a more independent life to find alterative appropriate accommodation with the right level of support for them.

As with any major change, leaving home presents many challenges and needs careful planning. It will be important that service users and carers are involved in choosing the right options.

The type and range of housing options available are varied and has grown over the last few years. However, Warwickshire's investment in housing options for people with a learning disability has been too narrow. To improve the supply and availability of housing a more mixed range of housing options are needed.

This strategy will focus on broadening the choices available and will include:

- Shared supported housing
- Shared lives – (formerly known as adult place schemes where a person lives with a family)
- Extra Care or assisted living schemes
- Community Living Networks such as the Keyring model
- Low cost home ownership – including home ownership for people with long term disabilities, home buy, new build and re-sales of existing schemes, family funded shared ownership
- Home ownership on the open market and support and advice to access
- Public sector rented properties
- Private sector rented properties in particular via housing association leasing schemes
- Family investment and trust funds to set up a range of housing models

Supporting People

The main aim of 'housing related support' is to develop and sustain an individual's capacity to live independently in their home. Each person is an individual and will need different levels of support. Housing related support can include the following:

- Support to manage money and pay bills
- Support to understand the rights and responsibilities of a tenancy agreement
- Signposting to other agencies
- Support to carry out house hold tasks
- Support to keep safe at home and in the community
- Support to access employment, education or training
- Support in using public transport

In Warwickshire the Supporting People Programme offers two main types of housing related support for people with a learning disability in the forms of:

Floating Support – the support worker travels to the person's home wherever they live to provide housing related support. If the person moves home then the support worker can visit them at their new home.

Accommodation Based Support – the support is part of the accommodation service, for example supported housing.

Currently 29 Supporting People providers based across the County are providing either floating support and/or accommodation based services to people with a learning disability. The table below shows the number of units provided through Supporting People in each district compared with the learning disability population profile.

District	Accommodation Based Support	Floating Support	Units %	% of LD Population
North Warwickshire		4	4 (5%)	12%
Nuneaton & Bedworth	19	39	58 (29%)	27%
Rugby	19	10	29 (10%)	16%
Stratford on Avon	24	11	35 (21%)	18%
Warwick	36	46	82 (35%)	24%

Source: LD (Draft) Housing Strategy 2010)

Compared to the distribution of LD population across the district most people live in the Warwick(24%) and Nuneaton and Bedworth (27%) districts. The majority of Supporting People funded support is provided in these areas however there may be an under supply in the Nuneaton and Bedworth area currently, based on the total number of units in that area compared with Warwick.

Assistive Technology including Telecare.

Telecare is a key element of both national and local strategies and cuts across health, social care and housing. The national vision in Lifetime Homes, Lifetime Neighbourhoods and the local vision for the transformation of housing support services in Warwickshire both see telecare as an integral part in the range of housing options as part of a wider and more joined up approach to meeting housing need in order to support people to live independently.

Assistive technology is defined by the Audit Commission as 'any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties.' It can help individuals maintain independence, increase safety and confidence and support carers alongside traditional healthcare, social care and housing initiatives.

As at December 2010 only 33 people with a learning disability were recorded as using telecare; 24 in Warwick District, 7 in Stratford and 2 in Rugby.

Learning Disability Teams need to ensure that telecare is an integral part of every assessment otherwise it is unlikely that the benefits, including the cost benefits, of using telecare will be realised.

Initial analysis suggests that there could be a cost benefit for learning disability services. However, further work is required with finance to produce a realistic savings plan. What is important is the significant flexibilities and independence that telecare can bring to peoples lives.

Working with Health

As part of this strategy we need to consider a joint (or at least) a collaborative partnership approach for all people with a learning disability to include those people with complex or profound & multiple needs who are funded by health. To address the challenging and cross cutting issue of continuing health care the LA should be the lead agency for LD and lead assessment and care management.

This would :

- make the best use of resources (ie reduce the current practise of assessing and reassessing people)(perverse incentive to shift cost due to no partnership agreement being in place at moment)
- enable the lead agency to negotiate on care contracts (in particular where both LA & PCT have people with the same provider), therefore making efficiencies across the health and social care economy)
- enable the lead agency to reduce/remove the effects of averaging out costs across clients or an environment by being able to individualise costs (like the current TP contract)Therefore creating ability to move service user within cost (efficiencies for health and social care)

- Right to Control/ Personal health budgets to include people with CHC funding - individual supports for complex people closer to home.
- reduce the disadvantages to service users who can loose other benefits and funding when they become defined by CHC therefore increasing the cost to SC when they are reassessed.(reduce loss to H & SC economy)
- increase reliability and continuity of funding for care packages (benefit for user, carer and provider)

Safeguarding

It is accepted that there is no single approach that will guarantee the safeguarding of all adults with learning disabilities. So the Department of Health has developed a set of approaches that mean that safeguarding issues are less likely to happen. These are stated in
the document "Safeguarding Adults with Learning Disabilities, Information for Partnership Boards". There are 5 key principles to incorporate safeguarding into everyday practice for people working with learning disabilities.

1. Right and Respect - People with learning disabilities have the right to a life free from abuse and neglect and to receive the full protection of the law, in all environments and service settings.
2. Independence - vital we give people with learning disabilities information and support to help them get better at protecting themselves and their friends and peers.
3. Choice - Respecting and understanding choice plays an important role in safeguarding adults. Listening to individual's preferences about issues such as where they wish to live and with whom, can ensure that people with learning disabilities can live alongside others with whom they feel comfortable and safe. This needs to be balanced with taking steps to protect individuals from risks or dangers which they have not appreciated or anticipated.
4. Inclusion - People with learning disabilities must be able to feel safe in their communities to ensure that their concerns are taken seriously. People with learning disabilities should be treated with equal respect by specialist Learning Disability and non- specialist organisations.
5. Collective responsibility - It is essential to recognise our shared responsibility to take sensible and effective actions to better safeguard people. although some agencies and individuals have been given lead roles we all have a part to play in ensuring that people with learning disabilities in our communities are better protected.

The Six Lives Report also places a responsibility on health and social care to ensure that people with a learning disability are treated as equal citizens and receive the same high quality services as anyone else. Together NHS Warwickshire and Warwickshire Adult Social Care services will continue to develop strategies to meet the outcomes of the six lives report.

PART THREE

Making it happen

Making it happen

Adult Social Care has set a challenging target of savings over the next three years. Known as the Transformation Programme, this will be the core activity of the Directorate for the foreseeable future. Central to this transformation programme is the development of the personalisation programme ensuring that the Directorate provides efficient, value for money services that deliver better outcomes and lower cost.

To measure success over the next three years there are a set of quantitative and qualitative measures that will be used, with service users, carers and key stakeholders to evaluate the progress made.

A lot of work has already been done nationally to develop person centred outcomes for how someone lives. These are called the 'Reach Standards'. There are 11 standards and they were developed with people with a learning disability to say what people should get from support at home. They include:

- I choose who I live with
- I choose where I live
- I have my own home
- I choose how I am supported.
- I get good support
- I choose my friends and relationships
- I choose how to be safe and healthy
- I choose how to take part in my community
- I have the same rights and responsibilities as other citizens
- I get help to make changes in my life

In addition central government have recently issued a paper on outcomes and quality. These include:

The number of people who use adult social care services who:

- have control over their own daily life.
- receive self directed support
- have a job
- are supported to be independent and in control of their condition (including people with complex needs)
- are involved in decisions (including carers involved in discussed about the person they care for)
- feel safe and secure

Together these standards provide a good suite of measures that we will use to monitor and evaluate the success of this strategy.

A number of key quantitative targets have also been defined and will also be used. These are:

1. Choice and Control

- By March 2012 all people with a learning disability who get help from social services will have a personal budget.
- By March 2012 at least 30% of people with a learning disability will have a direct payment
- By April 2011, agree a pathway for learning disabilities that includes revised business processes and structures.
- By April 2011, all clients and their carers will be more knowledgeable and informed about Personalisation.
- By September 2011, all people with a personal budget will have access to a range of support planning and brokerage options
- By March 2012, at least 10% of people with a learning disability and their families will do their own support planning and brokerage.
- By April 2011 customer information on a range of local services will be readily available

2. A Fulfilled Life

- By April 2011, complete a consultation process with users and carers about the future use of building based services with a view to move to more community based support.
- From February 2011, no new people will start using in house day services and transport
- By April 2011, a phased approach will begin to enable people to access universal services instead of building based provision
- By March 2012 everyone currently using day provision will have a personal budget and using universal services.
- By March 2012, 20% of people with a learning disability currently using day provision will be supported to find and keep a job.
- By March 2012, establish a social enterprise of personal assistants for people with a learning disability.
- From April 2011, all new people or those who have been reviewed will receive travel training.
- By April 2011, an information & advice service will be established
- By April 2011, people with moderate needs will no longer access social care support.
- By March 2012 there will be no internal building based day provision for people with substantial needs.
- By Sept 2013 there will be five local community resources jointly commissioned for people with profound and complex needs
- From Jan 2011, support planning and brokerage will be in place for people with a learning disability and their carers.

3. A Place to Live

- By April 2011 all new people will be supported to live in their own home with support
- By March 2014, 20% reduction in the number of people living in residential care
- By March 2014 the council will spend under 20% (£5 million) of its budget for people with learning disabilities on residential care.
- By March 2014 and using self directed support the average package costs will be 20% lower than in 2010-2011
- By March 2014, 25% of people using services will include the use of telecare in packages of support , including equipment to reduce dependency on other more formal forms of support
- By March 2012 all people living out of county will be reviewed and all people wishing to return are supported to do so

4. Good Health

- By March 2012, all GP practices will be offering annual health checks to people with a learning disability. Part of this health assessment will be to ensure that dental hygiene is actively followed.
- By March 2014 to reduce admissions to health funded accommodation because of a crisis or emergency.
- By March 2014 to increase local capacity to support people with more complex or profound and multiple needs to recue out of county placements
- By March 2011 all people will be discharged from campus accommodation
- By 2012 (x) people will have a personal health budget

5. Support to Family Carers

- By March 2012, ensure that all carers of people with a learning disability have access to information, advice and support to enable them to make informed decisions about their future and that of the person they care for.
- By March 2012, all carers known to the council will have an assessment of their needs and access to services.
- By March 2012, all older carers over the age of 65 years will have a ‘plan for the future’ in place.
- By March 2012 a strategic review of respite provision will be completed, including looking at more innovative ways of providing respite, such as; shared lives schemes, the use of assistive technology.

The Learning Disability Partnership Board has a responsibility for ensuring that the local strategy in response to Valuing People Now is delivered and that they know that the lives of local people with a Learning Disability are improving.

Working in partnership with Coventry University and the Learning Disability Partnership Board a group of service users and carers will be trained, by the University, as peer evaluators and by using the standards above will check whether they are being met.

A revised governance structure has been agreed between NHS Warwickshire and Adult Social Care. The revised governance structure places the transformation programme at the heart of these changes but also reflects the important role that the Learning Disability Partnership Board will have in ensuring that all elements of the strategy are delivered..

The Learning Disability Partnership Board will:

- Make sure an action plan is developed with costings. This will set priorities, targets and responsibilities for achieving change, and realistic timescales.
- Provide leadership for the implementation of the plan
- Link with other relevant partnerships, developments and strategies
- Work across all sectors to seek to change culture and raise expectations
- Recognise and communicate success
- Monitor, review and evaluate performance against the plan
- Report to the Learning Disabilities Strategic Group Board and other relevant strategic bodies.

Choice and Control

Learning Disability Delivery Plan 2011 - 2014

	Lead and Supporting officers
People with a learning disability want to have choice and control over how they live their life. In particular, they want to have choice and control over how they spend their money, do during the day at evenings and weekends, have a job and enjoy friendships and relationships.	**Jon Soros. Service Manager for Learning Disability Services**
Lead Organisation	

Action	**Start Date**	**End Date**	**Activity**	**Deliverable**	**Responsible officer and organisation**
1. Agree and share vision for new customer journey	Jan '11	March '11	1. Agree definition of Self Directed Support and produce material to communicate 2. Incorporate definition into strategy and communicate widely through consultation	1. Staff, service users and carers and partners understand the vision and underpinning values for learning disability services	**Jon Soros**
2. Understand impact of new customer journey on the role of local care management/commissioning teams and how this will respond to : -enabling citizens -brokerage development -engaging citizens in commissioning -ensuring transparent pricing/value for money -influencing strategic	Jan '11	March '12	1. Review business process for Self Directed Support and impact on locality teams 2. Revise structure and processes of teams. 3. Establish a co-production group 4. Review Carefirst data collection and update method of capturing individual outcomes ensuring this can be extrapolated for commissioning purposes.	1. Business process mapped, established and working **2.** Co-production group in place **3.** Revised structures of team implemented **4.** Relevant changes to ensure data collection	**Jon Soros**

commissioning				are completed	
3. Develop the business processes and mechanisms to ensure people a fair and transparent resource allocation	Jan '11	April '11	1. Agree process for Learning Disability- Self assessment questionnaire 2. Agree Resource Allocation System methodology 3. Agree what Personal Budget can be spent on e.g support planning, brokerage, appointees	1. Resource Allocation model agreed 2. Self assessment questionnaire and associated tools in place 3. policy including guidelines around personal budgets agreed and in place	**Gill Jowers**
4. People with a learning disability have access to the right information, advise, support and training opportunities	Feb '11	ongoing	1. Raise awareness with people with Learning Disability and family carers of the benefits of personalisation and self directed support via training and information events 2. Develop service information for customers including a resource directory of universal services 3. Identify service users and families who want further training on support planning & brokerage 4. Confirm external support planning and brokerage arrangements	1. information produced and available 2. Resource Directory produced 3. x number of families using support planning and personal budgets to support cared for 4. Brokerage in place	**Christine Lewington**
5. Understand the impact of the new customer journey on provider services and	Jan '11	April '11	1. Set up workshops with providers and communicate vision for	1. Providers aware of customer journey	**Christine Lewington**

manage change with suppliers			learning disability services in Warwickshire including new ways of working 2. Set up focus group to understand impact of changes on providers 3. Work with providers to implement revised ways of working		
6. Work with procurement colleagues/providers to develop more personalised and flexible contractual arrangements focussing on outcomes and increasing independence	April '11	March '12	1. Review each of the existing frameworks for; community services, respite. 2. Agree and Introduce Individual Service Funds with existing providers 3. Change core contract to incorporate a more enabling philosophy in all contracted services	1. Frameworks reviewed and working effectively within defined financial envelopes 2. Increased market capacity including more innovative provision 3. Vision and philosophy of learning disability service implemented across the county by all stakeholders	**Rob Wilkes**
7. Ensure that people with a LD have the support they need to make choices and decisions	Jan '11	ongoing	1. Understand the brokerage function and work with voluntary sector organisations to develop access to external person centred support planning and brokerage 2. Identify the future role of care managers/social work teams in new customer journey and in particular support planning to avoid duplication	1. Brokerage in place and working 2. Wide range of support planning implemented eg; carers, voluntary sector, frontline staff.	**Jill Gowers**

8. Extend SDS to all new assessments and existing people at time of review	Jan '11	March '12	1. Identify how many people over what time frame e.g focus on transition/new customers. 2. Implement business process for reviewing 3. Establish phased change to provision of service defined by review outcomes for each individual	1. Everyone has a personal budget 2. Reviewing teams fully implement Self Directed Support	**Jon Soros**
9. Relevant local services develop capacity to deliver the kind of personal services that people want to buy (in particular preventative, enabling services)	April'11	March 2014	1. Develop understanding of what people are purchasing and communicate information to market and inform strategic commissioning activity 2. Develop mechanism to aggregate intelligence from brokerage function to inform strategic commissioning activity	1. Commissioning informed by intelligence	**Rob Wilkes/Andy Sharp**
10. Develop a robust quality and performance framework	Feb'11	Mar'11	Outcome based reviews/service monitoring Activity forecasting and financial projections	1. Performance regime in place and working 2.	**Andy Sharp**

Key Outputs/Targets	Key Outcomes
By March 2012 all people with a learning disability who get help from social services will have a personal budget. .	Supported to be independent and in control
By March 2012 at least 30% of people with a learning disability will have a direct payment.	Daily control in their own lives
By April 2011, an agreed pathway for learning disabilities that includes revised business processes and structures	Self directed support

By April 2011, clients and their carers are more knowledgeable and informed about Personalisation.	People are involved in decisions
By September 2011, all people with a personal budget will have access to a range of support planning and brokerage options	Supported to be independent and in control
By March 2012, at least 10% of people with a learning disability and their families will do their own support planning and brokerage.	Supported to be independent and in control
By April 2011 customer information on a range of local services will be readily available	Self directed support

A Fulfilled Life				
Learning Disability Action Plan 2011 – 2014				
People with a learning disability want to live a fulfilled life.			**Lead and Supporting officers**	
People with a learning disability want to live a fulfilled life. In particular they want to have and keep a job, be able to travel independently, learn new skills, enjoy their leisure time, make new friends and relationships.			Christine Lewington. Service manager Steve Smith. Provider Services Manager Jon Soros. Service Manager LD Localities.	
Lead Organisation				
Action	**Start Date**	**End Date**	**Responsible Officer/s and Organisation**	**Additional Notes**
Consult users and carers, on moving from building based day services to more community based support and establish a co-production group	February 2010	April 2011	Christine Lewington	
From April 2011 and using a phased approach over 24 months, close all internal day provision.	April 2011	Sept 2013	Steve Smith	
Jointly commission with health services which support people with complex needs to use their personal budgets	March 2012	Sept 2013	Christine Lewington	
Everyone currently using	Jan 2011	March 2013	Jon Soros	

day services will be reviewed, have a personal budget and be supported to access universal services				
Working with The Shaw Trust, capitalise on their expertise and access to national funding to support people with a learning disability to find and keep a job.	January 2011	March 2014	Simon Veasey	
Explore the feasibility and cost benefits of keeping/transferring/or closing the WEST project to Shaw Trust	April 2011	April 2011	Steve Smith	
Increase the number of Personal Assistants for people with a learning disability. (possibly through the development of a social enterprise)	Sept 2011	March 2012	Lesley Kendall	
Work with District & Borough councils to promote access to leisure opportunities	Sept 2011	March 2012	Rob Wilkes (Brokers)	
Utilise existing learning and work environments, and build capacity where none exists within local	April 2011	March 2014	Rob Wilkes Market Facilitation/Brokers	

communities				
Reduce spend on transport by 75%	April 2011	March 2013	Steve Smith	
Support the Directorate development of an Information & Advice service including support planning and brokerage	January 2011	March 2011	Marcus Herron Gill Jowers	

Key Outputs/Targets	Key Outcomes
By April 2011, complete a consultation process with users and carers about the future use of building based services with a view to move to more community based support.	People are involved decisions
From February 2011, no new people will start using in house day services and transport	Supported to be independent and in control
By April 2011, a phased approach will begin to enable people to access universal services instead of building based provision	
By March 2012 everyone currently using internal day provision will have a personal budget and be using universal services.	Self directed support
By March 2012 20% of people with a learning disability currently using day provision will be supported to find and keep a job.	The number of people who use adult social care services who have a job
By March 2014 30% of people with a learning disability currently using day provision will be supported to find and keep a job.	As above
By March 2012, establish a social enterprise of personal assistants for people with a learning disability.	Supported to be independent and in control

From April 2011, all new people or those who have been reviewed will receive travel training.	Daily control in their own lives
By April 2011, an information & advice service will be established	Supported to be independent and in control
By March 2012 there will be no internal building based day provision for people with substantial needs.	Self directed support
By April 2011, people with moderate needs will no longer access social care support.	
By Sept 2013 there will be five local community resources jointly commissioned for people with profound and complex needs	
From Jan 2011, support planning and brokerage will be in place for people with a learning disability and their carers.	Supported to be independent and in control

A Place to Live					
Learning Disability Action Plan 2011 - 2014					
				Lead and Supporting officers	
People with a learning disability want a safe and secure place to live where their needs can be met.				Chris Lewington. Strategic Commissioning Service Manager for Learning Disabilities, Carers & Customer Engagement	
Lead Organisation					
Action	**Start Date**	**End Date**	**Activity**	**Deliverable**	**Responsible officer and organisation**
Strategic Commissioning principle 1: Commission future models of accommodation and support services based on robust needs assessment, supply and gaps analysis and sound financial information.					
1. Establish a housing and support need and demand database including understanding of: • Volume of housing units needed • Location of housing required • Types or models of housing needed And understand what the local baseline is for supported living models	Jan '11	Ongoing	1. Complete a housing needs survey to gather primary data on existing service users 2. Target 'housing option' plans with priority groups of people eg: • the '75' • people with a learning disability and dementia • people who have housing adaptation needs/wheelchair access • people who live with carers over 75yrs/ at identified risk • people currently in poor quality accommodation/identified need for change (e.g.	An appetite for change understood and a planned approach in place to respond to it Comprehensive data base of housing needs.	**Rob Wilkes/Jon Soros**

			campus/residential care) • young people in transition or living with carers over 65yrs 3. Incorporate Place to Live into Self Directed Support process. 4. work with Learning Disability community teams to record baseline information and agree feedback loop 5. Establish method of storing data in a way which informs housing and support developments e.g. health needs, ethnicity, housing need, through Carefirst 6. Interrogate domiciliary care data and improve recording and reporting of supported living on care first system	Support planning tools to include housing need assessment. A mechanism for recording and reporting housing needs identified and agreed Updated Carefirst 6 Complete list of current supported living services and service users and improved recording on Carefirst.	**Adam Long**

2. Ensure information about housing and support need/demand is shared with key stakeholders, Increasing stakeholder engagement and awareness in commissioning intention and local vision	June '11	June '11	1. Hold a visioning workshops/events with • care managers • district housing • housing providers • Support providers • Children's services(transition) • Supporting People team	**Full range of partners identified to plan and deliver wider housing options**	**Jon Soros**
3. Identify financial resource needed for delivering the strategy (revenue and capital for housing and at an individual level and strategic level)	April'11	Ongoing	1. Current capital funded housing development 2. Funding released from remodelled or decommissioned services 3. Access to shared equity/mortgages 4. Regional Homes and Ccommunity Aagency affordable housing schemes 5. Private finance or providers willing to invest 6. Supporting people 7. Personal budgets 8. Underused Campus Capital		**Chris Norton/ District housing**
4. Develop a comprehensive list of WCC owned property, location and any lease arrangements and identify opportunities to maximise their use with partners	Jan 2011	March 2011	1. Mapping completed 2. Link to recommissioning of services		**Jon Soros/Property Services**
5. Develop a vacancy management system for residential care voids and LA/RSL tenancy voids	June '11	Sept'11	Role within community teams	Vacancy management system in place	**Jon Soros**

6. Develop joint commissioning processes with Supporting people team	Feb'11	Sept '11	1.map current procurement and contractual processes 2. Align processes to offer more effective service delivery	A more effective service delivery with a joint system	**Rachel Norwood**

Strategic Commissioning principle 2. Commission housing related support and personal support services which are personalised to ensure they are flexible and enable independence, choice and control for people with a learning disability.					
1.Ensure that all stakeholders are informed about personalisation and the local Transformation agenda	Feb '11	Feb'11	- workshops with housing and support providers to be delivered -link with Self Directed Support project to ensure that people who are eligible for funding who need a home with support are involved in designing service solutions to suit their need and circumstances	1. Providers more informed about personalisation and impact.	**Transformation team**
2.Ensure stakeholders have knowledge of options for housing and support	Feb '11	Dec '11	Update local Learning Disability Partnership Board Housing Options booklet Share information available from other sources e.g District housing VP website Provider information		**Chris Lewington**
3. Ensure that people with a LD have the support they need to make choices and decisions about housing and support options	Feb '11	ongoing	1. map existing support planning and brokerage resources including: • mapping what is happening now • Work out what is missing • Agree priorities for commissioning 2. Scope current spend, providers and users of appointee/deputy of court	1. Publications produced and widely available	**Transformation team/SDS project**

			services. Identify future need. 3. Link with Choice & Control project		
5.Investigate the available resource to develop a dedicated Pathway to Housing team with a focus on working with housing providers to develop options to respond to identified need/demand	Jan 2011	April 2011	Identify existing resources within Community Learning Disability Team , district housing? 'Housing broker' role?		**Jon Soros**
Best practice and positive outcomes shared	April '11	ongoing	1. Collate example of good practice and share lessons learnt via the Learning Disability Partnership Board and governence processes. Outcomes/benefits/case studies from individual stories.	A systematic process for aggregating person centred/Self Directed Support outcomes is in place. Outcome focused reviews influence purchasing and commissioning decisions.	**Jon Soros/Customer First Team**
Risk enablement policies in place	Jan '11	March '11	Develop a person centred risk approach ie; how we support individual to take positive risks, to ensure safeguarding.	Policy in place and tools available	**Self Directed Support Team**

Strategic Commissioning principle 3: Commission services which are responsive to changes in peoples need as independence and active citizenship are increased and ensure that the culture within the local workforce promotes this approach					
1.Improve information about housing and support options for people with a learning disability, family carers, housing and support providers and social care professionals, LA housing	Feb '11	Feb '11	-Identify resources available -Develop Accessible information about housing options - Workshops and information events (general and targeted) -Partner with provider	Publication materials workshops completed	**Customer First Team**

professional			organisations and people with LD to support information and awareness raising		
2. Ensure that social workers and reviewing officers are informed and able to give information on housing options to clients	Jan '11	Feb '11	Staff training and access to local information Community Care Assessments include housing options and consideration of assistive technology	Support planning tools includes housing options Staff informed and able to share housing information	**Simon Veasey/Amanda Fawcett**
3. Ensure people have just the support they need not more or less	ongoing	ongoing	FACS eligibility is reviewed and support adjusted in response to need Regularly check what over night support does and achieves- money could be better spent when people are awake.	Alternatives to night support (such as Assistive Technology) to reduce individual package costs by 25%	**Amanda Fawcett**
4. People with a learning disability engaged in individual support planning are able to co design there their housing and support services	ongoing	ongoing	Link with Choice and Control project		**Social work teams/providers**
5. Community connections and citizenship	Feb '11	ongoing	Alternative ways of providing support that assists the development of relationships and to connect with communities.	Outcomes for service users reflects community connection and participation. Monitoring identified best practice	**Elaine Ives**
6. No new people go into residential care and where they do ensure that 'admission' into residential care becomes the starting point for planning alternative housing and support options	Jan '11	March '11	Agree policy position with regard to residential care placements going forward Communicate intentions with providers and care management staff.	Policy in place and communicated	**DLT decision**

7. Co produce service options with current and new providers			See 4 & 5 below		

Strategic Commissioning principle 4: Support the development of a range of housing with affordable support and care options for people with a learning disability.					
1.Identify the housing need of the people currently living in residential care over next 3 years and other priority groups	Jan'11	Mar '14	Undertake housing options planning work with individuals as identified	Savings target	**Christine Lewington**
2.Identify any opportunity to develop housing stock for individuals and groups of people with LD (volume /locations matched to need & demand)	ongoing	ongoing	Identify – -WCC and NHSW owned land or property -Development partners -Remodelling current provision	Housing available	**Christine Lewington**
3.Identify and cost funding requirements based on below list :					
4. Identify the need and demand for: • Family contribution to mortgages/inherited tenancies	Feb '11 ongoing		Conduct housing & support options survey with people with LD/Carers to understand current appetite :		**Jon Soros/Tim Willis**
• Community Networks					
• Core & cluster			Warwick- the Wharf ?		
• Housing & Support which responds to Specialist need			(E.g-dementia, autism, health, needs, people with multiple disabilities)		
• District housing/Registered Social Landlords			Share identified housing need with providers and work collaboratively to respond.		

• Private sector leasing			Private rented sector solutions/links within housing & HB with private landlords		
• Adult Placement/shared living scheme			Determine need for scheme and how this could be achieved		
• Ownership/part ownership			My Safe Home		
• Extra Care			Note ops TW extra care Bedworth (x units) Bidford		
5.Reshaping/decommissioning current provision			See below Contractual negotiations		
6.Re-registration of residential care as supported living			Identify where this is possible and support provider change		
7. Investigate the use of the campus capital beyond campus discharge for alternative housing options for transferred NHS clients			Make the case and joint application to DOH to reinvest funds not spent and if successful identify how investment can be maximised		SPF
8. Develop Costed and realistic delivery programme to widen range of housing and support options and increase capacity over next 5 years					CL

Strategic Commissioning principle 5: In the shorter term work with current providers to review current models of accommodation and support services in line with strategic fit and support them to remodel service provision so that it is cost effective, and meets current and future demand for service where this is possible..					
1. Work with residential care provider and Housing association in Stratford district to reshape traditional residential provision	Jan'11	March '11	Close one underused residential home in X and remodel existing home in X to create 4 x 2 bed flats Support x people to move to		**Sharon Padley Frazao/John Hopper**

			supported living from residential care		
2. Review service provision of the largest provider in Bedworth/Nuneaton with a view to reshaping or decommissioning some provision in line with strategic direction and demand	Jan '11	March '11	Plan and Undertake review to identify: Housing need of x people People in supported living/day care who could have Personal Budgets or Individual Service Funds Future use of Telecare/Assistive Technology to reduce cost and increase independence Value for money for residential care cost (Care Fund Calculator) Put contracts in place		**Sharon Padley Frazao/John Hopper**
3. Re-registration of residential care as supported living	Jan '11	Mar '12	Identify where this is possible and support provider change		**Jon Soros/Sharon Padley Frazao**
4. As part of contract review process identify where providers can maximise opportunity to remodel services or/and improve their offer with regard to residential care which promotes independence	April'11	ongoing	Identify cost savings which can be reinvested into alternative approaches. Work with providers to identify service gaps e.g. transition for young people, older peoples services, short term support/assessment in response to crisis Identify where assistive technology can promote independence and reduce costs negotiate re-provision of residential care which is rated adequate or poor.		**Jon Sorros/Sharon Padley Frazao**

			Reduce the spend on residential care by renegotiating existing contracts and /or using care funding calculator, investing in Assistive Technology. Link to Care Fund Calculator project		
6. Work with procurement colleagues and providers (including in house)to develop more personalised and flexible contractual arrangements focus on outcomes and increasing independence	Jan '11	March '12	Identify provider partners to trail the approach E.g. Individual Service Fund contracts Core and flexi block contracts Look to personalise block contracts using the core and flexi approach?	A systematic process for aggregating person centred /SDS outcomes. Outcome focuses reviews influence purchasing and commissioning decisions	**Paul White/Sharon Padley Frazao**
7. Work with high cost and out of area provider to deliver value for money/efficiency savings			Care Fund Calculator savings targets- link with CFC project		**Jon Soros**

Key Outputs/Targets	Key Outcomes
By April 2011 all new people will be supported to live in their own home with support	Reach Standard: I have my own home
By March 2014, 20% reduction in the number of people living in residential care	Reach standard: I have my own home
By March 2014 the council will spend under 20% (£5 million) of its budget for people with learning disabilities on residential care.	Reach standard: I have my own home and choose how I am supported
By March 2014 using self directed support, the average package costs will be 20% lower than in 2010-2011	Efficiency savings

By March 2014, 25% of people using services will include the use of telecare in packages of support , including equipment to reduce dependency on other more formal forms of support	Feel safe and secure Supported to be independent and in control
By March 2012 all people living out of county will be reviewed and all people wishing to return are supported to do so.	Feel safe and secure Supported to be independent and in control

Good Health					
Learning Disability Action Plan 2011 - 2014					
People with a learning disability want to be healthy and well.				**Lead and Supporting officers**	
				Sally Eason. NHS Warwickshire. Lead Commissioner for Mental Health and Learning Disabilities.	
Lead Organisation					
Improving the health and wellbeing of people with a learning disability					
Action	**Start Date**	**End Date**	**Activity**	**Deliverable**	**Responsible officer and organisation**
1. Develop a comprehensive needs assessment of numbers and health needs of people with a learning disability in Warwickshire	Dec 2010	Nov 2011	1. Secure funding post April 2011. 2. With support from the Health Access Team ensure all people with a Learning Disability are identified on GP registers and GPs offer annual health checks. 3. Monitor take up of annual health checks via vital signs 4. 3 Feedback prevalence and need data into commissioning. 5. Ensure GP's have robust electronic systems & processes in place to collect health data about	1. Health Access Team project plan 2. Reliable health data for people with Learning Disability contained in the Joint Strategic Needs Assessment	**Sally Eason** **Public Health** **Sheryl Gaskell & Warks Intelligence**

			the LD population. 6. Ensure GP's have systems in place to Read Code people who have a diagnosis of Autism. Ensure this data is captured through GP reporting mechanisms through Warwickshire Intelligence.		
2. Primary , Acute and community health settings	Nov 2010	Nov 2011	1.. Ensure people with a learning disability have access to health and wellbeing information & advice services. 2. Support the role of secondary care interface within the Health Access Team. Provide a framework for strategic, operational and individual levels of health facilitation. 3. Deliver the local action plan in response to '6 Lives' to respond to the health inequalities facing people with a learning disability and profound, multiple needs 4. Deliver training and raise awareness with providers and health staff of the health needs of people LD	1. Health action plans and health passports in place for those with the most complex needs.	**Health Access team** **All providers** **Community Learning Disability Team** Health access team
Ensure availability and access to specialist health care service locally to support mainstream practice and service a small number of people (early intervention, prevention inpatient)					

3. Agree an individualised pathway of care for people with a learning disability			1. Agree clinical outcome measures (based on need clusters) 2. Health Gain measure 3. process measures (based on care pathway process)		**Suki needs to input**
4. Review the role of the Multi Disciplinary Community Learning Disability Team and commission to service specification which responds to need			1. Develop knowledge and capacity to team to respond to those people with: • Complex needs • Profound and multiple needs • Complex health and mental health needs 2. investigate how the role can be developed to respond to crisis and outreach support to avoid admission to inpatient care		**tbc**
5. Emergency support/short term intervention for family carers			1. Look at alternative community solutions – link with a Place to Live project 2. Skilled family centred support options developed (Self Directed Support)		**Tbc** **SE/CL?**

6. Agree an appropriate role for inpatient admission for assessment and treatment which is highly focused includes an exit strategy and is closely defined with mental health needs			1. Agree the principle that hospital inpatient admission will only be an option where learning disability services can no longer sustain or manage the individuals needs in their current environment/community setting. Inpatient care should only be viewed as a small part of the individuals journey through services. Services delivered locally and in the current environment should remain the preferred option. 2. develop service specifications and performance monitoring arrangement	1. Agreed service specification in place 2. outreach/crisis intervention team, in place	**CEC decision?** **tbc**
Effective Commissioning of Specialist community services					
3. Agree and establish lead commissioner/define the commissioning role for both specialist community health and social care for people with learning disabilities			1. Agreement in place for joint commissioning (collaborative or partnership approach) 2. Seek to reduce the	Agreement in place for lead commissioning (collaborative or partnership approach) Agreed principles for	**DLT/CEC?** Decision will inform who will lead commissioning activity on behalf of health (Primary Care Trust)

			disadvantages to individuals funding defined through Continuing health Care (e.g. loss of Disability Living Allowance /ndependent Living Fund) and maximise resources to health and social care community by exploring the use of personal health budgets, pooled budgets for this client group. 3. review the cost effectiveness of health care packages and refocus on more individualised and local support. 4.	CHC funding that promote (i) shared funding responsibility (ii) ordinary life service solutions and (iii) quick decision making 4 people with a personal health budget Mechanisms to support self directed support in place (link to Choice and Control project group) and 4 people with a LD will have a personal health budget	**Gaby Reeves**
4. Understand the needs of people with a learning disability within the health context	Jan 2011	April 2011	1. Audit need in relation to people with: -complex needs (including behaviour that challenges, autistic spectrum disorders, forensic) -profound and multiple disability -Additional Dementia -Learning Disability and mental health	1. data included in the Joint Strategic Needs Assessment 2. Responsibility for assessment of people with autistic spectrum disorders agreed. 3.Protcols for joint work	**To be confirmed**

			2. Audit service provision including: -Young people in transition from school -People in services out of county -People living with carers -People in county funded by other authorities/Primary Care Trusts	with mental health services agreed (green light tool kit completed) to improve access to mental health expertise 5. Responsibility for assessment, planning and case management of people with Continuing Health Care need and those sectioned under Section 117 Mental Health Act agreed 6. Plan in place to develop and expand capacity of local services to respond to current/future need	
5. Complete discharge of people with learning disabilities currently living in NHS campus accommodation.			1. Re-commission services based on individual support and housing needs	**Discharge completed by March 2010**	**Sharon Padley Frazao**
6. Agree approach to reviewing out of county placements for specialist provision with a view to		March 2014	1. complete scoping exercise review (including as above) 2. Link with Place to Live	1. Identified list of people who could and wish to return to the local area	**To be confirmed**

developing local capacity and reinvesting in more innovative services to meet need.			project	2. Identified financial resource available for reinvestment .	
7. Increase local capacity to deliver effective service solutions to people with complex needs			1. Work with local residential providers to identify approaches to emergency admission to Out of County Placements and Assessment & Treatment beds	Increased local capacity to support people with more complex needs or profound and multiple needs to reduce out of county placements	**To be confirmed**
Seek regional opportunities to commission collaboratively for low volume, highly specialised services			1.(e.g. local forensic beds, Assessment & Treatment, Move on services for complex need Link to West Midlands Ardentia data base		**Sally Eason/To be confirmed**
Ensure availability and access to community facilities to support people with complex or profound and multiple needs and their families					
8. Ensure access to innovative day time resources in particular for those with complex needs and those that may be excluded or unable to access traditional day services			1. ensure a community base adapted to meet the most profound need 2. Explore individualised solutions with Self Directed Service approaches 3. Work with provider partners to develop the market in response to gaps 4. Link with fulfilling life		**Christine Lewington/Sally Eason**

			project		
9. Ensure family carers have access to short term breaks to support the caring role			1. Promote Self Directed Support as an alternative to traditional respite provision 2. work with provider market to develop innovative options to meet need 3. work with family carers as experts of supporting people with profound and complex needs to co-produce solutions for the future.		**Christine Lewington**
10. Access to mainstream services eg; housing leisure education, primary care			1. Link with health and wellbeing board ro raise awareness of needs of people with profound need in terms of equipment need and Disability Act responsibilities with key partners 2. Health budgets to focus on a wide variety of interventions as an alterative to 'specialist' responses.		**Christine Lewington/Gabby Reeves**
11 A place to live with support as needed			1. Link with the place to Live project to develop a		**Christine Lewington**

			range of options to meet the needs of those with profound or complex needs		

Key Outputs/Targets	Key Outcomes
By march 2012 all GP practises will be offering annual health checks to people with a Learning Disability.	Reduce inequalities to health
By March 2013 to reduce admission (by how manyxx) to health funded accommodation because of a crisis or emergency	Reduce number of (NB- we do not have baseline yet) admission to Assessment and Treatment and Out of county placements
By March 2014, all people with a learning disability known to health & social care will have an annual health check- improve the health and well being of people with a LD	Improved health and wellbeing Reduced inequality & access to health care
By March 2014 to increase local capacity to support people with more complex or profound and multiple needs to return from out of county placements	X increase in local provision available to those with copmelex and multiple need Increase choice and control
By March 2011 all people will be discharged from campus accommodation	No eople to be living in hospital accommodation
By March 2012 (xx) people will have a personal health budget	Increased choice and control
By March 2011, have an agreed joint arrangement for continuing health care.	Better integrated working/efficiency savings

Supporting Family Carers

Learning Disability Action Plan 2011 - 2014

	Lead and Supporting officers
Carers want a more fulfilled life of their own. They want confidence to know that any services provided to the person they care for are of the highest quality. Carers of people with a learning disability want to	Elaine Cook. Carers Development Manager
Lead Organisation	

Action	Start Date	End Date	Activity	Deliverable	Responsible officer and organisation
1. Provide information & advice to carers about the range of universal services available to support them	April '11	March '14	1. Re-tender of carer support service contract 2. build on existing resource directory for Breaks for Carers and make this sustainable for service users as well.	1. Trained staff in the voluntary sector to give information 2. Carer information champions recruited in localities 3. Carer led training with Confidence implemented across the county 4. Carer signposted to specific condition voluntary orgs eg; mencap	**Elaine Cook**
2. Enable carers to be better informed of the	Feb '11	ongoing	1. Produce clear information/material	1. Booklets, web pages, flyers, leaflets	**Elaine Cook/Amanda Burn**

benefits of personalisation			for use in communicating and promoting personalisation 2. Set up 6 x workshops across the county with carers to promote the benefits of personalisation 3. provide regular update and case studies of positive examples of impact of personalisation	2. increase in the number of carers better informed of personalisation 3. Newsheets/flyers distributed	
3. Identify carers willing to become active members of the co-production group	Jan '11	ongoing	1. Set up co-production group 2. Identify carers willing to participate 3. Establish regular meetings and terms of reference 4. Agree ways of working and enabling carers to influence the LD strategy outcomes	1. Identified carer group 2. Group established including terms of reference 3. Carers competent and willing to engage with stakeholders to promote benefits of personalisation 4. Carers influencing strategic outcomes	**Amanda Burn**
4. Implement the revised business process for assessing carers	April '11	March '12	1. Hold training sessions for frontline teams 2. Confirm budget allocation for each team to support carers 3. Revise and update policies, procedures and guidance	1. Staff more informed and knowledgable about the assessment of carers 2. All eligible carers	**John Soros**

			for staff on browser	assessed	
5. Review and increase the range of respite provision for families	Sept '11	March '12	1. Establish review project group including terms of reference 2. Agree review methodology including carer co-production 3. Complete desk top exercise including literature review 4. Complete survey of key stakeholders 5. Hold focus groups with key stakeholders 6. Produce revised model for respite provision	1. Best Practice defined 2. Carers co-producing 3. In depth survey completed 4. Revised model established which includes wider methods of providing respite, such as assistive technology, shared lives, natural breaks and short term breaks etc.	**Elaine Cook**
6. All elderly carers have 'plans for the future' in place and both carer and cared for and supported to put these plans in place when necessary	April '11	March '14	1. Identify dedicated team (or people/person) to lead 2. Identify resource/finances required for project 3. Establish business process for assessing and planning with all carers over the age of 65 years 4. Agree method of enabling planning for the future to be completed 5. Agree timescales for completing all plans 6. Establish business process to record and monitor ensuring process enables plans to be actioned as relevant	1. Team or person in place 2. Business process agreed 3. Plans for the Future in place for all carers over the age of 65 years and recorded 4. Timely execution of plans completed 5. Improved satisfaction with respite provision	**tbc**

Key Outputs/Targets	Key Outcomes
By March 2012, ensure that all carers of people with a learning disability have access to information, advice and support to enable them to make informed decisions about their future and that of the person they care	Carers feel they are able to make informed decisions about their future and that of the person they are for.
By March 2012, all carers known to the council will have an assessment of their needs and access to services.	Carers feel the assessment was helpful in meeting their needs and feel satisfied with services provided.
By March 2012, all older carers over the age of 65 years will have a 'plan for the future' in place.	Carers are confident that plans meet their 'peace of mind'
By March 2012 a strategic review of respite provision will be completed, including looking at more innovative ways of providing respite, such as; shared lives schemes, the use of assistive technology.	Carers feel they have access to a wider range of appropriate respite. Carers are satisfied with the respite they use.

'A Good Life for Everyone'

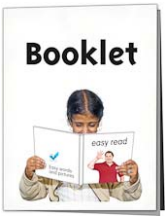
Warwickshire's Joint Commissioning Plan for Adults with a Learning Disability 2011-2014

Easy Read Version - DRAFT

Warwickshire County Council

Working for Warwickshire

Warwickshire NHS Primary Care Trust



What Information is in this booklet?

1. Introduction

Valuing People Now says that "Like other people, people with a learning disability want a real say in where they live, what work they should do and who looks after them…"

The learning disability partnership board want to make sure that real changes happen in the lives of people with learning disabilities and their family carers.

This Plan will have clear aims and priorities for the next three years.

It is based on what people with learning disabilities and their families have told us they need.

2. What is the Joint Commissioning Plan for adults with learning disabilities?

This joint commissioning Plan is our big plan for improving the lives of people with a learning disability and their carers who live in Warwickshire.

This plan tells you how services will work together to make sure people with a learning disabilities in Warwickshire have the same chances and choices as everyone else.

We will look at things like:

- Having choices about your care and support

- Having things to do in the day, evening and weekends
- Having a Job

- Being healthy
- Being safe

- Where you live

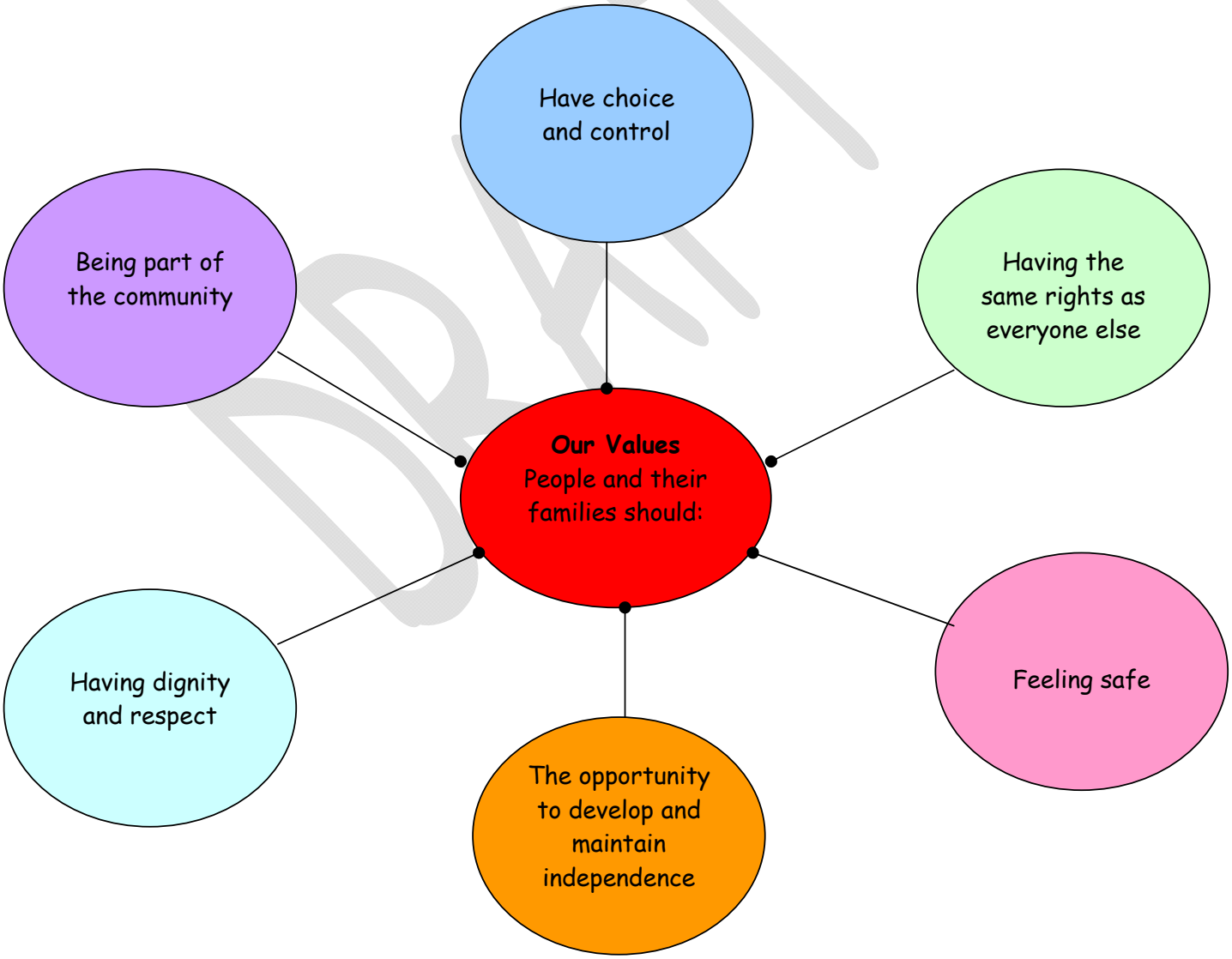
Better services using less money

Over the next few years we will have less money to spend on services. This means we must think of new and better ways of working.

3. Our Vision and Values

We will change how we do things by making sure we have a person centred approach. Thinking about the person, what they do well, what they like to do and what their hopes and dreams are.

We will support them and help them look at ways to have control and make good choices about getting a 'good life' for them.



4. Our aim – what we want to achieve

To promote the rights of adults with a learning disability to choose where they live.

To make the most of their independence through a choice of services.

We will make sure there is good information and advice about these services.

Advice and support for people with a learning disability to get a paid job.

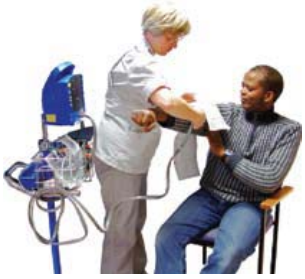
And better access to leisure and learning opportunities

5. Our objectives – how we want to achieve this

- **Through self directed support** – Making sure everyone who is eligible for social care has real choice and control over their lives and the services they use.

- **Through better commissioning** – Making sure people with a learning disability and their carers have access to a range of housing and support options which promote independence and wellbeing.

- **More involvement with the local community** – Making sure people have access to valued opportunities such as getting a job, being included in their local communities. Getting more involved in activities during the day, evenings and at weekends.



- **Make sure people have access to good health –**
  Getting help from doctors and nurses in GP practices and hospitals. Getting help from skilled staff in peoples own homes, preventing admission to hospital and residential care, where this is possible.

- **Support for people with complex needs**
  Helping other people such as people with profound and complex needs, people with autism and people form minority communities to make good decisions.

- **Support family carers –**
  Especially older family carers, to enable them to continue in their caring role where they are able, and to plan for the future of the person they care for when this is needed.

- **To have an effective governance structure –**
  Encouraging joint working and making sure the delivery of this strategy.

  A learning disability partnership board which is effective and efficient and also make sure that everyone one knows what is happening.

6.

Warwickshire Learning Disability Partnership Board

The members of the Partnership Board include:

- 7 People with a learning disability
- 3 Family carers
- 14 People from education, health, voluntary organisations, independent provider services, safeguarding, transitions, learning and skills.

What the board has to do:

- The Learning Disability Partnership Board will make sure that the local strategy in response to Valuing People Now is delivered and that they know that the lives of local people with a Learning Disability are improving.

- A revised governance structure has been agreed between NHS Warwickshire and Adult Social Care.
  The structure places the transformation programme at the heart of these changes but also the important role that the Learning Disability Partnership Board will have in making sure the strategy is delivered.

The Learning Disability Partnership Board will:

- Make sure an action plan is developed with how money is going to be spent. This will set priorities, targets and responsibilities for achieving change.

- The Partnership Board will provide leadership for carrying out the plan.
- Link with other partnerships, developments and strategies.
- Work across all other departments and organisations to look at changing the way we work and raise expectations.

- Monitor, review and evaluate performance against the plan
- Recognise and communicate the success
- Report to the Learning Disabilities Strategic Group Board and other relevant strategic bodies.

The development of strategies and implementation plans will continue to be developed and delivered through the learning disability partnership board subgroup structures.

7. What people with learning disabilities have told us they would like/want:

- **More Choice & Control – people with learning disabilities told us:**

What we like to do:

'I have my own bank account and look after my money.'

'I decide when to have a bath and go to bed.'

'I choose to go bowling'

'I choose what courses to do at college.'

Other things we want to do

'It is important to have a bus pass.'

'I would like to live in a flat in the future but not now.'

'I would like to get married one day.'

What we don't want to do anymore

'Staff decide where I go on holiday'

'I don't have the control over my money'

'I would like to make my own drinks and sandwiches at home'

'I was moved to another support worker without being asked if it was ok.'

More Choice and Control

People with a learning disability told us that they want to have choice and control over how they live their life.

Our Action Plan:

We will support people and their carers by:

- We will give information and advice so that people are able to make the right decisions based on this information.

- Making sure everyone can take up self directed support so that they can be in control of their own support.
- Give everyone a personal budget by March 2012.

- Support lots of different people, including people with Learning Disabilities, to do support planning and brokerage.

- Introduce different ways of managing a Personal Budget, such as Direct Payments, Council managed accounts or Individual Service Funds.

- **A Fulfilled Life – people with learning disabilities told us:**

What we like to do

'Relationships are important and people should help us without interfering and support us when it goes wrong.'

'I work in a community café'

'Getting a job – makes me feel great'

'I like socialising and doing drama'

'I enjoy going to the theatre.'

'I am going to Disneyland in Florida.'

'I go to Birmingham and Leamington on a train.'

Other things we want to do

'Meet and greet people.'

'My dream job is to be a farmer.'

What we don't want to do anymore

' Working in a chiller fridge on a cold day.'

'Having to pay lots of money to do college courses because I am not on a certain benefit.'

A Fulfilled Life

People with a learning disability told us they want to live a fulfilled life and get involved in a range of services.

Our Action Plan

People with a learning disability want a fulfilled life; they want to have more independence, get a job if they want and have access to other opportunities outside of social services.

We will support people and their carers by:

- Looking at how we can help people to get paid job.

- Move away from building based day services and instead help people to do things in their communities, such as going swimming, eating out with friends, going to college.

- Help people to travel more independently so that they can access work, learning and social opportunities.

- Put together information, give financial advice and any other advice to help people to access other opportunities that do not rely on day centres and other social services.

o A Place to Live – people with a learning disability told us:

What we like to do

'I live near shops and I can get around independently'

I live with my family, do the shopping and some house work'

Other things we want to do

'We want to be a couple in a bungalow that we have bought ourselves.'

'To be able to have a cat or a dog in my house'

'A house to live with my friends'

What we don't want to do anymore

'To move out of parental home before my parents are no longer with me. Need to learn independent living skills.'

Noisy motorbikes'

'Where I live there are some drug takers, it is not a nice place to live, it is frightening.'

'Bad neighbours'

A Place to Live

People with a learning disability told us they want a safe and secure place to live where their needs can be met.

Our Action Plan

To support people with a learning disability to have their own home we will look at lots of ways we can support people to get a home of their own with support if needed such as:

- √ Renting or buying instead of residential care for new people
- √ Living either on your own or with friends.
- √ Living closer to family and friends locally
- √ Moving from hospital or residential accommodation
- √ Look at new technology and equipment which supports and enables people to be more independent within their home.

We will also invest resources in the development of new supported living options so we will:

- ➢ Work more closely with the community and independent sector to develop more housing options.
- ➢ Promote shared ownership as a good option for supported living.

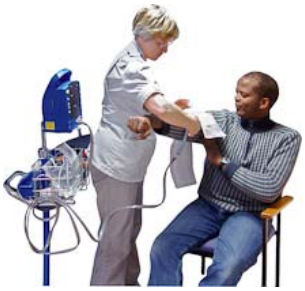
- ➢ Develop the use of family monies to develop housing options (including home extensions).
- ➢ Enable people to take over the tenancy or ownership of parental homes.

- ➢ Review the services of people currently living in a different areas with the aim of building local capacity, so that they can return to Warwickshire if they wish.
- ➢ Look at people who live in care homes who wish to look at other supported living options.

- **Good Health - people with a learning disability told us:**

What we like to do

'I enjoy eating healthy foods – yoghurt and vegetables.'



'Going to hospital was ok, staff supported me and explained things so I wasn't worried. I could ask questions.'

'Annual Health Checks are good.'

Seizures are a worry but I received help and support and medication is good.'

'I enjoy going to the gym, walking and keeping fit.'

'Running – I have won lots of medals.'

'I walk up the town at weekends.'

'People at the club are my friends, they take me out I am happy when I go to new places.'

Other things we want to do

'Carry on keeping fit and doing Olympics training.'

'Do more exercise.'

'Need lots of support at hospital.'

'To keep going out and about, to be supported to do this.'

What we don't want to do anymore

If I have CHC then decisions not made in a timely fashion (i.e. takes months to make a decision)

'If CHC awarded need plan of action (at the start) in the event no longer eligible, need closer working partnership with health and social services.'

Good Health

People with a learning disability have told us they want to be healthy and well and learn about healthy eating and have a balanced diet.

Our Action Plan

Everyone has a right to good health and to feel healthy and safe. To support people with a learning disability to have good health and well-being we will:

Ask the Health Access Team to:

- Support doctors to undertake annual health checks for all people with learning disabilities, including young people moving to adult services.
- Encourage healthy lifestyles, including healthy eating, good dental hygiene and exercise.
- Improve the patient experience in a hospital setting.

- Provide training to staff within hospitals on effective communication with people with a learning disability.
- Collect health information for future service planning and development.
- We make sure that we look at new ways to assess your needs.

- To make sure there are more locally based services to prevent crisis, hospital and residential care admissions.
- This will include 24-hr support which enables people to keep living with their families and own homes.

o Support For Family Carers – Carers told

<u>What we like to do</u>

- Have access & contact to Carers Support Services

'SWCSS groups work well.'

'Guideposts send out a lot of good information.'

- Have good experiences of health services for cared for person

'NHS Day Centre – works well, good level of support and range of activities. NHS respite – good service, provides continuity of care (staff & surroundings).'

- Enjoy talking with other family/parent carers

'Helped us through transition.'

<u>Other things we want to do</u>

- Have more opportunities to get involved

'Carers should be listened to and not sidelined = partnership'

'Need to enable Carers to make contribution to bodies such as Warwickshire Learning Disability Partnership Board.'

- More flexible and responsive support staff

'Good communication is needed between support staff about the people they are caring for.'

Need continuity of care on a daily basis.'

'Paperwork is important but don't forget to spend time with the people who need to be cared for.'

- More consistent travel training

<u>What we don't want to do anymore</u>

- Not have joined up working arrangements

'Carers still being asked to repeat information, especially in hospitals'

'Continuity of care – what happens when I am gone? Need to improve change over processes.'

- Have inaccessible information & advice

'Need information on available providers and their quality.'

'Knowing who to talk to, where to go for help.'

- Not able to work due to caring responsibilities
- Experience difficulties with carers assessments

'I would like the person assessing my needs to be open minded and not try to tell me what they think my disability is like – I am an individual with individual needs so would like to be treated as such.'

Carers assessments – not happening and people don't know about them and whom to contact.'

Support for Family Carers

Carers told us they want a more fulfilled life of their own. They want confidence to know that any services provided to the person they care for are of the highest quality.

Our Action Plan

To support this we will:

- Give all carers good information and advice about the range of services available to support them within their caring role.

- Increase the overall numbers of carers assessed and who have a Direct Payment.
- Look at other different ways of supporting carers, including short break options.

- Work with older carers to plan for support in the future.

- Ask carers to work with us to develop better ways of providing short breaks, such as; shared lives schemes or technology (equipment which enables you to live safely and independently).

8. Helping you to understand the words we use

Accommodation	Somewhere to live
Assessment	Looking at a persons needs as to what they r
Assistive	To help somebody to do something
Commissioning	Buying services
Commitment	promise
Community	Local people that live in your area
Consistent	Steady
Contract	An agreement
Development	To increase and build on something
Dignity	Self – respect
Direct Payment	Having money to buy your own services
Diversity and equality	Different people with different needs and treating everyone equally
Effective	Of use and works well
Efficient	Of use and works well
Eligible	Allowed to have
Enable	allow
Encouraging	To give support and help
Evidence	Proof
Focused	Looking at something with a lot of attention
Fulfilled Life	A life with more opportunities and choices
Governance Structure	The arrangement of groups and people with influence
Implementation	To put into action or carry out
Independently	Without help
Institutional	Organisation
Intention	The things we want to achieve or reach
Invest	To put in (money)

Involvement	Taking part in a group or work
Joint	To work together
Maintain	Keep up
Monitored	To find out things
Objectives	How we want to do things
Opportunities	Having the chances to do things
Outcome	The result of something
Participate	To take part
Person centred approach	Making sure that everything we do has the p involved and at the centre of everything tha happens with them
Priorities	Main aims and concerns
Practical	Sensible and reasonable
Process	The way of doing something
Protocols	The procedures
Preventing	To try and stop doing something
Promote	To help and support
Realistic	In a way that seems real
Respect	To value
Resources	Information available
Responsive	Quick to take action
Self-directed	Able to something by themselves
Services	Help and support which is provided to people
Strategy	A big plan
Transparent	See through
Values	Standards
Vision	An idea
Valuing People Now	The Government has written this document involvement with people with learning disabil and family carers. The paper is about makin that people have the same opportunities as

	everyone else and a better quality of life.

Contact Us

Warwickshire Learning Disability Partnership Board

If you would like this information in another language, in large print, or on audio please phone us on 01926 742414

Or email us:
ldpartnershipboard@warwickshire.gov.uk

Go online to our website at:

http://warwickshire.ldpb.info

and fill in the questionnaire or
tell us what you think about this plan

You can also can call the Partnership Board Office.

The pictures in this plan have been provided from Photo symbols and Valuing people Clipart.

Put delivery plan here

Comment [WCC1]:

'A Good Life for Everyone'

Warwickshire's Joint Commissioning Plan for Adults with a Learning Disability 2011-2014

Easy Read Version - DRAFT

Your Services Are Changing

Let's Talk .....

The Learning Disability Strategy 2011 – 2014 sets out the vision for learning disability services in Warwickshire.

It provides clear aims of the things we want to achieve around buying services, over the next 3 years.

It also tells us in the delivery plans what steps will be taken to make sure that people with a learning disability have a fulfilled life.

VISION

We will change how we do things by making sure we have a person centred approach. Thinking about the person, what they do well, what they like to do and what their hopes and dreams are.

We will support them and help them look at ways to have control and make good choices about getting a 'good life' for them.

AIM

We Want To:

- Promote the rights of adult with a learning disability to live locally as the same as everyone else.

- Make the most of their independence through a choice of services.

- Make sure there is good information and advice about these services.

- Provide support for people with a learning disability to get a job.

- Improve access to leisure and learning opportunities.

Why Are We Doing This?

There are 2 reasons why we are doing this:

1. We need to save £4 million over the next 3 years.

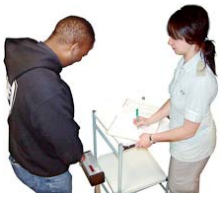
2. We need to deliver better outcomes for people with a learning disability and their carers.

We Will:

- Use self directed support to assess people's needs including their carers.

- Give everyone (who is eligible) a personal budget so that they can decide how this money is spent to support them.

- Use more services that are in the community and less building based services.



- Use less residential care and instead use more supported accommodation.

- Make sure everyone has an annual health check.

- Support carers, in particular elderly carers. This will include reviewing respite services.

- Work with the police and community groups to stop hate crime.

- Work together with health and other people, such as providers and the voluntary sector.

How Will We Do This?

We Will:

Self Directed Support and Personal Budgets

- Train all of our social workers to use the 'My Assessment and Support Plan' tools.

- From April, give people who are reviewed or re-assessed an indicative budget.

- Give training to people, including people with a learning disability, any carers, and/or friends or neighbours, about support planning.

- Put in place a good information and advice service

- Work with providers to put in place support planning and brokers and/or a brokerage service

- Train people with a learning disability, and any carers, to look at how good we are delivering the personalisation agenda.

Daytime and Community Activities

- Find lots of different things that people can do locally and in their communities.

- Reduce the number of big buildings that we use

- Get lots more ‘Personal Assistants’ particularly those who have lots of experience working with people with a learning disability.

- Work with different providers, to help people to find and keep a job, including working with the council.

More supported housing options

- Give people with a learning disability and their carers information about the range of housing options available to them.

- Stop putting people into residential care wherever possible. But when they are, see this as the beginning of helping them to plan and look at other housing options

- Find lots of different ways of supporting people to live independently with support, including setting up a 'Moving On' team.

- Look at other ways of supporting people, such as shared lives schemes and assistive technology

- Work with district and borough councils and providers to improve the housing options in Warwickshire

Helping people to stay healthy

- Ask the Health Access Team to work with GPs to make sure that everyone with a learning disability has an annual health check

- Give lots of information about healthy eating, dental care and taking lots of exercise to keep healthy and well.

- Working with hospitals, GP practices and other health units to be better informed about the needs of people with a learning disability so that they get the same service as everyone else.

Support for Carers

• Make sure that all eligible carers have an assessment of their own needs so that they can stay healthy and well.

• Get more carers to take a Direct Payment to help them to have a life outside of caring.

• Work with carers to find lots of different ways to support them to take a short break.

• Work with all carers, especially elderly carers to 'Plan for the Future'.

AND FINALLY

We want to know what you think about our plans. You can get a copy of our questionnaire from:

The website: www. ????????

Calling us on: 01926 746995

Writing to: RRXX-KTSC-XYLA
Customer First Team, Adult Health and Community Services, Saltisford Office Park, Ansell Way, Warwick CV34 4UL

Emailing us at: customerfirst@warwickshire.gov.uk

Coming to a meeting and talking to us:
Phone the Customer First Team on 01926 746995 to find out about dates and times of consultation meetings.

'A Good Life for Everyone'

Warwickshire's Joint Commissioning Strategy for Adults with a Learning Disability

2011 - 2014

Consultation Summary

This consultation summary is Easy to Read.

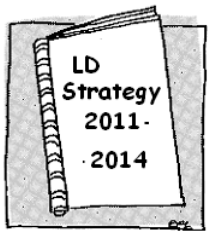
Warwickshire County Council

Working for Warwickshire

Warwickshire NHS Primary Care Trust

Your Services Are Changing

Let's Talk .....



We want to know what you think about our plan **Warwickshire's Joint Commissioning Strategy for Adults with a learning disability 2011 - 2014**.

This is a plan for services over the next 3 years for people with learning disabilities and their carers in Warwickshire.

From **March to June 2011** we will be asking people to tell us what they think about our plan.

You can do this by:

- filling in the questionnaire and sending it back to us at the Freepost address below.

or

- you can fill in the questionnaire on the computer by going to: www.????????

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What is the Joint Commissioning Strategy for adults with learning disabilities?

This Joint Commissioning Strategy is our big plan for improving the lives of people with a learning disability and their carers who live in Warwickshire.

This plan tells you how services will work together to make sure people with a learning disabilities in Warwickshire have the same chances and choices as everyone else.

This plan has been written by staff from Warwickshire County Council, health services, people with learning disabilities and their carers.

Better services using less money

We need to save £4 million over the next 3 years and we will have less money to spend on services.

This means we must think of new and better ways of working.

We will look at things like:

- Having choices about your care and support

- Having things to do in the day, evening and weekends
- Having a Job

- Being healthy

- Being safe

- Where you live

1. More Choice and Control

People with a learning disability told us that they want to have choice and control over how they live their life.

We will support people and their carers by:

- We will give information and advice so that people are able to make the right decisions based on this information.

- Making sure everyone can take up self directed support so that they can be in control of their own support.

- Give everyone a personal budget by March 2012.

- Support lots of different people, including people with Learning Disabilities, to do support planning and brokerage.

- Introduce different ways of managing a Personal Budget, such as Direct Payments, Council managed accounts or Individual Service Funds.

2. A Fulfilled Life

People with a learning disability told us they want a fulfilled life; they want to have more independence, get a job if they want and have access to other opportunities outside of social services.

We will support people and their carers by:

- Looking at how we can help people to get paid job.

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- Put together information, give financial advice and any other advice to help people to access other opportunities that do not rely on day centres and other social services.

3. A Place to Live

People with a learning disability told us they want a safe and secure place to live where their needs can be met.

To support people with a learning disability to have their own home we will look at lots of ways we can support people to get a home of their own with support if needed such as:

- Renting or buying instead of residential care for new people.
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- Promote shared ownership as a good option for supported living.

- Develop the use of family monies to develop housing options (including home extensions).

- Enable people to take over the tenancy or ownership of parental homes.

- Review the services of people currently living in a different area with the aim of building local capacity, so that they can return to Warwickshire if they wish.

- Look at people who live in care homes who wish to look at other supported living options.

4. Good Health

People with a learning disability have told us they want to be healthy and well and learn about healthy eating and have a balanced diet.

Everyone has a right to good health and to feel healthy and safe. To support people with a learning disability to have good health and well-being we will:

Ask the Health Access Team to:

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- Provide training to staff in hospitals on effective communication with people with a learning disability.

- Collect health information for future service planning and development.

- We make sure that we look at new ways to assess your needs.

- To make sure there are more locally based services to prevent crisis, hospital and residential care admissions.

- This will include 24-hr support which enables people to keep living with their families and own homes.

5. Support for Family Carers

Carers have told us they want a more fulfilled life of their own. They want confidence to know that any services provided to the person they care for are of the highest quality.

To support this we will:

- Give all carers good information and advice about the range of services available to support them within their caring role.

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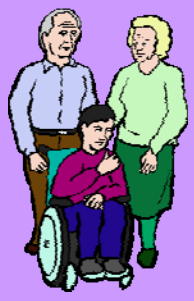
- Work with older carers to plan for support in the future.



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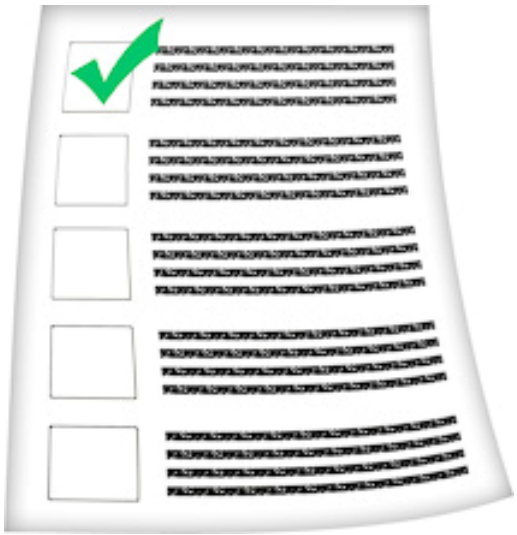
The pictures in this strategy have been provided by Photo symbols and Valuing People Clipart.

Warwickshire County Council • January 2011

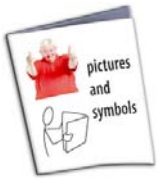
'A Good Life for Everyone'

Warwickshire's Joint Commissioning Strategy for Adults with a Learning Disability

2011 - 2014



Consultation Questionnaire



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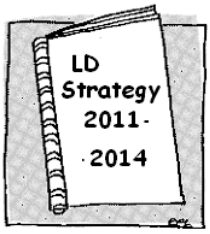
Warwickshire County Council

Working for Warwickshire

Warwickshire NHS Primary Care Trust

Your Services Are Changing Let's Talk .....



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1. More Choice and Control

People with a learning disability told us that they want to have choice and control over how they live their life. (Page 5 of the easy read summary)

Do you agree with what we plan to do?

Please tick (☑) a box below.

Yes ☐ Or No ☐ 

Would you like to tell us more?

2. A Fulfilled Life

People with a learning disability told us they want a fulfilled life; they want to have more independence, get a job if they want and have access to other opportunities outside of social services (Page 6 of the easy read summary)

Do you agree with what we plan to do?

Please tick (☑) a box below.

Yes ☐ Or No ☐

Would you like to tell us more?

3. A Place to Live

People with a learning disability told us they want a safe and secure place to live where their needs can be met. (Page 7 of the easy read summary)

Do you agree with what we plan to do?

Please tick (☑) a box below.

Yes ☐ Or No ☐

Would you like to tell us more?

4. Good Health

People with a learning disability have told us they want to be healthy and well and learn about healthy eating and have a balanced diet. (Page 9 of the easy read summary)

Do you agree with what we plan to do?

Please tick (☑) a box below.

Yes ☐ Or No ☐

Would you like to tell us more?

5. Support for Family Carers

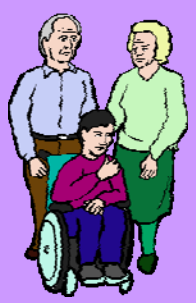
Carers have told us they want a more fulfilled life of their own. They want confidence to know that any services provided to the person they care for are of the highest quality. (Page 11 of the easy read summary)

Do you agree with what we plan to do?

Please tick (☑) a box below.

Yes ☐ Or No ☐

Would you like to tell us more?



About you

You do not have to answer the following questions, but if you do, it will help us plan better services for people with learning disabilities in Warwickshire.

1. How old are you?
Please tick (✓) a box below.

☐ 25 or under

☐ 26 to 34

☐ 35 to 44

☐ 45 to 54

☐ 55 to 64

☐ 65 or over

2. Are you a:
Please tick (✓) a box below.

☐ Person with a learning disability

☐ Carer or parent of a person with a learning disability

☐ Person who works with people with a learning disability

☐ Other (member of the public, service provider, voluntary and community organisation etc)

3. Are you:
Please tick (☑) a box below.

☐ Male

☐ Female

4. Do you think of yourself as:
Please tick (☑) a box below.

☐ White British

☐ Asian or Asian British

☐ Black or black British

☐ Mixed

☐ Other

☐ I don't want to answer this question

5. Which area do you live in?

☐ Warwick District
☐ Stratford District
☐ Rugby Borough
☐ North Warwickshire Borough
☐ Nuneaton and Bedworth Borough
☐ None of the above
Please state:
……

Talk to us:

If you would like to help us by taking part in meetings or talking to us on the phone, or giving us your views about our services, please tell us your name and contact details below:

Name:

……

Address:

……

……

Phone number:

……..

Email:

……

Data Protection Act 1998

The personal information on this form will be kept safe and is protected by law.

If you would like a copy of this consultation summary in another language, in large print, in Braille, on audio tape or CD, please phone us on **01926 746995** or send an email to **customerfirst@warwickshire.gov.uk**

The pictures in this questionnaire have been provided by Photo symbols and Valuing People Clipart.

Warwickshire's Joint Commissioning Strategy for Adults with a Learning Disability 2011-2014

'A Good Life for Everyone'

Consultation Plan

1. Introduction

Adult, Health & Community Services Directorate have undertaken a refresh of the Strategy which supports a significant shift in the way services are organized and delivered and also supports the vision and principles set out in Valuing People Now, Valuing Employment Now and Putting People First and looks at how these can become realised in Warwickshire.

It is important that service users, carers and key stakeholders, particularly our partners, have a thorough understanding of the vision and philosophy and have a real opportunity to express their views and for those views to be listened to and heard in the final decisions made.

2. *'A Good Life for Everyone.' (2011-2014)*

This Strategy will focus on creating a more coherent direction to the way services for people with a learning disability and their families are delivered to ensure the best use of limited resources. It will create a more enabling and individualized approach which reduces the dependency on high cost solutions that do not deliver the choices and preferences individuals with a learning disability should be empowered to take.

The Strategy will make clear the commissioning priorities for the next three years. It will be based on what we know about the needs of the local learning disability population and their families and what people with learning disabilities and their families have t old us they need.

Vision

We will change how we do things. Starting with the person at the centre, thinking about what they do well, what they like to do, what their hopes and dreams are.

We will support them and help them look at ways to have control and make good choices about getting a 'good life' for themselves.

Aim

Our aim is to promote the rights of adults with a learning disability to live locally as equal citizens, to maximize their independence through the provision of a range of services including, good information and advice, access to employment, leisure and learning opportunities.

3. Consulting customers, families/carers, staff and key stakeholders

A 3 month consultation period will be undertaken starting from March – June 2011. Existing customers, their carers, frontline staff and key stakeholders need to be aware that Adult Health and Community Services is refreshing the strategy as well as being provided with a range of opportunities to put forward their views on future service provision and influence the decision making process.

For consultation to be effective, meaningful, and to fulfil legal and moral obligations, there are key groups who require consideration for communication, consultation and engagement.

These include:

- People who use our services (adults with a learning disability residing in Warwickshire
- Their relatives/carers
- Frontline staff
- Key stakeholders – district & borough councils, health, voluntary & community groups, the independent sector & private industry, general public.

4. Objectives of Engagement

The key objectives of the consultation will be to:

- Discuss future commissioning priorities as outlined in the Strategy, exploring alternative options for future day opportunities, including leisure, jobs and education under the following commissioning outcomes.

- *More Choice & control*
- A fulfilled life
- A Place to Live
- Good Health
- Support to Family Carers

- Consult with existing customers & their carers/relatives on moving from building based day services to more community based support.

- Raise awareness and promote the benefits of personalisation and self directed support via training and information events.

5. Methods of Engagement

Due to the significant changes (some of which are of a sensitive nature), outlined in the strategy, there will be a variety of methods of consultation used to respond to and engage with each audience group.

Using the 'Putting People First' model 'working together for change – using person centred information in commissioning' will enable us to evidence that the strategy refresh and its commissioning intentions are based on what people have already told us. It provides a positive framework on which to build and '…*focuses on people's strengths, passions, interests and the things that they like to do providing a tremendous starting point for a co-productive relationship.* This will be a valuable tool that provides a positive platform on which to build discussion and dialogue.

See attached comprehensive and detailed engagement plan, including various methods of engagement. (appendix 1)

i) Adults with a Learning Disability –

In order to ensure that individuals are given the opportunity to have their say on the key objectives. It is vital to provide a variety of consultation/communication methods, which meet their varying levels of understanding of the information provided and their ability to communicate their views effectively. A series of small focus groups (within each day service) will be undertaken using the information gathered at earlier workshops to influence and stimulate discussions with other consultees. *'You have already told us this…does the strategy reflect what you said?.'*

ii) Family Carers/relatives –

The 'Putting People First' model (as outlined above) can also be used when consulting and engaging with family carers and relatives. It is important to note that the carer consultation should occur **after** the service user events. So that the outcomes, aspirations and information gathered from service users can be utilised to stimulate further discussion and dialogue. *'you told us ……. regarding your caring role and from your perspective as a carer of an adult with learning disabilities – does the strategy reflect what you said?'*

iii) Staff –

Frontline staff (Social work teams & day service support staff) will have opportunities to put forward their views recognising their significant skill base and through their direct experience can add value to the strategy, particularly in relation to implementation.

iv) Key stakeholders –

It is important to involve and consult with a range of stakeholders in order that they have an opportunity to hear the views of both service users and carers but also to look at how they can meet the future needs of customers within the personalisation and self directed support arena. *'Service users and carers*

have told us ……. How can you support them to achieve this and provide services to meet their future needs?'

6. Consultation Material/Communication Methods

The following will be used in a combination of different ways in order to effectively consult with people with a learning disability. These methods may require additional support from specialist organisations eg: Speech & Language Therapy, New Ideas Advocacy.

- **Advocacy**
- **Sign language – BSL**
- **Makaton – Widget**
- **Symbols – Line drawings – Large font**
- **Easy Read – Pictures – Photographs - Layout – Design**
- **Person centred approaches**
- **Audio tape – CD – Music**
- **Talking Mats**
- **Graphics**

Here are a variety of ways of communicating with people who have profound and multiple learning disabilities.

- **Multimedia** - Reactions to services/activities can be recorded on video
- **Storytelling** - Enabling people with profound learning disabilities to demonstrate their own experiences through supported storytelling.
- **Presentations with objects of reference** - A person with Profound & Multiple Learning Disabilities (PMLD) could be supported to share their experience through a presentation with objects of reference. Use creatively – Sound? Smell? So that the person can make a link between the objects.
- **Peer advocacy** - Training for self advocates with learning disabilities to include and advocate for people with more complex needs.
- **Communication aids** – 'Big Mack' - Record a sound and stick pictures onto it. Video and digital photography.

- **Intensive interaction** – 1:1 time with a key worker/family carer to explore how the person engages with the outside world.

- **Communication passports dictionary** – Draws together information from past and present to help staff understand the person. Helps others to understand how the person communicates.

Need to be mindful that many people with PMLD experience the world largely on a sensory level. Need to consider multi-sensory environments which tune in to those senses to ensure that they are able to have a say.

7. Communication Plan

Due to the nature of the consultation, a communication plan outlining key stakeholders will need to be developed in order to identify those people who may be affected by the consultation and also determine the method and frequency of the communication to be used. The 4 key groups of stakeholders have been highlighted previously but there are a number of other teams, groups & organisations who will need to be kept informed of the consultation.

Please see attached detailed Communication Plan. (appendix 2)

8. Engagement Plan

A comprehensive engagement plan (see attached Appendix 1) has been developed which offers a diverse range of innovative methods of engagement to a range of consultees.

Adults with a Learning Disability

- Focus groups within each day service

- Peer Evaluators training

- Self Directed Support Co-production group

- Case Studies

Engaging with people with Multiple and Profound needs

- Undertaking 1:1 sessions - Utilising a variety of communication methods including a number of visual aids eg: photographs, symbols and props

Family Carers/Relatives

- Workshops – a series of 5 workshops in each district & borough

- Carers co-production group

- Peer Evaluators

Frontline staff - (Social work teams & day service support staff)

- Staff workshops/focus groups

- Training sessions for teams

Key Stakeholders – (district & borough councils, health, voluntary & community groups, the independent sector & private industry.)

- 2 x workshops (North & South)

9. Primary Consultation Materials

In order to effectively consult and engage with a wide ranging audience (as outlined above) it is important to develop a toolkit of consultation materials which not only provides information but also allows consultees to express their views in a number of creative ways.

The following materials will be utilised throughout the consultation –

- **Key information –**
  - **Easy read version of the Strategy -**
  - **What is Personalisation?** - Information available in a range of easy read and picture supported formats. Providing clear definitions of Personalisation, Self Directed Support, Personal Budgets & Person Centred Planning to aid people's understanding.
  - ***'Your services are Changing Lets Talk***…….' – Information sheet outlining the aims and objectives of the strategy and key areas for discussion and dialogue.

- **Questionnaire** – providing a platform for people to have their say about the strategy and future service provision. Also available on line version accessible via web pages.

- **DVD** – to provide key information on personalisation and self directed support. Also, providing highlights of the earlier service user workshops, will further aid discussion and understanding.

- **Dedicated web pages** – to include information on the consultation process, including an on line version of the questionnaire and other information on personalisation and self directed support.

- **Case Studies** –promoting people's positive experiences of personal budgets.

- **Photographic evidence** – A3 laminated photographs, gathered from earlier service user and carer workshops, detailing people's future dreams and aspirations.

- **Keepad Equipment (Audience Response System)** – participants are able to respond to questions using a simple key pad device which provides an instant group response.

10. Mechanisms for People to 'Have Their Say'

There are various ways people will be able to express their views which include completing a questionnaire from the following:

The website: www.ldpb.gov.uk

Calling us on: 01926 746995

Writing to:
Amanda Burn.
Customer First Team,
Adult Health & Community Services
Saltisford Office Park
Ansell Way
Warwick
CV34 4UL

Email us: customerfirst@warwickshire.gov.uk

Attending one of our meetings: Information will be made available on the website.

Following the 3 month consultation period, all information gathered will be collated, interpreted and analysed. A report of the key findings will be produced and presented to Cabinet in June 2011.

'A Good Life For Everyone'
Summary Engagement Plan

Consultee	Method of Engagement	Aim of consultation/engagement	Consultation material/tools	Who is involved?	Timescales
Adults with a Learning Disability	**Focus groups** –a series of small focus groups held within each day service for people with learning disabilities (no more than 6/7 people per group).	To explore the outcomes of discussions from earlier workshops – *'You have already told us this …does the strategy reflect what you said?.'*	- Utilising the **previous workshop material** to facilitate discussions. Eg: Photographic evidence of what people said during the events. -Using a **DVD** to provide a visual format and communicate key messages regarding personalisation and self directed support.	Customer First team & supported by New Ideas Advocacy	March-June 2011
	Peer Evaluators training - accredited training programme for adults with a learning disability.	Work with Coventry University to develop training to provide service users with a range of skills to enable them to undertake a range of future co-production activities, including reviewing and monitoring of services and self directed support outcomes.	- Using a range of communication methods to provide interactive training sessions. - Developing a toolkit for templates for monitoring and reviewing.	Customer First Team & Coventry University	May-Oct 2011
	Self Directed Support Co-production group	To work collaboratively with staff, carers and partners to understand the vision and	- Looking at existing information on self directed support and	Customer First Team/Choice & Control Project	Nov – March 2011

		underpinning values for learning disability services. Focus on self directed support information and processes.	actively involved in producing accessible and easy read formats.	group.	
	Case Studies	Provide case studies/success stories of positive examples of impact of personalisation.	Utilising existing **DVDs**, photographs, diaries, leaflets etc. to illustrate examples.	Customer First Team/ Promotions/Publications Team	March – June 2011
Engaging with people with multiple and profound needs	**Undertaking 1:1 sessions**	To explore the outcomes of discussions from earlier workshops – *''You have already told us this …does the strategy reflect what you said?.'*	Utilising a variety of communication methods including a number of visual aids eg: photographs, symbols and props. Eg: Big Mack	Customer First Team with support from either family carer or key worker/ New Ideas Advocacy	March-June 2011

Consultee	Method of Engagement	Aim of consultation/engagement	Consultation material/tools	Who is involved?	Timescales
Family Carers/ relatives	**Workshops** – a series of 5 workshops in each district & borough Carer consultation should occur **after** the service user events.	Outcomes, aspirations and information gathered from service users can be utilised to stimulate further discussion and dialogue. Discussions will allow time to cover two distinct perspectives -Their caring role - Their perspective from the person they care for. *' you previously told us ……. regarding your caring role and from your perspective of the person you care for – does the strategy reflect what you said?'*	- Utilising the previous workshop material to facilitate discussions. - Photographic evidence of what people said during the events. -Using a DVD to provide a visual format and communicate key messages regarding personalisation and self directed support. - Keepad devices – (utilising questions from consultation) provides instant response rate to a range of questions	Customer First Team/New Ideas Advocacy	March– June 2011
	Carers co-production group	To establish a group to be involved in a wide range of opportunities to influence the LD strategy outcomes.	Co-producing accessible information and advice on promoting personalisation, co-designing booklets, leaflets, web pages etc.	Customer First Team/Promotions & Publications Team	March-June 2011
	Peer Evaluators/ Champions	Provide opportunities for carers who have undertaken accredited training programme to be involved in a wide range	Utilising a range of different communication methods.	Peer Evaluators with support from Customer First Team	March 2011 - onwards

		of co-production activities, (Experts by Experience) including review of services, communicating and informing staff of positive impact of personalisation.			

Consultee	Method of Engagement	Aim of consultation/engagement	Consultation material/tools	Who is involved?	Timescales
Frontline staff (Social work teams & day service support staff)	**Staff workshops/focus groups**	Feeding back information obtained from service user and carer events – to be used as foundation for discussion. *'Service users and carers have told us ……. How can we support them to achieve this in the future?'*	Feed back information obtained from service user and carer events – to be used as foundation for discussion/dialogue. - DVD from service user events. - Keepad devices - provides instant response rate to a range of questions	Customer First Team	March- June 2011
	Training sessions for teams on Personalisation	To communicate key information on personalisation and self directed support.	Update on Transformation Programme progress with Learning Disability services. Range of scenario based examples to aid understanding.	Jon Soros/ Amanda Fawcett	Feb & March 2011

Consultee	Method of Engagement	Aim of consultation/ engagement	Consultation material/tools	Who is involved?	Timescales
Key Stakeholders **-** district & borough councils, health, voluntary & community groups, the independent sector & private industry, general public.	**2 x workshops (North & South)**	- To feedback the views of both service users and carers. - To look at how they (as providers) can meet the future needs of customers within the personalisation and self directed support arena. *' Service users and carers have told us ……. How can you support them to achieve this and provide services to meet their future needs?'* - To communicate the vision for learning disability services in Warwickshire, including new ways of working, - To understand the impact of changes on providers. - Exploring opportunities for partnership working, pooled	- Utilising the previous workshop material to facilitate discussions - Photographic evidence of what people said during the events. - DVD from service user events - Keepad devices (with key questions) - Case Studies – Show and discuss case studies/success stories of positive examples of impact of personalisation. Staff involvement – Invite frontline staff to the workshops to discuss their new role within the vision for learning disabilities, identify any potential barriers to new ways of	Customer First Team	March – June 2011

		resources and also providing a wider variety of services/options for people to choose from including, leisure, jobs & education.	working and explore how the revised way of working can be implemented.		
Other opportunities for a wider audience to be engaged.	**Via post or web pages**	Providing more opportunities for a wider audience to be engaged.	Letter – outlining consultation process Supporting information – easy read version of Strategy, Personalisation & Self Directed Support information. Questionnaire – available in paper format or on line via webpages. Dedicated webpages on WCC website – including all key information and on line questionnaire.	Customer First Team	March- June 2011

Potential Action by WCC	Who will be affected (Stakeholders)	How Will They Be Affected	When Will They Be Affected	Who Will Communicate Potential Action/Main WCC Contact	Action to be Taken By (Date)	How Will it be Communicated	Comms Staff
LD Strategy Vision and Transformation of Services	Cabinet	Cabinet paper May 2011	May-11	Wendy Fabbro and Cllr Seccombe briefing Group Leaders	TBC	Cabinet Report + press release by RD	CL/RD briefing note + press release
	Overview & Scrutiny	Pre O &S meeting 23 Feburary 2011	N/A	Wendy Fabbro and Cllr Seccombe briefing Group Leaders	O & S Paper produced	O & S Report	CL + RD
	Other Members	Complaints or comments from customers, carers and other interested parties	14th January onwards	Wendy Fabbro and Cllr Seccombe briefing Group Leaders		Broad, high level note to all members - RD to draft	RD to assist Cllr Seccombe and Wendy Fabbro on briefing note based on O & S report, plus press release if required.
	MPs	Potential complaints from constitutents		Chris Lewington/Rebecca Davidson	prior to 23rd February	Briefing Note based on press release offering a meeting with Wendy Fabbro and Cllr Seccombe	RD
	Media	Potential negative media news		Chris Lewington	prior to 23rd February	Press Release to be produced	RD - press release + Media Q & As
	Area Committee Meetings	Public meeting - to inform wider community		Chris Lewington/Rebecca Davidson	24th February - 30th April 2011	Briefing on implementation, if queries we will offer for someone to go along to answer questions.	RD to assist Cllr Seccombe and Wendy Fabbro on briefing note based on press release, if required.
	DLT/Transformation Board	Need to be fully aware of vision and transformation of services and impact on stakeholders	23rd December 2010	Chris Lewington		Paper to DLT and briefing by CL	CL
	Customer Service Centre	Awareness of vision and choice for customers and carers	Post 23rd February onwards	Chris Lewington	01/02/11-30/04/11	Briefing	CB to assist CCE Team as required
	Customer Relations Team	Awareness of potential complaints	Post 23rd February onwards	Chris Lewington	prior to 23rd February	CL to brief Karen Smith + briefing note	
	Learning Disability Partnership Board	Prior to consultation for approval and final report about consultation outcome.	18th January 2011	Customer First Team to engage using variety of media based on presentation and DVD and national resources.	23rd February onwards	Face to face briefing plus briefing note	CB to assist CCE Team as required

	Customers	Need to be fully aware of the strategy, vision and transformation of services and its impact	23rd February onwards	Carer & Customer Engagement Team using a variety of appropriate media for the audience.	24/02/11-30/04/11	In variety of ways - focus groups, 1:2:1 session for people with multiple and profound needs; peer advocates working with Coventry Uni; Self Directed Support Co-production group, Case studies.	AB leading. CB to assist CCE Team as required
	Families and Carers	Need to be fully aware of the strategy, vision and transformation of services and its impact	23rd February onwards	Carer & Customer Engagement Team	24/02/11-30/04/11	5 district based workshops; information leaflets/booklets, DVD and presentation; peer advocates; Carers' Co-Production Group.	AB leading. CB to assist CCE Team as required
	AHCS LD Staff	Need to be aware of the strategy, vision and transformation of services and its impact	23rd February onwards	Carer & Customer Engagement Team	24/02/11-30/04/11	Staff workshops/focus groups; training for frontline teams, including DVD	CB to assist CCE Team as required
	Other AHCS Staff	Need to be aware of the strategy, vision and transformation of services and its impact	23rd February onwards	Carer & Customer Engagement Team	24/02/11-30/04/11	Core Brief	CB - Core Brief
	Other WCC staff	Need to be aware of the strategy, vision and transformation of services and its impact	23rd February onwards	CB + RD to devise article	23rd February onwards	Intranet + W4W	CB + RD + Sarah Antill
	Wider Community/Public	Raise overall awareness of vision and transformation of services and its impact	23rd February onwards	RD + CB for web - linked to LDPB website	drafted web page for release 23rd February onwards	CL to provide appropriate wording for web	RD + CB
	District & Borough Council housing departments, Town & Parish Councils, independent and voluntary sector housing providers, care managers, support providers, children's transition team, Supporting People team	Raise overall awareness of vision and transformation of services and its impact	23rd February onwards	Carer & Customer Engagement Team + Jon Soros	24/02/11-30/04/11	Workshops and presentations	CB to assist CCE Team as required
	Pressure/Opposition Groups	All WCC staff to be aware of pressure groups forming and potential media risk	23rd February onwards	All staff to notify Chris Lewington of any groups	23rd February onwards		
	Care Quality Commission (CQC)?	Awareness of LD Transformation Vision	24th February onwards	CL to send letter?	23rd February onwards	Individual letter	CL
	Independent Advocacy	Advice and support to LD Customers	23rd February onwards	Carer & Customer Engagement Team	23/02/11-30/04/11	Face to face briefings and briefing note	CB to assist CCE Team as required
	New Ideas Support Staff	Advice and support to LD Customers	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings and briefing note	CB to assist CCE Team as required
Impact							
Likely closure of same day centres	Managers of Day Centres	Potential redundancy/redeployment	23rd February onwards	Jon Soros + Steve Smith + Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefing plus briefing note	CB to assist CCE Team as required

	Staff of Day Centres	Potential redundancy/redeployment	23rd February onwards	Jon Soros + Steve Smith + Carer & Customer Engagement Team	23/02/11 -30/04/11	Face to face briefing plus briefing note	CB to assist CCE Team as required
	HR	Need to advise staff and provide notifications as applicable.	23rd February onwards	Nadia Williams + Chris Lewington	1st May 2011 onwards	CL to liaise with HR	CB to assist CCE Team as required
	Unions	Advice to Union members.	23rd February onwards	Chris Lewington	1st May 2011 onwards	CL to liaise with HR	CB to assist CCE Team as required
	Staff Care (WCC)	Advice and support to staff	23rd February onwards	Chris Lewington	1st May 2011 onwards	CL to discuss support with Staff Care	CB to assist CCE Team as required
	Customers/service users	Options of better community based services for less money	23rd February onwards	Carer & Customer Engagement Team	23/02/11-30/04/11	Face to face briefing plus Easy Read briefing note	CB to assist CCE Team as required
	Families/Carers of Learning Disability Customers/Service Users	Options of better community based services for less money	23rd February onwards	Carer & Customer Engagement Team	23/02/11-30/04/11	Face to face briefing plus briefing note	CB to assist CCE Team as required
	WCC Transport	Potential reduction/change in transport requirements	23rd February onwards	Chris Lewington	23/02/11 - 30/04/11	Memo/email to Marcus Herron	CL
	Independent Advocacy & New Ideas Advocacy	Advice and support to LD Customers throughout transformation of service	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings and briefing note	CB to assist CCE Team as required
	WCC Property	Potential closure of WCC owned property	23rd February onwards	Chris Lewington	23/02/11-30/04/11	Memo/email to Marcus Herron	CL
	WCC Legal	Preparaion of legal documentation around closure/sale of property	23rd February onwards	Chris Lewington	23/02/11-30/04/11	Memo/email to WCC Legal Services	CL
Reduction in the use of residential care and increased use of supported accommodation and other alternatives	Residential Care Customers	Options of better communit based/alternative services based on assessment	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings with residential care customers plus briefing note	CB to assist CCE Team as required
	Families/Carers of LD Residential Care Customers	Options of better community based/alternative services based on assessment	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings with carers through residential care customers plus briefing note	CB to assist CCE Team as required
	Residential Care Staff	Options of better community based/alternative services based on assessment	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings with staff plus briefing note	CB to assist CCE Team as required
	Out of County Customers and their Carers	Options of better Warks based community based/alternative services based on assessment	23rd February onwards	Carer & Customer Engagement Team	23/02/11 -30/04/11	Face to face briefings with customers and carers plus briefing note	CB to assist CCE Team as required
	Staff of Out of County Customers Accommodation	Options of better Warks based community based/alternative services based on assessment	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings with staff plus briefing note	CB to assist CCE Team as required
	New Ideas Support Staff	Advice and support to LD Customers	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings and briefing note	CB to assist CCE Team as required
	WCC Care & Assessment Staff	Advice, support and assessment for LD customers and carers	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Jon Soros + Carer & Customer Engagement Team using presentation, briefings, DVD	CB to assist CCE Team as required

	Steve J Smith	Advice and support for LD customers and carers	23rd February onwards	Carer & Customer Engagement Team	23/02/11- 30/04/11	Briefing of Local Provider Services staff	CB to assist CCE Team as required
	Carers Support Services - Guideposts, SWCSS	Advice and support for carers	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Briefing of Carers Support Service Managers	CB to assist CCE Team as required
Annual health checks to be made available and health staff trained in communicating with LD Customers	Health Access Team	Advice and support of GPs, hospital and health care staff to enable annual health care checks and communicate with LD customers	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefing with HAT so briefings of GPs and GP consortia and health staff. PCT through Wendy Fabbro atendance at PEC.	HAT briefing.
More flexible ways of procuring and contracting services in the future e.g. introduction of Individual Service Funds	Rob Wilkes & Andy Sharp	Advise on strategy and new ways of providing services	23rd February onwards	Carer & Customer Engagement Team	23/02/11 - 30/04/11	Face to face briefings by RW and AS plus briefing note to independent and voluntary sectgor	CB to assist CCE Team as required
	Independent and voluntary sector service providers	To be advised on strategy and need for new services needed	23rd February onwards	Rob Wilkes & Strat Com staff to meet with independent service providers	23/02/11 - 30/04/11	Face to face briefings by RW and briefing note	CB to assist CCE Team as required
Changes to the way needs are assessed including thos eof carers towards all having personal budget	WCC Care & Assessment Staff	Changed way of working using new tools My Assessment and My Support Plan (LD versions) using personal budgets rather than traditional services	23rd February onwards	Jon Soros + Carer & Customer Engagement Team	23/02/11 - 30/04/11	Staff workshops/focus groups; training for frontline teams, DVD plus Directorate Core Brief and intranet	CB to assist CCE Team as required
Additional use of Assistive Technology to increase and maintain independence	Rachel Norwood, Maggie Marshall. WCC Care & Assessment Staff	Encourage more creative and less expensive services to increase and maintain customer's independence whilst remaining safe and well	23rd February onwards	Jon Soros + Maggie Marshall _ CCE Team	23/02/11 - 30/04/11	Staff workshops/focus groups; training for frontline teams, DVD plus Directorate Core Brief and intranet	CB to assist CCE Team as required
Provision of Information and Advice service including planning and brokerage	Marcus Herron and Gill Jowers	To be advised on strategy and need for new services needed	23rd February onwards	Chris Lewington	23/02/11 - 30/04/11	Brief on scope	
Choice of housing and accommodation	District & Borough Council housing departments, housing providers, care managers, support providers, children's transition team, Supporting People team	To be advised on strategy and transformation of services included alternative accommodation for permanent housing, shared ownership, passing tenancy or owned property from parents to children, etc.	23rd February onwards	Jon Soros + Carer & Customer Engagement Team	23/02/11 - 30/04/11	Workshops and presentations	CB to assist CCE Team as required
Review of respite provision	?						
HR	Human Resources	RD	Rebecca Davidson	CB	Christine Butler		
P & P	Promotions & Publications Team	HAT	Health Access Team	CCE Team	Carer & Customer Engagement Team		

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview and Scrutiny Committee**
Date of Committee	**23rd February 2011**
Report Title	**Transformation of Day Centre Services within Learning Disability & Physical Disability**
Summary	As part of the current transformation programme within Adult, Health & Community Services work is being undertaken to review and revise our models of provision for Physical Disability & Sensory Impairment and Learning Disability Day Services. Specifically this work is looking to re-model our approach to the use of building based day services specifically the focus is on the expansion of the use of Direct Payments and Personal Budgets as an alternative to traditional social care interventions.
For further information please contact:	Christine Lewington, Service Manager, Adult Social Care (for LD) Tel: 01926 743259 Andrew Sharp Service Manager, Adult Social Care (for PD) Tel: 01926 745610
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	☐	Health Overview and Scrutiny Committee
Local Member(s)	☒	Not Applicable
Other Elected Members	☒	Councillor L Caborn, Councillor D Shilton, Councillor C Watson, Councillor S Tooth, Councillor C Rolfe, Councillor J Tandy, Councillor J Ross, Councillor P Balaam, Councillor R Dodd
Cabinet Member	☒	Councillor Mrs I Seccombe, Councillor H Timms
Chief Executive	☐	.....
Legal	☒	Alison Hallworth, Adult and Community Team Leader

Finance	☒	Chris Norton, Strategic Finance Manager
Other Chief Officers	☐	.....
District Councils	☐	.....
Health Authority	☒	Warwickshire PCT
Police	☐	.....
Other Bodies/Individuals	☒	Michelle McHugh, Overview and Scrutiny 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 9

Adult Social Care and Health Overview and Scrutiny Committee – 23rd February 2011

Transformation of Day Centre Services within Learning Disability & Physical Disability

Report of the Strategic Director, Adult, Health and Community Services

Recommendations

The committee are asked to:

1. Consider and review the actions already taken by Directorate Leadership Team to re-shape of physical disability services to date including vacating the Ramsden and transferring customers to alternative bases where appropriate.
2. The committee consider the proposed approach and make recommendations to Cabinet.

1. Background

1.1 Part of the current transformation programme within the Directorate portfolios of work is focused upon addressing our models of provision for day centre based day opportunities. In relation to physical disabilities the Directorate currently directly manages and provides building based day services using three day centres and commissions' services through two further centres operated by the Circles Network.

1.2 Building based day services are traditional in nature and current thinking suggests that this model of provision creates dependency and reduces customers' ability to access community resources to enable them to remain independent. The use of building based services is not cost effective and for physical disability, as the cohort of clients who access this type of service is older and therefore reducing, the unit cost of these services continues to grow. It is important to note that younger and new customers with a physical disability tend to opt for alternative methods of support such as Direct Payments and as a result we have received limited new referrals to building based services in the last 12 months.

2. Physical Disabilities

2.1 Currently across the five physical disability day centres we have the following customer base against allocated service or contract budgets:

Table 1

Service title	Places per day	Customers	Budget 2011/12	Unit Cost
The Ramsden Centre (Nuneaton)	15	27	£139,650	£5,172
The Sesame Centre (Rugby)	20	23	£162,569	£7,066
The Saltway Centre (Stratford)	15	30	£154,540	£5,151
Circles Atherstone	15	26	£116,780	£4,491
Circles Fordsfield Centre (Leamington)	15	24	£128,966	£5,374
Totals	**80**	**130**	**£702,505**	

2.2 As a first stage of our work to develop an alternative model of provision for physical disability day services we have reviewed the majority of customers accessing these services through our PHILLIS team. As a result of these reviews the numbers of customers who are eligible to receive a service has reduced and a further significant group of customers have been identified as being potentially better supported through a direct payment or personal budget, the following table shows the outcomes in full:

Table 2

	Current Customers	No longer eligible/attends	Supportable by DP/PB or alternative	Not reviewed or service required
Ramsden	27	12	10	5
Saltway	23	8	5	10
Sesame	30	10	15	5
Circles Fordsfield	26	0	6	20
Circles Atherstone	24	10	10	13
Total	**130**	**40**	**46**	**53**

Of those still considered to require a service at this stage, currently around 40 customers, were not reviewed during this first phase. The decision not to review these customers at this point was based on legal advice and related to customers who had had a review or re-assessment within the last three months.

As we are now at a point where we are seeking to implement a new model of provision outstanding reviews will need to be completed.

2.3 All physical disability customers considered no longer eligible for services have received a letter to serve notice that their service will end. These customers will no longer be accessing services as at the 21st January. Opportunity for appeal has been given to ineligible customers to allow them to challenge our decision. These appeals are being heard by the allocations panel in Localities. To date six

formal appeals have been received from customers who have been told that their service will end. A procedure is in place to deal fully with these appeals and is based upon the use of our allocations panel which meets on a regular basis to review high cost packages.

2.4 This panel which is made up of senior managers and practitioners from Localities review the information provided by the customer as part of their appeal letter together with the review documentation competed by the PHILLIS team and any other recent review or relevant information contained on CareFirst in relation to the customer.

2.5 As an outcome of this assessment there are three potential options, these being to:

- Confirm the decision to end the provision of a day centre service
- A re-assessment is requested to address gaps in information
- The original decision is overturned

If the panel confirm the decision to end service a letter to this effect is sent to the customer. As part of this letter they are reminded of the option to make a complaint to the local government ombudsmen if they still feel that our decision is inappropriate.

3 Operational Decisions

3.1 At Directorate Leadership Team on the 23rd December the following operational decisions were taken with regards to the future of PD day services across the County:

- The remaining customers within the Ramsden Centre who require a building based service to be transferred to the LD day service operated at Freeway and to vacate the Ramsden Centre once this has taken place.

- Learning Disability day services customers receiving a building based day service will move from Bloxham to Sesame which will continue to host services for the small number of remaining PD customers ensuring that the unit cost of this provision makes this option financially viable.

- Continue to operate a PD day service from the Saltway centre but with a reduced staffing base over the short term

- Serve notice to the Circles network to end their contract to provide building based day services in Leamington and Atherstone

3.2 At present, no reductions in staffing have resulted from these changes as front-line staff work in both PD and LD services. The position is however under review and discussions will commence shortly with unions and staff on the implications of this service change.

Termination of Circles Contract

3.3 Following the DLT decisions, notice has been served to the Circles Network and negotiation has commenced with regards to future provision for customers receiving a service through the centres they currently operate. As notice to end the contract has been served, staff at Circles have been placed at risk with a view to contracts being terminated on the 31st March. Due to the length of time since the contract was let, although some staff remain within these centres who were transferred to Circles from the County Council under TUPE, we have no remaining liability.

3.4 The timescale involved in developing and implementing revised models of provision for customers at the Circles centres does create a risk to continuity. In order to address this we have verbally agreed the potential for services to continue beyond the 31st March on a non contract basis (at the existing rate) to be covered by existing staff on a sessional basis if possible. All possible efforts are being made to ensure that this arrangement is not necessary but it was felt important that a contingency be developed in the event that we are unable to complete the move to our new model of service before the contract ends.

3.5 Our preferred option is to move all remaining Circles customers onto Direct Payments or Personal Budgets. Based on discussions with Circles they have expressed an interest in taking on a lease for the buildings from which they currently operate and offering existing customers the opportunity to access services through them using a direct payment. Initial contact with corporate property would suggest that it would be possible to enter into a lease which would allow for Circles to use the building and to undertake sub letting generating additional income to support their business model.

3.6 Again through negotiation with Circles they would under this arrangement be happy for us to use these buildings as “hubs” for people with disabilities to access specific facilities such as changing regardless of their status as customers with them. If we were to use these centres as “hubs” we have suggested that this would be reflected in a reduced cost associated with leasing the building from the County Council. The development of “hubs” of this nature close to local communities and amenities is a component part of the LD strategy and is likely to form part of a strategy for complex needs to cover both LD and PD customers which is due to be developed over the next few months.

Supporting the transition from building based to direct payments

3.7 In order to support the delivery of a new model of provision based on an increased use of direct payments and personal budgets, it is recognised that additional support for customers is required to facilitate this transition. We currently fund the Council for Disabled People on a grant basis. Through a contract variation with the council for disabled people, we are seeking to enter into a formal agreement with the CDP to act as champions for direct payments and personal budgets with our customers and at the same time reduce their current funding by 44% saving £8K. A meeting has been arranged to discuss this option with our intention to reduce our financial commitment and secure significantly increased strategic value from the work that they do.

4. Learning Disabilities

4.1 Currently Warwickshire spends in the region of £5.5 million on day time support for people with a learning disability. The service provides a wide range of activity based sessions, learning and training, as well as socialising to over 590 people access internal day time support, 460 of whom are paid for by the local authority. This assumes that the remaining 130 are people who pay for their own care or are paid for by other local authorities resulting in some income generation.

4.2 There are also 28 external providers that adult social care currently purchase day time support from for a further 91 people with a learning disability.

4.3 From our commissioning intelligence including transitions information, it is likely that there will be two pressures points over the next five years; firstly from elderly carers, Warwickshire has a higher than average growth of elderly carers – 16% over the next 5 years and secondly a growth of younger people with more complex needs which is around 11% growth over the same period.

4.4 All of the things people with a learning disability have told us confirms that the move towards personal budgets will achieve better outcomes. Through the introduction of personal budgets, individual service users and their carers will be more able to shape and control what and how services are delivered to them in the future. To ensure that this is meaningful and works for everyone, people will need to be confident in working in a personalised way. Part of these changes will require service users, carers and staff to understand the values and principles of the personalisation agenda which is at the core of what adult social care delivers. In making these changes we need to:

- Give people better information about personalisation
- Put in place ways of enabling people with a learning disability and their families to use self directed support which includes support planning and brokering services for themselves.
- We need to give people information about all of the different things that they could use their personal budget on
- We need to have high standards in place to make sure that all of these services are of the highest quality and work in a person centred way.

4.5 Over the next three months (March – May) we will be consulting widely on the revised Learning Disability Strategy which includes consideration to move from building based support to community based activities. As part of the formal consultation for the learning disability strategy, a significant focus will be on the redesign of day time activities for people with learning disabilities. This will include consultation with; service users, carers, providers and staff.

5 Next Steps

5.1 It is proposed, as a result of this consultation, that recommendations for a revised combined service model for both learning disabilities and physical disabilities is developed as an outcome of the learning disability consultation process. As an example we will consider co-locating people with complex needs

from both client groups to maximise resources and deliver better outcomes and lower costs. Any revisions to the learning disability strategy including a revised model for day time activities for people with learning disabilities and physical disabilities will be presented to Cabinet in June.

WENDY FABBRO
Strategic Director of Adult, Health
and Community Services

Shire Hall
Warwick

February 2011

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview and Scrutiny Committee**
Date of Committee	**23rd February 2011**
Report Title	**Home Care Commissioning Strategy 2011–14**
Summary	This report outlines proposals for a new Home Care Commissioning Strategy for the period 2011 to 2014. Since the report to Cabinet in February 2010, which included plans to tender existing home care services, further work has been needed to significantly modify our requirements in light of changing financial constraints and the need to increase the pace of modernisation in line with the latest legislative and policy drivers. Committee is asked to consider the draft Home Care Commissioning Strategy 2011-14 and make recommendations to Cabinet as appropriate.
For further information please contact:	Kim Harlock Head of Strategic Commissioning Tel: 01926 745101
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	Cabinet Paper 25th February 2010 Rob Wilkes 01926 745371

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 Watson, Councillor C Rolfe, Councillor R Dodd
Cabinet Member	☒	Councillor Mrs I Seccombe
Chief Executive	☐	.....
Legal	☒	Alison Hallworth, Adult and Community Team Leader
Finance	☒	Chris Norton, Strategic Finance Manager

Warwickshire County Council

Other Chief Officers	☐	.....
District Councils	☐	.....
Health Authority	☐	.....
Police	☐	.....
Other Bodies/Individuals	☒	Michelle McHugh, Overview and Scrutiny Manager

FINAL DECISION YES/NO

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	☐	.....

Adult Social Care and Health
Overview and Scrutiny Committee – 23rd February 2011

Home Care Commissioning Strategy 2011–14

Report of the Strategic Director of Adult, Health and Community Services

Recommendations
It is recommended that the Committee:

- Consider the draft Home Care Commissioning Strategy 2011-14 and make recommendations to Cabinet as appropriate.

1. Background

1.1 The "mainstream" home care service (also known as 'domiciliary' care) was last tendered out across the private and voluntary sector in 2005, resulting in a range of contracts being awarded from April 2006 for up to 3 years. On 16/10/08, Cabinet agreed to endorse seeking an exemption from tendering under Contract Standing Orders for up to a further 18 months (i.e. from April 2009 to the end of September 2010) to facilitate the extension of existing contracts while the implications of the new personalisation agenda were considered and while the County Council's own 'In-house' service was modernised.

1.2 Permission was granted by Cabinet in February 2010 to enter into a tendering process to award contracts in the external sector on expiry of this 18 months extension period at the end of September 2010. However, significant political and financial changes have subsequently meant a revision of these plans including the need to increase the pace of modernisation across all of our home care services. It was felt that these changes were so significant that an overarching home care commissioning strategy was required to capture the range of complex issues and inter-dependencies in the proposed new models of service delivery.

1.3 The new Home Care Commissioning Strategy therefore provides details about demographic and market conditions together with the latest legislative and policy drivers. The strategy also highlights the case for modernisation of home care and the resulting implications for the County Council's internally run service, which will need to be refocused on one specialist area, 'reablement'. Appendices are also attached for reference including an outline procurement plan and risk log.

1.4 A number of key factors stand out in the strategy as requiring special attention for consideration, namely:

- The need to ensure that customers and other stakeholders are consulted appropriately and that any disruption from the changes is kept to a minimum.

- Quality and choice standards are maintained and developed such as the close monitoring of providers through electronic visit recording systems and the implementation of fee rates that facilitate improved capacity in hard-to-reach rural areas of the county.

- Developments will dovetail with our implementation programme for personalisation and self directed support, such as the introduction of Individual Support Funds to enable customers more control over the allocation of their care.

- Warwickshire County Council currently spends approximately £18 million on external home care to provide 1.24 million hours of care per annum, with an average rate in the external sector of £14.62 per hour for block and call off contracts, and spot purchases averaging £15.76 per hour. Analysis estimates in-house provision, excluding reablement, delivers just over 2,000 hours per week (104,000 hours per annum) which equates to just 7% of total provision at an approximate cost of £26 per hour.

- In general terms, internal home care unit costs are higher than external unit costs for a number of reasons. These include higher rates of basic pay driven by equal pay legislation, better allowances in terms of the provision of pay enhancements, better terms and conditions, and a better pension scheme. In addition, external services have the facility to cross-subsidise local authority rates if they wish to, the potential to operate with lower overheads and the application of years of competitive testing which has forced external providers to continually challenge costs and quality. As a consequence only the best value external providers continue to operate. It should be noted that the prices quoted are the direct unit cost of the internal service and the direct price of externally purchased services, and these costs can be compared directly as both costs exclude overheads. Overheads would add approximately £2-£3 per hour to internal unit costs, but only up to £1 per hour to external costs.

- The requirement for the County Council and AHCS to make substantial savings to meet the requirement to reduce expenditure by at least 25% over the next 3 years. It is anticipated that the current financial climate will permit the current savings target of £150,000 to be increased as part of the procurement and financial remodelling process.

- Tough choices will be required to transform home care services to enable us to meet the required savings target. Therefore, in line with the County Council's intention of becoming an increasingly 'commissioning'

rather than provider led organisation, it will be necessary to continue the modernisation of the council's In-house home care service to focus on one specific area i.e. reablement, thus requiring a transfer of the remaining internally operated mainstream, dementia care and fast response services to the external sector.

- The need for a whole systems approach with greater alignment and integration with health services including joint planning of the recent allocation of government funding to NHS Warwickshire for reablement and dovetailing with the successful In-house reablement service.

- The requirement to consider a more sustainable fast response service, again in partnership with health service colleagues to enable swift responses to emergencies which assist in maintaining people in their own homes.

- The need for a domiciliary care response service for increasing numbers of customers benefiting from assistive technology (telecare/telehealth) systems and who have no informal support networks.

- The opportunity to enable both the County Council and NHS Warwickshire to benefit from economies of scale and efficiencies in the new contractual arrangements by including the provision of continuing health care home care services in the overall tender process.

- The opportunity to include breaks for carers in the domiciliary care tender.

2. Conclusion

2.1 Committee is asked to consider the Home Care Commissioning Strategy 2010-14 and make recommendations to Cabinet as appropriate to facilitate the continued transformation and modernisation of home care services across Warwickshire. This will include detailed plans for the transfer of in-house mainstream, dementia and fast care services to the external sector.

2.2 It is proposed that the tendering process be implemented in line with the plans outlined in the strategy, but it is suggested that the method of procurement and the subsequent award of contracts are delegated to the Strategic Director of Adult, Health and Community Services, the Strategic Director of Customers, Workforce and Governance and the Strategic Director of Resources.

WENDY FABBRO
Strategic Director of Adult, Health and Community Services

Shire Hall
Warwick

February 2011

Warwickshire County Council

Home Care Commissioning Strategy 2011 – 14

Final Draft – 9 February 2011

Warwickshire County Council

Working for Warwickshire

Contents

1. Introduction

The agenda for adult social care is changing; there is a clear and real shift in direction through the Putting People First agenda with increased focus on personalisation, self direction and increased levels of choice and control for customers. These changes place a significant expectation upon adult social care and the way in which we operate in conjunction with our partners.

In addition, the recent economic downturn and the responses to that crisis have resulted in a real and imminent need for the public sector to shrink in line with the current political and economic landscape. The Adult Health and Community Services Directorate has put in place a radical set of proposals to reduce the level of spending in the Directorate by circa £20m over the next few years and has a transformation programme to deliver a number of initiatives to achieve its savings target.

Aside from these recent economic and political shifts there continues to be significant demographic pressure, with significant growth across all client groups. As the chart below evidences, this is particularly true in respect of older people, who form the largest proportion of the customer based and especially the over 85s.

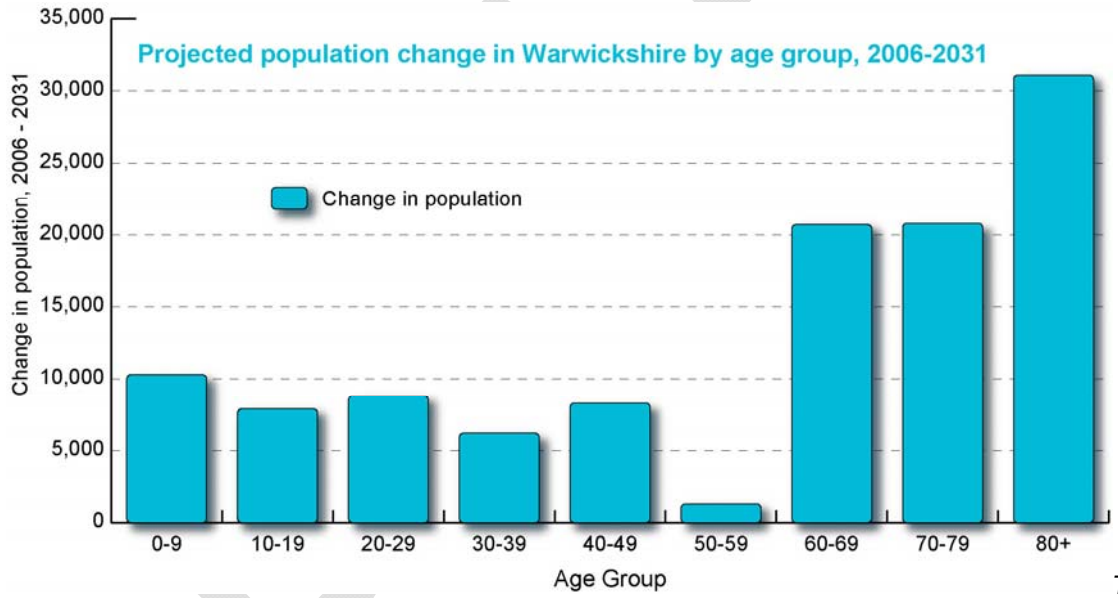


Table 1

As well as the ongoing growth in the older population, the number of people with dementia is increasing at a very high rate; with studies predicting a 37% increase to almost 11,000 people by 2025. Not only will this increase have an impact upon carers and statutory services but it will also mean that the types of services and support we provide will need to change.

One of Warwickshire County Council's corporate priorities is Care and Independence, with the aim to:

- Fulfil our duty of care to older and vulnerable people
- Offer everyone eligible an adult care personal budget
- Increase scope of reablement services

- Improve numbers of older people living independently in their own homes
- Continue to improve our relationship with Health services including transferral arrangements with GPs and of Public Health.

In his ambitions, Warwickshire County Council's Leader describes the authority moving towards becoming a strategic commissioner of services, significantly increasing integration of services with partners and working across organisational boundaries; particularly where there are complex, cross agency problems to ensure services remain sustainable and based around need.

In line with this, the Adult, Health and Community Services Directorate's vision is to:

"ensure people can maximise all opportunities to live independently. Our mantra is recovery, rehabilitation and reablement, where people need care, they have this delivered in the most personalised and cost effective way"

The Adult, Health and Community Services Directorate's transformation programme has been initiated to deliver a four year programme of change. With the help of the Care Service Efficiency and Delivery Programme we have developed a benefits realisation model that will provide an overarching framework for all projects within our transformation programme.

The benefits realisation model is illustrated in Appendix 1 and work has been undertaken to calculate the use of current resources across each stage of the model. The model clearly communicates the overarching direction of travel for all future initiatives and enables improvements to be evidenced. This model will be used to illustrate improvements by evidencing changes in how we manage the flow of customers (demand) by the way we use resources. Simplistically, this means changing the focus from dependence to independence though greater investment in enabling services and minimising the need for complex services through promotion of independence.

Firstly, we need to ensure that we have organised through the Council's Open Door Policy, a range of good quality information and advice that will enable people to meet their own needs outside of social care settings wherever possible. For all service users, our strongest emphasis must be recovery, rehabilitation and reablement. This will be our front line service, other than for a very small number of people and our assessment processes will only take place after people have been through reablement.

Everyone who is eligible for a service will be offered this in the form of a personal budget, which will be accompanied by a support plan describing how the budget can be used to deliver the agreed outcomes. Again, the support plan will focus on reablement and explore innovative ways in which community resources can be used to meet the assessed needs. We will continue to promote Direct Payments as a way of people utilising their personal budgets.

Our continued emphasis will be to help people remain in their own homes within the context of affordable choice. We will ensure that there is an increase in the supply of

services in the community that will enhance affordable choice and we will work in partnership with providers and personal assistants from all sectors to deliver choice.

It is customers who determine the quality of services they receive and we will continue to work with them to ensure they are safeguarded and empowered within the service they receive.

As such the key home care commissioning outcomes we aim to deliver are:

- More choice and control for service users
- More flexible, cost effective, integrated services that offer value for money
- Quality services at an affordable cost that focus on commissioning outcomes with a strong emphasis on enabling people to live independently
- Services that promote independence, recovery, rehabilitation and reablement
- Services that prevent ill health and promote well being
- Support for people to regain or attain independence outside of social care services wherever this is possible.

The overall aim of the home care commissioning strategy is therefore to provide services that support people to maintain their independence in their own homes.

2. The Case for Modernising Home Care

The modernisation of home care services in Warwickshire is set within the context of the Coalition Government's Programme of reforming social care to provide much more control to individuals and their carers. Many of the drivers for change are outlined in the Vision for Adult social Care – Capable Communities and Active Citizens (published in November 2010), which focuses on the Government's commitments to:

- Break down barriers between health and social care funding to incentivise preventative action
- Extend the greater rollout of personal budgets to give people and their carers more control and purchasing power
- Use direct payments for carers and better community based provision to improve access to respite care.

This vision sets a new agenda for adult social care to make services more personalised, more preventative and more focused on delivering the best outcomes for those who use them; ensuring service users and their carers are given sufficient timely information and advice to enable them to have choice and control over their services.

People want to maintain independence and good health. A considerable amount of care needs can be avoided or significantly reduced if we intervene earlier. When people develop care and support needs, our first priority should be to restore an individual's independence and autonomy.

Meeting carer's needs is important as their support stops problems from escalating to the point where more intensive packages of support become necessary. Therefore

we need to recognise the value of offering a range of personalised support for carers, to help prevent the escalation of needs that fall on statutory services.

New technology opens up new horizons for care; from community alarms to sophisticated communication systems, telecare can help people stay in their own homes and live independently longer.

The government is supporting an expansion of reablement services across the NHS and social care, with £70m investment nationally in 2010/11 and up to £300m a year earmarked in the next Spending Review period. Reablement covers a range of short stay interventions which help people recover their skills and confidence after an episode of poor health, admission to hospital etc. We know that reablement can help people to continue to live independently in their own homes without the need for on-going social care packages and work is being undertaken with NHS Warwickshire to develop an integrated reablement model.

This strategy primarily focuses on those people who do require ongoing care. Many people need social care because of the effects of long term conditions and therefore good partnership working between health and social care is vital for helping them to manage their condition and live independently. Consequently continuing health care and community services will be jointly procured in the future.

The Supporting People housing related support programme also facilitates good outcomes; enabling people to live independently in their own homes and avoid more costly interventions. Therefore, strategic linkages need to be strengthened to avoid duplication and maximise benefits.

Warwickshire County Council is currently developing a prevention strategy, which it will be consulting on in the spring. Our aim is to develop community capacity and shape local service early intervention and preventative services, such as reablement and telecare to promote health and well-being and prevent dependency.

An aim of this strategy is for people to have choice and control about their care. Individuals not institutions should take control of their care and personal budgets, preferably as direct payments, are a powerful way to give people that control.

With choice and control people's dignity and freedom is protected and their quality of life enhanced. We recognise that information and advice about available services needs to be a universal service and that people funding their own care also require information and guidance about available services to help them plan how their care needs can be met. Warwickshire County Council is currently developing a resource directory to achieve this. The increased use of personal budgets will act as a catalyst for change. People will demand the services they want to meet their needs, creating truly person centred care. These will be delivered by a range of organisations, including main stream and specialist providers from voluntary and private sectors that can respond to the demands of communities.

To meet the diverse needs of Warwickshire's population, we need to ensure there is diverse service provision where care and support is delivered in partnership between ourselves, individuals, communities, the voluntary and private sectors and the NHS.

To achieve this Warwickshire County Council will be taking a more proactive role in stimulating, managing and shaping the market; supporting communities, voluntary organisations and social enterprises to flourish and develop innovative and creative ways of addressing care needs. As such we will be moving away from traditional block contracts and increasing the use of personal budgets, including direct payments. To ensure a fair playing field for providers, strategic commissioners will work with suppliers to better understand market capacity and capability to promote innovation and incentivise best value.

In developing future home care models, Warwickshire County Council will have a greater focus on partnership working with, the NHS, Districts and Boroughs housing and other sectors to create more flexible, joined up services that achieve better outcomes for people and greater efficiencies.

Providers and commissioners of service are responsible for their quality and safety. We must ensure that staff provide safe, high quality care and that there are safeguards in place against the risk of abuse or neglect. However, this should not be at the cost of people's right to make decisions about how they live their lives. The Care Quality Commission (CQC) will continue to set the essential level of quality and safety home care providers must follow.

Within Warwickshire, each year a survey is sent to homecare service users to measure customer satisfaction and the following table shows the results for all block and call off providers, together with their utilisation from the sample week in November 2010, as well as their CQC star ratings at that time.

				Excellent / Very Satisfied			
		Service Usage		2009/10		2008/9	
Provider	**Star Rating**	**Service users**	**Hours**	**Replies**	**%**	**Replies**	**%**
Allied Healthcare Group	✶✶	137	1472				
Carewatch (South Midlands)	✶✶	136	1295	2	29	16	64
Crossroads Coventry & Warwickshire	✶✶	211	1861	16	73	NA	NA
Goldsborough Home care	✶✶	163	1442	11	85	NA	NA
Helping Hands Home care	✶✶✶	239	2299	26	79	29	60
Mobile Care Services Limited	✶✶	322	2698	22	81	33	62
Radis Community Care	✶✶✶	140	1474	9	69	NA	NA
The Care Bureau	✶✶	637	5499	46	72	64	63
Universal Domiciliary Care	✶✶	138	1387	6	67	12	60
Warwickshire Home Care Services	✶✶	140	1125	10	83	NA	NA

Key: ✶✶ = Good, ✶✶✶ = Excellent *Table 2*

3. Demographics and Analysis of Future Home Care Needs

The following charts show the population projection for Warwickshire and each of the five districts based on ONS data, split between 18-64 and 65+ age groups. This data suggests that there will be an increase of 38,000 adults living in Warwickshire over the next 10 years, equivalent to roughly 9% with respect to the 2010 figures.

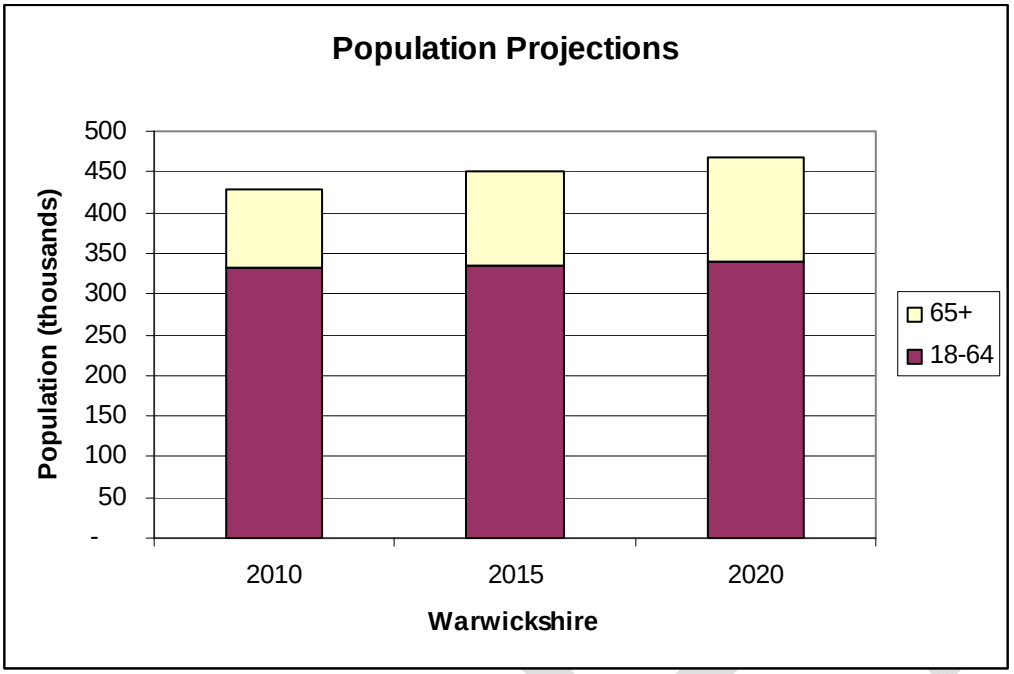


Table 3

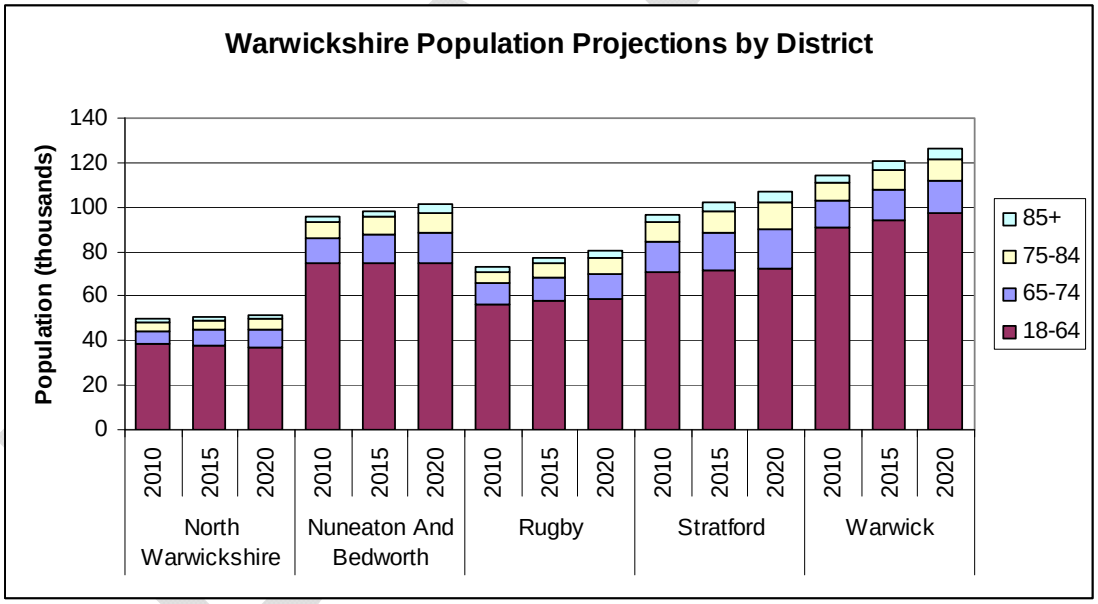


Table 4

However, as the table shows above, the greatest increase in population expected is in 85+, where between 2010-20 we expect to see a 44% growth, with the greatest growth being in the Stratford district with an additional 1,800 (53%) growth. Significant increases in the number of people aged 85+ are also projected for North Warwickshire (46%) and Nuneaton and Bedworth (52%).

Whilst population projections indicate a 21.6% growth in people aged 65-74 and a 35% increase in people aged 75-84, the highest increases are projected in Stratford, North Warwickshire, and Nuneaton and Bedworth.

In addition to a growth in the number of elderly likely to access social care with home care needs, as the table below shows, we are seeing a growth in the number of home care hours and intensity of packages being delivered.

	1st January 2008	1st December 2010	Percentage Change
Customers	2,723	2,578	-5%
Hours per Week	28,492	30,965	9%
Hours per Customer per Week	10.5	12	15%

Table 5

Between January 2008 and December 2010 although the number of older people receiving home care reduced by 5% (2723 in January 2008 compared to 2578 in December 2010), the number of home care hours per week increased by 9% (28,492 hours per week in January 2008 compared to 30,965 hours per week in December 2010). The average number of hours per customer, per week increased by 15% in the same time period; from 10.5 hours per week in January 2008 to 12 hours per week in December 2010.

Analysis of home care packages of 20 hours per week or more showed that in March 2007 there were 127 complex, this increased to 245 in March 2010, an increase of 93%.

This has impacted on the total spend on home care for older people; which has risen from £21.2m in 2007/08 to £22.9m in 2009/10, an increase of 8%.

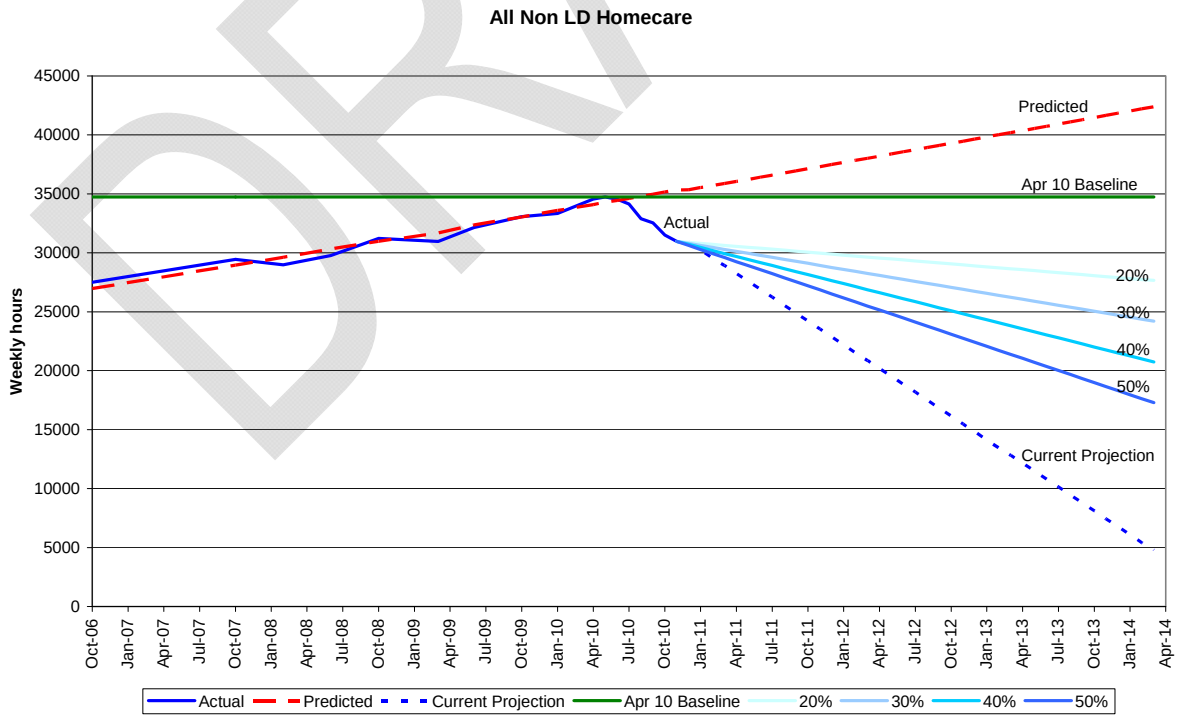


Table 6

The modelling undertaken and shown in the graph above indicates that if we did nothing to manage demand and mitigate against the ageing population, demand for

home care would continue to increase. This could result in a further 35% increase (11,000 hours per week) by 2014. Given the reducing resources that will be available, it is important that we change the social care offer and apply the principles of the new benefits realisation business model shown in Appendix 1 to reduce demand through the implementation of reablement and telecare to reduce demand for on going care.

The blue line in the graph evidences that since April 2010, the number of home care hours delivered per week has started to decrease, as the new social care offer has begun to be implemented; with the weekly hours decreasing from 34,544 in April 2010 to 30,965 in November 2010 (a decrease of over 10%). We are anticipating this will fall further as a result of the expansion of reablement and telecare services and a number of scenarios have been modelled. The blue lines on the graph indicate a range of assumptions of what future demand may look like in coming years, depending on the percentage reduction in growth we can successfully deliver modelled against the April 2010 baseline.

If we assume the population increase as projected and we are able to deliver a 20% decrease in demand against the April 2010 baseline through initiatives such as reablement and telecare, this would equate to an overall 35% reduction against the projected increase in demand shown by the red line on the graph. Assuming we stem the demand by this amount we would expect to reduce the number of hours we commission to 27,653 per week by 2014; a reduction of 6,591 hours per week compared to April 2010.

4. Resource Availability

The Spending Review settlement for social care requires rigorous prioritising of expenditure to ensure that as much money as possible goes to those most in need.

As a consequence of the Comprehensive Spending Review, Warwickshire County Council are required to make £60m of efficiency savings by 2013/14, with the Adult, Health and Community Services Directorate having savings targets of £19m to meet; an element of which will be achieved through the modernisation of home care services, improvements in the value we get from homecare contracts, and the development of the Reablement service.

However the Spending Review also allocated additional resources to develop reablement services jointly with Health. It is vital in utilising this new resource to redesign services that we deliver efficiencies and transform how social care is delivered by working in a more integrated way and improve outcomes for service users.

To strengthen and mainstream reablement services, the Department of Health will be amending the “Payment by Results” tariff from April 2012 so that the NHS pays for reablement and other post discharge services for 30 days after a patient leaves hospital.

5. Current Service Provision and Market Analysis

Warwickshire County Council currently spends approximately £18m on external home care to provide 1.24 million hours of care per annum, with an average rate in the external sector of £14.62 per hour for block and call off contracts, and spot purchases averaging at £15.76 per hour.

Analysis estimates the unit cost of in house home care (excluding reablement cost) to be approximately £26 per hour, or £29.70 if management and support costs are included.

The "mainstream" external home care service was last tendered in 2005, resulting in a range of contracts being awarded in April 2006. Exemptions from tendering under Contract Standing Orders have since been granted to extend existing block and call off contracts until 31 March 2011, while the implications of the personalisation agenda was considered and the in-house service modernised.

There are currently 70 providers registered in Warwickshire and approximately 600 within the West Midlands as a whole. A number of these providers will only work with specific customer groups e.g. learning disabilities and market intelligence indicates that many will not wish to work across county borders, or do not currently have the capacity to do so. The contracting framework in Warwickshire currently comprises of:

- Block contracts where volumes are guaranteed to offer best value through economies of scale. There are currently 6 block contract home care providers covering 10 geographic areas and approximately 570,000 hours per annum, but no block contract in North Warwickshire.
- Call off contracts with no guaranteed volumes but access to referrals in preference to ad hoc or "spot" contractors in return for certain quality standards. There are 7 home care call off providers, covering 11 geographic areas and approximately 480,000 hours per annum.
- Spot providers which are ad hoc contract arrangements to meet individual needs, often in an emergency, but where packages can be transferred to block and call off contracts who are normally (but not always) less expensive. There are approximately 60 spot providers covering all parts of Warwickshire who provide about 45,000 hours per annum. However, work has been successfully undertaken during 2010 to reduce the level of spot contracted hours to achieve significant savings (over £300,000). Some of the changes included the renegotiation of prices downwards without the need to transfer to block and call-off providers, thus securing consistency for customers although not reducing the nominal amount allocated to spot contractors.
- In-house services delivered across the county to 2,300 service users (as at November 2010) providing 30,965 hours a week of care.

Services are currently provided to all customers assessed as needing home care between 7am and 10pm and are predominantly accessed by older people, but is also provided to people with learning disability, mental health and physical disability. However, the majority of "specialist" community support services across learning

difficulties have already been tendered and a separate framework is in place for these services.

72% of service users sampled in 2009/10 indicated they were satisfied with their home care service, an improvement on the 2008/09 score of 63%. 92% of respondents felt that their visits always or mostly took place at a time that suited them; again this was an improvement over the previous year's satisfaction rate of 89%. Nearly all respondents (98.7%) stated they were always or usually happy with the way they were treated. However, variation in satisfaction response rates was apparent when the results were analysed by provider as the table below shows and therefore work has been undertaken with providers, where necessary, to improve quality and satisfaction.

The current total expenditure per year on older people and physical disability home care services is £21.5m. The table below provides a weekly snapshot of current weekly activity (based on a sample week in November 2010), for home care services provided by both in house and external providers, excluding service users with a learning disability.

District		Mental Health	Older People	PDSI	Unknown	Total
North Warwickshire	**Service Users**	0	310	27	2	339
	Hours	0	2957	369	10	3335
Nuneaton & Bedworth	**Service Users**	3	616	75	6	700
	Hours	31	6129	1476	122	7758
Rugby	**Service Users**	6	407	54	0	467
	Hours	26	4043	829	0	4897
Stratford	**Service Users**	5	555	62	8	630
	Hours	32	5186	1001	47	6265
Warwick	**Service Users**	5	613	67	7	692
	Hours	187	6336	1900	104	8526
Unknown	**Service Users**	1	10	2	0	13
	Hours	14	61	108	0	183
Total	**Service Users**	20	2511	287	23	2841
	Hours	289	24712	5682	282	30964

Table 7: Number of service users and hours for each District split by Client group

In the sample week a total of 30,965 hours of care were provided to 2,841 service users, averaging at 11 hours per customer per week. However, there is variation between districts in the average allocation of home care hours per week per service user, Warwick being the highest with an average of 12.32 hours per week per customer and North Warwickshire at 9.8 hours. This is particularly interesting as there is no block provider in North Warwickshire and therefore in house provision is greatest in this district.

Type	Non LD Hrs	%	LD Hrs	%	Total Hrs	%
Block	11032	36%	424	2%	11456	21%
Call Off	9173	30%	58	0%	9231	17%
Spot	8569	28%	21739	97%	30307	57%
Internal	2192	7%	110	0%	2301	4%
Total	**30965**	**100%**	**22330**	**100%**	**53295**	**100%**

Table 8

As the table above indicates there are in excess of 30,965 hours of home care provided to non-learning disability clients in the county per week. 36% of hours are provided by block contracts with only 7% of hours being delivered by in-house provision. The split of external contract provision is further highlighted in the chart and table below.

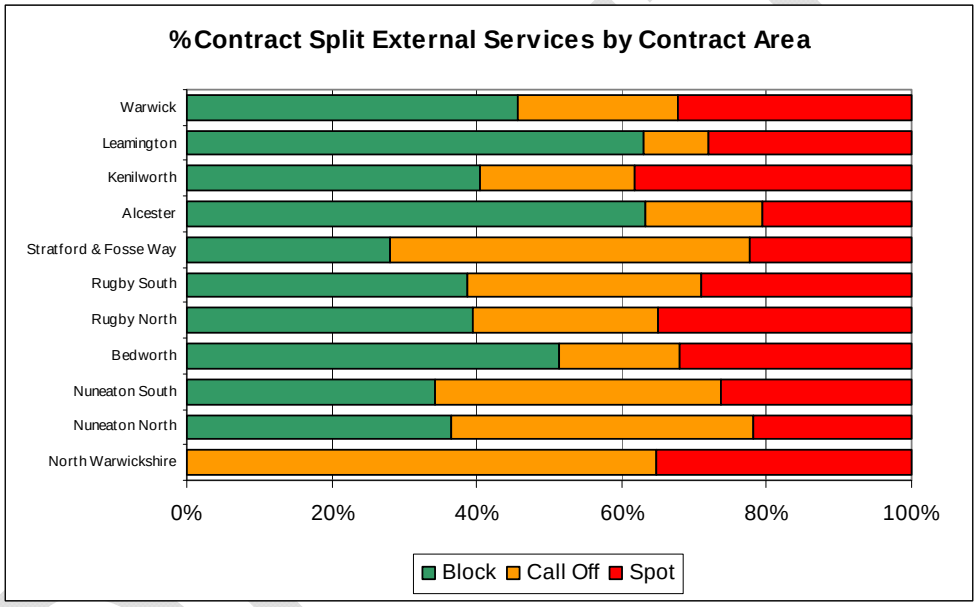


Table 9

District		Block	Call Off	Spot	Internal	Total
North Warwickshire	**Service Users**	0%	61%	23%	16%	100%
	Hours	0%	59%	32%	9%	100%
Nuneaton & Bedworth	**Service Users**	40%	33%	12%	15%	100%
	Hours	37%	28%	24%	11%	100%
Rugby	**Service Users**	39%	27%	22%	12%	100%
	Hours	36%	26%	30%	7%	100%
Stratford	**Service Users**	43%	37%	12%	8%	100%
	Hours	39%	36%	21%	4%	100%
Warwick	**Service Users**	61%	19%	12%	8%	100%
	Hours	46%	17%	32%	5%	100%
Unknown	**Service Users**	8%	38%	46%	8%	100%
	Hours	4%	18%	76%	2%	100%
Total	**Service Users**	41%	33%	15%	11%	100%
	Hours	36%	30%	28%	7%	100%

Table 10: Percentage split of Service users and hours for each District Split by Contract Type
Figures in red indicate a variance of 10% points or greater between Service Users and Hours

From the table above, it is possible to compare the variation in type of contract and its usage by district. Rural variations have built up pockets of spot providers in some areas of the county over time. Market forces have come into play where some providers have been more successful in securing business to the detriment of others.

North Warwickshire is distinguishable, due to its current lack of block provider as being the district making the largest use of both call off contracts (61%) and internal provision (16%). Nuneaton, Stratford and Warwick seem to be well serviced by their block providers. However, in Warwick whilst 61% of service users are provided for by the block contract, this only accounts for 46% of hours delivered; with 32% of the hours being provided through spot purchases. Whereas in Nuneaton and Bedworth 24% of the total hours are provided through spot provision but to only 12% of the clients.

By looking at the analysis in the table below, the variation in the number of hours provided in each district and range of service packages e.g. the percentage of clients receiving a low level of service across the county is apparent. The lowest number of service users is in North Warwickshire where there are 339 (12% of the total across the county). Nuneaton and Bedworth have the greatest number of home care packages with 25% of cases being provided here; closely followed by Warwick where there are 692 home care service users. There is wide variation in the weekly hours provided to customers as shown in the table below.

In looking at the size of packages being delivered it is apparent that 3% of service users are receiving less than 2 hours per week. When this low level service is analysed further, the variation in this practice across the county is clear, with 24 service users in Stratford (4% of their total service users) receiving less than 2 hours per week.

An additional 972 (34%) service users receive between 2 and 6 hours of care per week; with an additional 1295 (46%) receiving 7 to 14 hours. A total of 496 receiving more than 15 hours of care; of whom just 11% (315) receive more than 20 hours.

	Weekly Hours					
District	**Under 2**	**2-6**	**7-14**	**15-20**	**Over 20**	**Total**
North Warwickshire	4	135	148	20	32	339
Nuneaton & Bedworth	21	227	320	42	90	700
Rugby	10	162	209	32	54	467
Stratford	24	235	263	43	65	630
Warwick	18	209	349	44	72	692
Unknown	1	4	6		2	13
Total	78	972	1295	181	315	2841

Table 11: Hours bands for all non LD customers (internal & external)

The table below indicates how people aged over 85 are the predominant users of home care with over 40% of all users being 85+. This is constant across all districts. From the table it can be seen that Stratford has the highest (46%) proportion of 85+ home care service users. Therefore, given the population projections for further increases in the 85+ population, this will cause further pressure on social care demand and resources, unless the service model is changed to focus more on

recovering, rehabilitation and reablement to avoid the need for ongoing care packages.

District	18-64	65-74	75-84	85+	No DoB	Total
North Warwickshire	378	388	1258	1311		**3335**
Nuneaton & Bedworth	1352	1254	2254	2898		**7758**
Rugby	851	523	1550	1973		**4897**
Stratford	948	582	1843	2885	8	**6265**
Warwick	2126	1016	2041	3344		**8526**
Unknown	122	10	25	26		**183**
Total	**5777**	**3773**	**8971**	**12437**	**8**	**30965**

Table 12

As the table below evidences some of the differences can be explained when the usage of home care is standardised per 1000 population aged 65+. The highest standardised usage of home care is in the Nuneaton and Bedworth district where there are 30.29 service users per 1000 population accessed the service, which is well above the average for the county of 25.98.

District	Service Users 65+	Population 65+	Service Users Per 1000 population
North Warwickshire	310	11,200	27.68
Nuneaton & Bedworth	624	20,600	30.29
Rugby	408	16,900	24.14
Stratford	565	25,500	22.16
Warwick	619	23,400	26.45
Unknown	10		
Total	**2536**	**97,600**	**25.98**

Table 13

6. The Future of In House Home Care

Tough choices will be required to transform home care services and meet efficiencies to deliver the required savings target. Despite growth in the private and voluntary sectors, Warwickshire County Council's in house home care service (excluding reablement) still delivers 7% of provision, in addition to leading on reablement services. However, the Leader's Ambitions are for Warwickshire County Council to move the authority towards being a strategic commissioner and to significantly increase integration of services with partners. In this way, the Leader is looking for us to work with other public sector organisations to ensure services remain sustainable and based around need. Therefore it is proposed that we continue to work with NHS Warwickshire to develop integrated reablement services but externalise in-house maintenance care.

Warwickshire County Council's in-house maintenance home care service delivers services from 7am to 10pm 365 days per year. As at November 2010, it provides approximately 2,300 contact hours per week to approximately 350 service users.

However the number of service users and hours of care delivered continues to fall, as no new referrals are being referred to the in house service. By 3rd January 2011 the weekly contact hours had fallen to 2274 and the number of customers decreased by six.

The table below indicates in-house's market share is now only 4% of the total home care market in Warwickshire, which is equivalent to 7% of non learning disability hours.

Type	Non LD Hrs	%	LD Hrs	%	Total Hrs	%
Block	11032	36%	424	2%	11456	21%
Call Off	9173	30%	58	0%	9231	17%
Spot	8569	28%	21739	97%	30307	57%
Internal	2192	7%	110	0%	2301	4%
Total	**30965**	**100%**	**22330**	**100%**	**53295**	**100%**

Table 14

The information below, taken in a sample week in November 2010, indicates the in house service provided care to 334 non learning disability service users who received 2192 hours of care that week. The majority of in house provision is centred in the north and east of the county with 14% of hours being provided in North Warwickshire, 39% in Nuneaton and Bedworth and 16% in Rugby. He total split of hours and number of packages is shown in the table below.

Contract Area	Non LD Hrs	Non LD Packages	LD Hrs	LD Packages	Total Hours	Total Packages
North Warwickshire	298	59	12	2	310	61
Nuneaton North	245	29	0	0	245	29
Nuneaton South	270	35	19	2	289	37
Bedworth	348	42	0	0	348	42
Rugby North	185	32	6	1	190	33
Rugby South	175	25	4	2	179	27
Stratford & Fosse Way	150	28	18	2	168	30
Alcester	130	23	6	2	136	25
Kenilworth	182	22	40	2	221	24
Leamington	110	20	7	2	117	22
Warwick	95	18	0	0	95	18
Out Of County	5	1	0	0	5	1
Total	**2192**	**334**	**110**	**15**	**2301**	**349**

Table 15

There is also a significantly different ratio of average contact hours provided to service users by in house services. In the sample week, 2301 hours of care were delivered to 349 service users; equating to an average of 7 hours per customer. This compares to 11.5 hours per week per service user in the external sector; indicating that in house may be providing services to the less complex / dependent cases.

Current staffing establishment within the in-house service is:

- Home Care Managers x 2 FTE

- Team Administrator x 0.41 FTE
- Team Clerk x 1 FTE
- Home Care Supervisors x 14.98 FTE
- Home Carers x 78.3 FTE

However staffing numbers are also declining with a reduction in December of 3.87 FTE home carers.

The current unit cost of in house service is £25.57 and the non-contact time of the service (including annual leave, sickness, training and travel) is 40% The implementation of reablement and the natural reduction in customer hours with the remaining home care service has had a dramatic effect on service utilisation. Home carers are employed within 5 hour bandings and Warwickshire County Council is contractually obliged to provide work up to the minimum of the banding. If this is not possible, a top up payment is paid to the home carer. Due to the lack of work for all home carers in certain geographical areas of the county, significant top ups are being paid, which is not an effective use of the resources available.

Therefore a number of options for the future use of in house home care services have been identified and apprised. The action plan for externalisation is attached at appendix D.

7. Future Commissioning Intentions

Ongoing "Mainstream" Home Care

The mainstream or standard home care service will be tendered in line with the overall volumes and scope described in Section 5. However, changes will be introduced to the service specification to focus more on independence, recovery, rehabilitation and reablement. This will be essential to ensure that the progress customers make from passing through the earlier Reablement Service stage is not lost. A greater emphasis will be placed on achieving outcomes in care plans rather than the traditional task orientated approach.

It is anticipated that the procurement process, outlined in Section 8, will involve the application of 'framework' contracts to improve choice and quality. The introduction of 'Individual Service Funds', a way of calling off their entitlement in a more flexible way, will ensure that customers who do not wish to have a direct payment can take more control over their care, thus improving longer term outcomes. Measures are being taken minimise any possible disruption to customers when new contracts are awarded i.e. new referrals will be allocated to the framework contractors but existing care packages will remain in place wherever possible.

Reablement

Reablement services help people to regain independence after a crisis and can have a significant positive impact on people's quality of life. National benchmarking evidences that reablement is cost effective for authorities such as ourselves, in that people's care costs after a reablement programme can be around 60% lower than

for those who have not gone through a reablement programme. This significantly outweighs the initial costs of providing a reablement service.

In October 2010, Cabinet received an initial review of the in house reablement service. This showed that 54 out of the 83 people (74%) required no further support after reablement and of the 26% requiring ongoing support, there was an average reduction of support hours provided after reablement. These outcomes compare very favourably with national evidence outlined above. These outcomes compare very favourably with national evidence outlined below.

Nationally the success of reablement in improving outcomes for service users and reducing the cost for local authorities is evidenced in the Prospective Study undertaken by the Social Policy Research Unit and published by Care Services Efficiency in November 2010; where 3 out of the 4 schemes that participated reported 53 to 68% of service users left reablement requiring no immediate home care package. Of these 36 to 48% continued to require no care package 2 years after reablement. Of those who did continue to require a home care package within 2 years of reablement, 34 to 54% had maintained or reduced their home care package.

Service user outcomes reported from the study showed that reablement services have a significant impact on outcomes and the final report confirms that these benefits continued with significantly better social outcomes and improvement in perceived quality of life.

Analysis of the cost of reablement in the study highlighted that during the initial period, the cost of reablement exceeded that of conventional homecare. However over the course of the follow up period, this was more than offset by higher costs of conventional care, compared with post reablement. The survey outcomes indicate a break-even point, on average, for all recipients at approximately 30 weeks. The costs of social are services used by people in the reablement group during the 12 months of the study (excluding he cost of the reablement intervention itself) were 60% less than the cost of the care services used by people using conventional homecare.

The revision to the NHS Operating Framework 2010/11 introduced changes to the tariff to cover reablement and post discharge support, including social care. Reablement services help people with poor physical or mental health accommodate their illness by learning or relearning the skills necessary for daily living. Such an approach creates real opportunities for acute providers to work with GPs and local authorities and would require the full engagement of the wider health and care economy before discharging patients. It should encourage the use of services such as community health services, social care, home adaptations (including telecare) and extra care housing. These services should contribute to improved patient outcomes and significantly reduce the risk of emergency readmission into hospital, which increased by 50% from 1998/99 to 2007/08.

Alongside this there is now an intention to ensure that hospitals are responsible for patients for the 30 days after discharge. If a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment. This strengthens an existing expectation that avoidable readmissions due to poor quality

care are not reimbursed. From 1 December 2010, the Department of Health expects providers and commissioners to apply the provisions of this guidance if they are not already doing so, making hospitals responsible for a patient's ongoing care after discharge will create more joined up working between hospitals and community services and may be supported by the developments in reablement and post discharge support. This will improve quality and performance and shift the focus to the outcome for the patient. The department of health are leaving the exact method for determining how non payment should occur up to health economies' discretion in consultation with GPs and local authorities so that the NHS comes up with a solution that fits its circumstances.

Through the use of reablement services we aim to maintain independence and prevent people's needs from escalating, minimising g the need for on- going intensive packages of care or the need for admission to residential care.

Additionally allocations have been made to the PCT this year for post discharge support. NHS Warwickshire have received £660,000 via increased revenue resource and cash limit allocations this year to develop local plans in conjunction with local authorities and community health services on the best way of using this money to facilitate seamless care for patients on discharge from hospital to prevent avoidable hospital readmissions.

The DH have stipulated that a proportion of this funding should be used to develop current reablement capacity in councils, community health services, the independent and voluntary sectors according to local needs, Resources can be transferred to local partners, including setting up of pooled budgets wherever this makes sense locally.

PCTs are asked to use the plans developed for this year as a basis for coordinated activity on post discharge support in 2011/12 and 2012/13 when changes to the tariffs will take effect. In 2011/12 non payment to Trusts for emergency readmissions will create savings for commissioners to reinvest in reablement and post discharge support in year, whilst the intention is that from 2012/13 the tariffs are increased to cover the cost of post discharge support, including reablement.

The DH intention is to create as simple and transparent system as possible, whilst recognising complexities such as patients who are treated by hospitals not in their local area. The DH have asked that partners work to ensure that people leaving hospital have access to appropriate levels of professional support that will enable them to live independently and as far as possible, fully return to life prior to hospital admission.

There is a commitment between Adult, Health and Community Services and NHS Warwickshire to cut the cost of frailty in the ways outlined above and joint work has begun to scope reduced need for acute hospital care and/or long term care through admission avoidance, early supported discharge and comprehensive geriatric assessment, within the following principles and four key changes of:

- emergency response services to identify people with frailty presentations and refer to rapid response step up intermediate care services

- patients requiring acute care in hospital or community settings should be under the care of old age specialist teams, with movement between wards or facilities kept to a minimum
- once acute care needs are met, patients should be transferred to post cute care services 9 in community settings - bed or domiciliary) with 24 hours of notification and assessed for their post acute care in these settings i.e. discharge to assess not assess to discharge
- comprehensive assessment should be undertaken during their post acute care, with discharge or transfer of on going services such as social care reablement, long terms conditions management, end of life care, or long term residential care.

Work with health colleagues is already underway to align Warwickshire's Reablement service with health. This will ensure that intermediate care services can directly access the reablement service once the customer has received their acute support within the community. There is also an expectation that reablement will play a fundamental part in preventing an individual admission to hospital by providing reablement and assessment within the persons home. Staff modelling is being undertaken to identify potential demand for reablement, once service access is extended to health. It is clear that the service will need to extend significantly to meet demand in the future. The additional DOH funding will be used to respond to this additional resource requirement.

In the interim, reablement has extended its assessment capacity to respond to winter pressure demand and additional staffing resource is being used from within the directorate to meet this increase in customer throughput. This will assist to ensure that hospital discharges are not delayed and the customer can be discharged into their home and receive a reablement assessment within a number of hours. The reablement service is also transferring front line staffing provision to Warwickshire Community Health to assist with the development of CERT (Community Emergency Response Team). This service is being developed to prevent hospital admissions by providing acute care and support to the customer within the community.

Carers Short Breaks

Informal carers are the main provides of care in the community and underpin social are services. However, caring can have a major impact on a carer's life and can affect their economic status, health and well-being as well as limiting opportunities to pursue independent social or leisure activities. Effectively supporting carers and ensuring they are able to continue in their caring role wherever possible can reduce carer breakdown and a subsequent dependence on higher cost services for the cared for person.

The 2001 census identified 53,221 carers in Warwickshire. Nearly 9,500 of these carers were providing in excess of 50 hours of care per week. More recent national research has since identified that the number of carers providing over 50 hours of care per week has doubled and that there is a direct correlation between a higher number of hours of care provided and the impact on the carer's health.

Carers short breaks can provide an opportunity for the carer to take some time away from caring and "recharge their batteries" to be able to return to their caring role

more relaxed and able to cope. Carers short breaks may also be used, where appropriate, as part of a support package to enable carers to return to or retain employment.

Our vision for carers is that by 2015,any individual, whether they are new to caring or have cared for a considerable period, will have timely access to breaks, which will be tailored to meet individual needs and enable carers to maintain a balance between their caring responsibilities and a life outside caring. As an outcome of this service carers will be able to exercise choice and control in relation to their caring responsibilities; with thee services being provided flexibly to meet the needs of the carer.

Carer's short breaks (including 6 hour short breaks and up to 72 hours "In Your Place" breaks) have evolved in Warwickshire since introduced. The 6 appointed block and spot contractors are all CQC registered domiciliary care providers and provide "replacement care" to customers to allow carers to enjoy a short break.

The current budget for contracted carers short break services is £362,430 plus £121,000 for "In Your Place". However, where contracts have been exceeded spot purchasing has also taken place.

The rates at which Warwickshire County Council purchases such care are quite varied across providers and therefore it is proposed that we begin to mainstream these services and purchase carers short breaks via domiciliary care contracts in the future, once the current contracts expire.

This proposal would deliver the following opportunities:

- Increased choice for customers
- Increased services available to customers
- Increased spend with mainstream Domiciliary providers, possibly increasing future leverage and value for money
- Increased quality of services via EVR and other quality measures
- Increased visibility of providers via Contract Monitoring.

Rapid Response

National case studies suggest that an integrate crisis response service that responds within a four hour period can be cost effective and reduce unnecessary admissions to hospital and residential care.

In the sample week in November 2010, only 15.75 hours of fast response service were delivered by the in-house service to 2 service users, one in Bedworth and one in Rugby. However, in the 12 month period 01/01/2010 to 31/12/2010 the in-house service delivered an average of 90 hours of rapid response service per month; with the greatest number of hours being provided in the Bedworth area and fewest in Stratford.

It is clear that a fast response home care service is vital to assist with the prevention of carer breakdown and also to prevent hospital admission. The current in house

provision is bolted on to the maintenance service and decisions are required about how this service is provided in the future. It is recommended that the Fast Response service is externalised alongside the in house maintenance service. This ensures that the Cabinet recommendations of Reablement being in house provision core business are met. It also ensures that the service is provided at a competitive rate within the private home care market. If the Fast Response service was maintained in house, significant staffing infrastructure would need extending to meet the ongoing service demand. This would be costly to the directorate and would have a negative impact on meeting ongoing savings targets In the interim, work is underway with health colleagues so that the 'health line' can directly access the service. This will take pressure off intermediate care provision as fast response may be offered as an alternative. Health colleagues are clear that this fast response service provision is vital long term to contribute to individuals receiving crisis intervention within the community and away from hospital environments. This provision is currently free for up to 10 days with the expectation that following this period reablement may be offered to the customer, if they are eligible.

Telecare

Providing people's care and support in the most appropriate and cost effective way is vital. Telecare enables people to live at home independently for longer by providing technologies that make their homes safer and more secure. Self-evaluation form other council's indicate that adult social are could save at least 1.5% per annum of their home and residential care spend by introducing integrated telecare support.

Assistive Technology is defined by the Audit Commission as 'any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties'.

Telecare is an aspect of Assistive Technology and relates to a combination of equipment, monitoring and response and has been defined as the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living. It can help individuals maintain independence, increase safety and confidence and support carers alongside traditional healthcare, social care and housing initiatives.

A strategic review of Telecare in Warwickshire evidenced that the physical response service to those customers without other key holders should be provided by a care provider. Within the future home care commissioning intentions we will look to provide an emergency physical response service to support Telecare customers who require a home visit in response to an alarm if they do not have other key holders. The right response through a care provider is critical in responding appropriately to the customers needs and in reducing unnecessary hospital and residential admissions.

It is evident that Warwickshire will see a significant change in the profile of older people, with an increase in population and of numbers of people over the age of 70. This increase will also bring with it associated support and care needs for older people with more people living with dementia, learning disability and long-term

limiting illness, and in some areas particularly the north of the County, older people living in deprivation. Stratford on Avon is likely to see the most significant change where the population of older people and older people with dementia is predicted to increase more than other areas of the county.

There are currently 460 Telecare customers in Warwickshire. Based on experiences in Warwickshire and another local authority who have implemented a similar service model, the financial toolkit assumes there will be 220 new customers in 2010/11 rising to 400 new customers in 2014/15, giving an estimated total of 2000 Telecare customers in 2014/15. During these timescales it estimates that expenditure on Telecare will rise from £436,492 in 2010/11 to £1,079,840 in 2014/15. However, this expenditure will result in anticipated savings to social care of £493,453 in 2010/11 rising to £2,307,560 savings in 2014/15. These savings make significant assumptions about steep growth in Telecare, although growth in other local authorities has exceeded that predicted in Warwickshire.

Of the 460 current Telecare customers, there are approximately 30 customers in Warwickshire who require a physical response service from an external provider. Anecdotal information from other local authorities suggest that there are low numbers of customers without key holders who require a physical response service for Telecare with an average of 18 customers for two other local authorities.

Dementia Care

The National Dementia Strategy (Living Well with Dementia) published by the Department of Health in 2009, describes a joint commissioning care pathway including personal support in the home. This is an opportune time therefore to consider options for providing future models of support to people with dementia and their carers, in line with the national and local dementia strategy, as well as the needs of people with different stages of dementia to enable people to stay in their own homes for longer.

There are opportunities for service redesign that provide better outcomes for people with dementia , that offer more flexible and personalised care, as well as the realisation of savings whilst supporting people to maintain their skills and abilities, to maintain their social networks and to remain living at home.

Services provided (which can include SP home support services) offer a person support to live at home offering initially between 5-10 hours of support per week, increasing with progression/severity of condition. Services provided will need to range from:

- Home based support in respect of maintaining a safe and secure home, finances and paying bills, and staying healthy whilst maintaining the individuals right to dignity privacy and confidentiality
- Accommodation based personal support and care which includes delivering a 24/7 flexible care element to Extra Care and Very Sheltered Housing
- Generic Domiciliary Care where staff are trained in dementia awareness and are aware of how to refer to specialist services and memory assessment services

- Enabling of independence and retaining life skills through supportive enabling to complete tasks i.e. washing, dressing, eating etc. This will be a longer /slower process for the worker who will need to spend more time with the client, doing with not doing for
- 24hr support and care in the home which can include 'live in 'care to prevent admission to acute or specialist care or facilitate early discharge home from hospital
- Significant level of defined risk and complex/case management
- Intermediate care type services
- Support to maintain in-reach into a person's community
- Palliative care
- Respite to carers can be any element of above.

Common to all of the above will be a need to jointly commission with Warwickshire PCT and to ensure all workforce are trained in dementia and are familiar with dementia working.

Specialist Domiciliary care provision for people with dementia is a necessary component of support to enable people with dementia to be supported to live in their own homes.

Not all people with dementia necessarily require specialist dementia domiciliary care as their needs follow a continuum and many people's needs are appropriately met through standard domiciliary care where staff had been trained appropriately. Often this level of training need only be dementia awareness training. This may particularly be the case where a person's needs are primarily for personal care rather than mental health care.

However, there are a small number of people whose needs do require specialist care. The homecare requirements for people with dementia have been discussed with the Older People Mental Health Service Co-ordinator who advised that a specialist dementia service is only likely to be required where a Customer has challenging behaviour. If there is a primary healthcare need then the Customer may meet the eligibility criteria for Continuing Healthcare in which case health would be asked to fund the care package. Social care needs can however generally be met by homecare providers whose staff have received some dementia training at a significantly lower cost.

In November 2009, elected members in house approved the establishment of a 2nd specialist dementia in house home care service in Nuneaton and Bedworth, to mirror the one that had been operating in Stratford. To date there are a total of 61 service users who have received an internal dementia homecare service who all have a specific dementia diagnosis recorded on Carefirst. The table below indicates the length of time each of the customers spent in the internal dementia service, including those who are receiving on-going care.

As can be seen from the table below, since the launch of the internal dementia service there have been 61 service users, of these only 22 are still currently in receipt of an internal dementia service.

	Number of Service users		
Length of service (weeks)	**Nuneaton & Bedworth**	**Stratford**	**Total**
0-10	1	1	2
11-20		1	1
21-50	1	3	4
51-75	2	4	6
76-100	1		1
101+	4	21	25
Ongoing	16	6	22
Total	**25**	**36**	**61**

Table 16: All service users who have received an Internal Dementia service since roll out

In the November 2010 sample week there were a total of 26 service users in receipt of an in house dementia service and the table below identifies how and where the service is being provided.

	Weekly Hours				
District	**Min**	**Max**	**Average**	**Total**	**Clients**
Nuneaton & Bedworth	2.75	18.75	8.1	137.75	17
Stratford	0.5	16	7.9	70.75	9
Total	**0.5**	**18.75**	**8.0**	**208.5**	**26**

Table 17: Internal Dementia Service users in the sample week

The budget for the in house dementia services is £454,855.

The external provision of dementia specific services is provided through a specialist Dementia Homecare Service provider, who provided service to 32 service users in the sample week as detailed in the table below.

	Weekly Hours				
District	**Min**	**Max**	**Average**	**Total**	**Clients**
Rugby	3.5	49.0	15.0	240	16
Warwick	0.2	31.5	10.8	173	16
Total	**0.2**	**49.0**	**12.9**	**413**	**32**

Table 18: External Dementia Service Users with Dementia Homecare type in the sample week

The external provision of dementia home care service is provided through a specialist provider who provided a service to 32 clients totalling 413 hours and a range of other external providers. These are detailed below and it is noticeable that two providers (Helping Hands and The Care Bureau) provide the highest number of hours equating to 38% of the 1001 hours provided by the range of other providers.

Provider	Weekly Hours				Service Users
	Min	**Max**	**Average**	**Total**	
Allied Healthcare Warwick	11.0	11.0	11.0	11	1
Alzheimers Society	3.0	3.0	3.0	3	1
Barnfield Care Agency	14.0	14.0	14.0	14	1
Bluebird Care	5.8	5.8	5.8	6	1
Bluebird Care (Stratford & Warwick)	7.0	7.0	7.0	7	1
Carewatch (South Midlands)	2.3	10.0	5.3	37	7
Carewatch (South Warwickshire)	14.5	28.0	21.3	43	2
Crossroads Coventry & Warwickshire Rugby	1.0	10.0	5.2	52	10
Everycare Rugby	3.0	30.5	12.3	37	3
Gateway Health And Social Care	6.3	31.5	19.6	59	3
Goldsborough Home Care	1.0	15.5	6.4	51	8
Helping Hands Home Care	2.0	21.0	9.1	110	12
Ingleby Care Ltd	4.3	8.3	5.8	17	3
Mobile Care Services (Atherstone)	3.0	15.8	6.7	73	11
Phoenix Employment Services Ltd	4.0	4.0	4.0	4	1
Radis Community Care	0.5	14.0	6.3	32	5
Sevacare (UK) Ltd	7.3	8.8	8.0	16	2
Surecare Warwickshire	3.5	14.0	8.1	49	6
The Care Bureau Ltd	0.8	35.0	9.4	272	29
Universal Domiciliary Care	7.0	28.0	17.5	35	2
Warwickshire Homecare Services	2.0	15.8	7.6	76	10
Total	**0.5**	**35.0**	**8.4**	**1001**	**119**

Table 19

Continuing Health Care

The key priorities in relation to NHS Warwickshire's requirements for a jointly commissioned home care service are as follows:

- To establish a framework of quality providers with improved contractual arrangements
- Improve the performance and quality monitoring of providers
- Create a foundation to enable the improvement of care outcomes to clients.
- To deliver affordable and Value for Money (VfM) Continuing Healthcare (CHC) Domiciliary Care services – a savings target of 8-10% on new packages.

The service specification will need to include the following elements (subject to further input from relevant clinicians):

- General i.e. end of life and standard personal care covering most older people
- Significant specialist groups i.e. Mental Health (including Dementia) and Learning Disabilities
- Specialist medical input i.e. Spinal Injuries, Acquired Brain Injury, Physical Disability Neurological conditions or complex medical care e.g. Ventilator use, Tracheotomies with Suctioning

The annual expenditure by NHSW is large (i.e. approximately £7m per year) and the tender would be structured in line with the above as three separate lots.

8. Recommended Procurement Approach

In re-tendering modernised home care we aim to achieve a number of deliverables including affordability, quality, capacity, choice and accessibility across the county.

The outcomes required of future home care services will include:

- More choice and control for service users
- More flexible, cost effective, integrated services that offer value for money
- Quality services at an affordable cost that focus on commissioning outcomes with a strong emphasis on enabling people to live independently
- Services that promote independence, recovery, rehabilitation and reablement
- Services that prevent ill health and promote well being
- Support for people to regain or attain independence outside of social care services wherever this is possible.

Why do we need to change our approach from the plans outlined to Cabinet in February 2010?

Permission was granted by Cabinet on 25th February 2010 to tender for the mainstream domiciliary care service and plans were subsequently developed for a programme to award new contracts in October 2010. The two key guiding principles at that time were to commission more personalised services for customers as well as meet the requirements of Contract Standing Orders, especially as the contracts had already been extended well beyond their originally tendered timescale.

Engagement was undertaken with customers and providers that helped to inform how a more flexible approach would be taken to replace the traditional 'block' contracting arrangements. Open book accounting had been shared by providers to ensure that financial modelling was sound and that recent gains in quality across the service such as the introduction of electronic monitoring systems would be maintained.

The increase in personal budgets and direct payments take up over the coming years necessitates more flexible contracting terms and conditions and a more creative approach to market management to ensure the directorate is able to generate provision from which service users can directly purchase their care, if they choose to do so.

However, the directorate's need to quicken the pace of transformation across all services during the course of 2010 has meant that we have reviewed our key commissioning intentions, particularly in light of the growing financial pressures bearing on the County Council as a whole. The in-house reablement service continued to be rolled out across the county but an in-house 'maintenance' service still remained at a relatively high unit cost. A relatively small In-house specialist dementia home care service was also being piloted in the north and south of the

county but was not due to be evaluated until August 2010, too late for consideration in the 2010 tendering timetable. In order to promote the independence, recovery, rehabilitation and reablement of customers, it was also clear that a more integrated service would be required with telecare/assistive technology and other services.

How can we best secure these new services and achieve our desired outcomes within available resources?

Plans have now been formulated to procure a more integrated and transformational domiciliary care service which will include joint commissioning with NHS Warwickshire e.g. the inclusion of Continuing Health Care services in any new contracts. In line with the council's intention to focus on being a commissioning rather than a provider led organisation and to reduce overall costs, the In-house service will now need to be concentrated on the Reablement Service and so the existing Maintenance, Fast Response and Dementia services will be delivered by the external sector. It is proposed that the new tender process should take the form of a standard core home care specification with a range of modules for the specialist areas such as dementia care, carer's short breaks and telecare/assistive technology and fast response.

In light of the competing pressures for the re-commissioning and procurement of services it is important to address whether new services could be developed without tendering the bulk of the standard service which is stable and delivering good quality services (as reported by the Care Quality Commission compared with national and regional comparators). Under WCC's Contract Standing Orders, it is clear from discussions with corporate legal and procurement colleagues that whilst a short extension would be favourably considered to undertake a suitable tender process, it will not be possible to extend existing contracts by a significant period i.e. more than 6 to 9 months.

However, the opportunity will be taken during this major procurement exercise to update service models and specifications which are still largely based on those issued in 2005/06. For example, the implementation of 'Individual Service Funds' (ISFs), which are a new way of providing more choice and control by customers calling off their funds directly from the providers when they want rather than as now prescribed, will be included in the tender process as a requirement for providers to improve outcomes.

What are the key technical considerations for the forthcoming procurement of the new home care services?

A number of lessons were learnt from the previous tender undertaken in 2005/06:

- Block contracts could risk the transfer of customers against their wishes and TUPE legislation will not ensure the smooth transfer of staff if contracts change hands

- Clarity must be secured before the tender regarding the financial envelope available for the range of new and existing services, especially in light of

expectations regarding quality and efficiencies

- The procurement exercise must not be the key driving force – commissioning intentions need to include meaningful reference to customers and providers

- Referrals to the range of block, call-off and spot contracts need to be managed more closely to avoid inappropriate and costly transfers of work

- The costs of high cost home care packages will need to be compared more effectively with other service options to ensure that value for money is secured.

The main challenge will be the need to gain efficiencies and affordable prices whilst endeavouring to secure more choice and control for customers. Block contracts can deliver lower prices through guaranteeing income for providers whilst framework contracts are difficult to implement successfully in a social care setting. For example, the framework for community support services in Learning Disabilities services led to an overall increase in prices of approximately 7%, even through this had been predicted from the outset.

It is proposed that a framework approach is still undertaken but with the application of 'cost and volume' contracts i.e. an element of 'block' within the wider framework structure. We will also include enhancements to promote better coverage in hard-to-reach rural areas across Warwickshire. This was recently introduced as part of the wider work on driving up quality standards in home care and so specific areas have already been implemented in contracts and accommodated on our financial systems. The monitoring of quality standards will be an essential feature of any new contracts, including the continuation of the home care 'workbooks' for providers where key returns are collated such as electronic visit recording data, staffing profiles and the outcome of complaints etc.

Monitoring will be focused on what really matters most to customers such as the timing and duration of calls, the consistency of carers and being treated with dignity and respect. Electronic visit recording systems and customer surveys provide key reference data for contract compliance with providers. This approach will compliment the role of the Care Quality Commission (CQC), which has statutory duties to regulate and inspect providers in light of the new 'Essential Standards of Quality and Safety'. The CQC ensures that fundamental expectations are in place regarding customers' involvement, needs and safety and makes requirements on providers regarding their own internal checks on quality, staff skills and qualifications.

Value for money and affordability will also be reflected in how the framework arrangements will be structured. .A 'tiered' approach to the framework would see different levels of contracts depending on the level of services being offered by the provider, linked to what customers have been allocated in their personalised budgets. Certain providers could offer more cost effective domestic/cleaning services or even lower levels of dementia support as part of a more tailored menu of provision. However, some providers will focus on very high quality services which

will attract higher prices than normally allocated within personalised budgets. Customers will have the choice of 'topping up' payments should they wish to do so.

The tier aimed at those contractors who offer the essential services required by the bulk of customers and the County Council e.g. electronic visit recording, good customer satisfaction rates, price and monitoring requirements would be the first point of call for those customers wanting the council to purchase their care directly on their behalf. However, these and other tiers would be available to customers wanting to purchase services either on a mix and match basis or wholly through a personalised budget or direct payment.

It is proposed that the tendering of the in-house maintenance service is included in the overall procurement process but as a separate 'lot', especially as this will only appeal to a very small number of providers in the market given the complex legal and financial implications. The tender process will invite expressions of interest alongside the range of other home care services but special consideration will be given to the quality and capabilities of any new provider. For example, a proven track record of successfully transferring both staff and customers in a TUPE environment will obviously be critical in addition to meeting core service specification requirements. Robust communication and implementation strategies will be essential to ensure that all stakeholders, including elected members and trade unions are informed about how this will be achieved with the minimum disruption to staff, customers and their relatives.

It is recommended that the method of procurement and the subsequent award of contracts are delegated to the Strategic Director of Adult, Health and Community Services, the Strategic Director of Customers, Workforce and Governance and the Strategic Director of Resources. Consideration will have to be given by corporate legal and procurement colleagues for the need for to avoid or mitigate the transfer of customers as a priority despite the normal procurement process which can lead to the transfer of contracts. Clarity will be required for the intensity of home care packages i.e. in comparison with other models of care including residential settings. More robust measures will also be required to ensure that any contracts are used to maximum effect, possibly by applying new 'brokerage' models which would also serve to improve outcomes for customers.

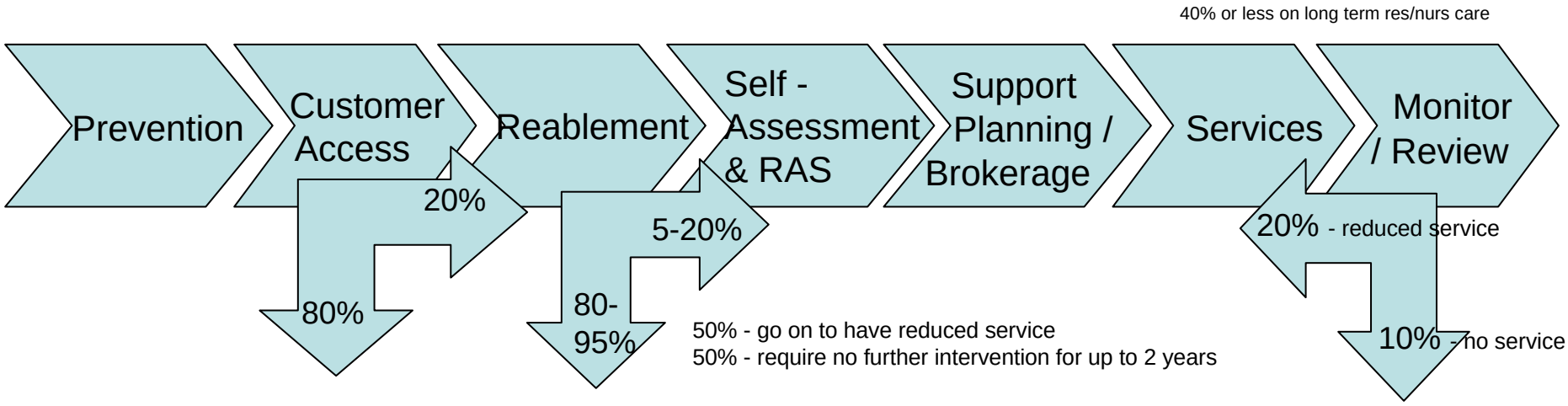
List of Appendices

A. New business model
B. Home care maps
C. Risk register
D. Outline procurement process and plan

Appendix A - Benefits Realisation

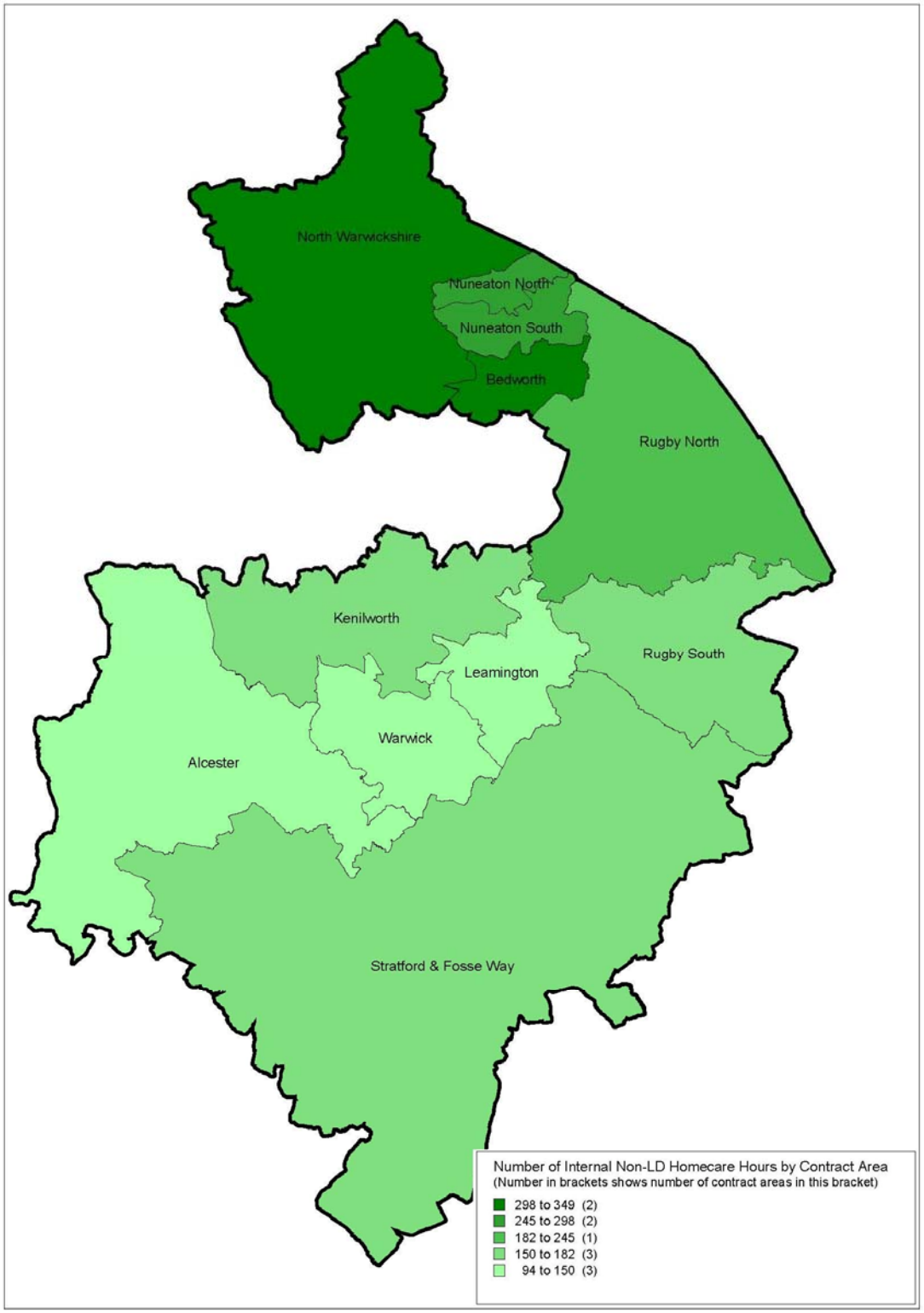
First time resolution

Minimum number of steps to resolve

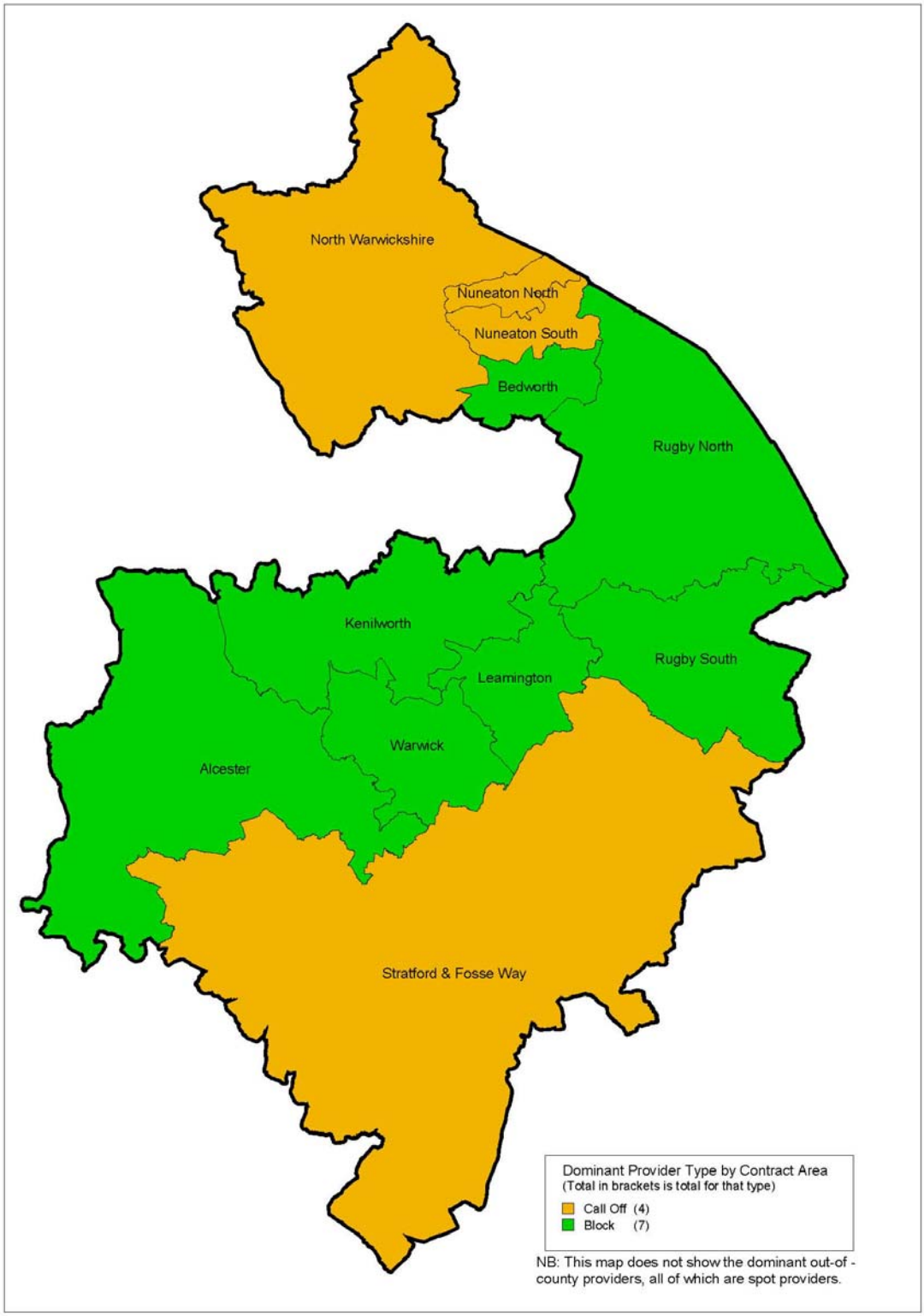


Safeguarding operates throughout the model

Appendix B


North Warwickshire
Nuneaton North
Nuneaton South
Bedworth
Rugby North
Kenilworth
Rugby South
Leamington
Warwick
Alcester
Stratford & Fosse Way
Number of Internal Non-LD Homecare Hours by Contract Area
(Number in brackets shows number of contract areas in this bracket)
298 to 349 (2)
245 to 298 (2)
182 to 245 (1)
150 to 182 (3)
94 to 150 (3)

Appendix B


North Warwickshire
Nuneaton North
Nuneaton South
Bedworth
Rugby North
Kenilworth
Rugby South
Leamington
Warwick
Alcester
Stratford & Fosse Way
Dominant Provider Type by Contract Area
(Total in brackets is total for that type)
Call Off (4)
Block (7)
NB: This map does not show the dominant out-of - county providers, all of which are spot providers.

Warwickshire County Council

Appendix C

Subject of risk assessment: DSPP Domiciliary Strategic Procurement Project…

Risk Reference	Corporate Objective	Project/ Partnership Objective	Risk Owner	Review Date	Opportunity/ Threat	Risk Category	Risk Description			Gross Risk			Risk Action (in place)	Net Risk			Further Risk Action	Risk Action Owner	Target Date
							Cause	Risk (Uncertainty)	Effect	P	I	Score		P	I	Score			
PROC1		Procurement Process	DSPP		Threat	Regulatory	Adherence to Contract Standing Orders	A procurement process is not in line with contract standing orders	A procurement project would become void and have to be run again; possible litigation from Applicants	1	5	5	All Procurement Officers are made aware of Contract Standing Orders and their effect. Line Managers are aware of work being undertaken by Procurement Officers and adherence to Contract Standing Orders	0	5	0			
PROC2		Procurement Process	DSPP		Threat	Regulatory	Adherence to UK Public Contracts Regulations	A procurement process is not in line with regulations	A procurement project would become void and have to be run again; possible litigation from Applicants; possible litigation from EU Commission	1	5	5	All Procurement Officers are made aware of regulations and their effect. Line Managers are aware of work being undertaken by Procurement Officers and adherence to regulations	0	5	0			
PROC3		Procurement Process	RW		Threat		Procurement Plan	Procurement Plan is not approved	Delay in procurement process therefore not meeting milestones and service delivery; could result in gap in service provision.	1	5	5	Detailed planning has taken place, existing contracts expire in October 2010.	0	5	0			
PROC4		Procurement Process	DSPP		Threat		Little or no response from market	Unable to continue with procurement process as non-competitive	Procurement process would have to restart; delay in process and therefore service delivery. Commissioners may have to revisit service specification and or budget to enable market participation.	1	5	5	Anticipate good response from market for framework and by extending marketplace to new providers.	1	3	3			
PROC5		Procurement Process	JR		Threat		Specification is not fit for purpose	Unable to start procurement process	Delay in procurement process therefore not meeting milestones and service delivery; could result in gap in service provision.	2	5	10	Specification will be robust and created in consultation with all stakeholders. Outcome based contract will facilitate WCC's response to personalisation.	1	3	3			
PROC6		Procurement Process	DSPP		Threat		Winning bids are not suitable	Winning bid does not meet the needs of service user, WCC, commissioners and or stakeholders	Abandonment of procurement process to avoid award of contract Award of contract to winning bid resulting in a poor service being delivered; potentially affecting service user lives	2	4	8	Appropriate weightings used to evaluate bids to focus highest weighting on most important sections (i.e. quality, service delivery).	1	3	3			
PROC7		Procurement Process	DSPP		Threat		Financial evaluation of Applicant organisations	Financial evaluation of Applicant organisations reveals risks that are high; especially in relation to SMEs, Third Sector and new organisations	Exclusion of SMEs, Third Sector and new organisations based on risk therefore resulting in larger organisations becoming predominant in service delivery	2	4	8	Framework agreements should extend opportunities for all organisations and extend choice for users.	1	3	3			
PROC8		Contract	JW		Threat		High prices	Move from blocks to framework	WCC cannot afford cost of services.	2	4	8	Opening market to more competition. Replacing spots with framework - no more spot prices.	1	3	3			
PROC9		Contract	JW		Threat		Customer Choice affected	Move from blocks to framework - providers able to take bookings from other local authorities, self funders etc. Possible geographical inequity.	Customers cannot get beds in their choice of provider/ local area.	1	4	4	Framework will increase choice and allow customers a real alternative to in house or block provision which resulted from the 2006 tender.	0	4	0			
										0	0	0		0	0	0			
										0	0	0		0	0	0			
										2	0	0		0	0	0			
										0	0	0		0	0	0			
										0	0	0		0	0	0			
										0	0	0		0	0	0			
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										0	0	0		0	0	0			
										0	0	0		0	0	0			

Domiciliary Care

Outline Procurement Process and Plan – 2011

Stage	Process	Timescale
1.	Domiciliary Care Strategy – commissioning intentions The key home care commissioning principles are as follows: • An understanding of local needs and priorities that have been co-produced with local citizens and communities • Service user choice and control over the range of services and support available. • Quality services at an affordable cost that focus on commissioning outcomes with a strong emphasis on enabling people to live independently • Support for people to regain or attain independence outside of social care services wherever this is possible • More flexible, cost effective services. The final strategy, which includes all of the required needs and service analysis, will be confirmed by O&S Committee in February 2011 and by Cabinet in March 2011. (Kim Harlock)	February 2011
2.	Service Model and Specifications Financial and service modelling will need to be directly linked to service specification requirements to ensure that the following areas are accommodated: • A core home care service specification (including links to the In-house Reablement service) • Carers short breaks – accommodation within core service specification • Rapid response service specification • Telecare/Assistive technology response service specification • Dementia care service specification (including any TUPE implications) • Continuing Health Care service specification • Any other specialist Health areas e.g. specific medial conditions • Hard-to-reach areas, particularly in rural areas of the county • Electronic visit recording and other quality/monitoring requirements • The externalisation of existing In-house maintenance provision The key focus will be to deliver the desired level of quality with resources, taking account of possible efficiencies and any inflation award for 2011/12. (Rob Wilkes/Andy Sharp & Mike Letters)	March 2011

3.	<u>Customer and Provider Engagement</u> Although a significant amount of engagement has taken place with providers during 2010, there has been only limited engagement with customers. Further engagement with customers will be required before the service models and specifications are finalised. Equality Impact Assessment to be completed and signed off by Tejay De Kretser. (Chris Lewington)	March 2011
4.	<u>Procurement process for 2011/12</u> Procurement process and schedule to be confirmed including the following areas: • Type of process i.e. EU/Part B, Open/Restricted/Negotiated or Competitive Dialogue (bearing in mind the need to minimise customer transfers), application of 'tiered' approach with framework arrangements • Allocation and deployment of procurement resources • Finalisation of Procurement Plan, notices/advert, PQQ, tender pack, e-procurement, evaluation, implementation • Finalisation of contract terms and conditions • Contract Management System update and award notice (Paul White & Gen Davey)	March – September 2011
5.	<u>Other key technical and implementation requirements</u> The following technical issues will also be required before the tender can be implemented: • Extension of existing contractual arrangements via exemption for CSOs (to accommodate the length of the tender) • Communication strategy – regular briefings to Members and the media • Risk Log – maintenance and reporting of risks • Possible sub-regional procurement opportunities e.g. Coventry • Carefirst – development and testing of system codes • Brokerage – setting up process for referrals to providers post award • Legal support including TUPE and pension issues relating to the externalisation of In-house Maintenance service (Rob Wilkes/Andy Sharp & Paul White)	March 2011
6.	<u>Tender and Award</u> Project management of the overall tender, award and implementation process. Regular communication and progress updates in line with the Communication Strategy and Risk Log, including liaison with Localities Teams, customers and providers as necessary. (Paul White & Rob Wilkes)	October 2011

Agenda No 11

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care And Health Overview And Scrutiny Committee**
Date of Committee	**23 February 2011**
Report Title	**Work Programme**
Summary	This report contains the Work Programme for the Adult Social Care and Health Overview and Scrutiny Committee.
For further information please contact:	Michelle McHugh Overview and Scrutiny Manager Tel: 01926 412144 michellemchugh@warwickshire.gov.uk Ann Mawdsley Principal Committee Administrator Tel: 01926 418079 annmawdsley@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	☐	
Chief Executive	☐	.....
Legal	☐	.....
Finance	☐	.....
Other Strategic Directors	☐	
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 ☐ .....

To an O & S Committee ☐

To an Area Committee ☐ .....

Further Consultation ☐ .....

Agenda No 11

Adult Social Care and Health Overview and Scrutiny Committee - 23 February 2011

Work Programme

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

Recommendation

The Committee is recommended to agree the work programme, to be reviewed and reprioritise as appropriate throughout the course of the year.

1. Summary

The Committee's Work Programme is attached as Appendix A. 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.

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

Shire Hall, Warwick,
11 February 2011

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

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	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
13th April 2011	Maternity Services	Preconsultation presentation (Rachel Pearce, NHS Warwickshire)			✓					
	Virtual Ward video	NHS Warwickshire								
	CAMHS	To consider the progress made on the implementation of the recommendations from the CAMHS Scrutiny review			✓	High				
	NHS Transformation, NHS Warwickshire	To receive an update on the transformation of NHS, including an update on Public Health	✓	✓	✓					
	Personalisation Agenda, Kim Harlock	To consider progress made in the personalisation agenda	✓	✓			High			
	Orthopaedic Surgery	Plan for Financial Year from April 2011 following decisions to reduce activity and commissioning plan for 2011/12		✓						
	Concordat between NHS Warwickshire and WCC. Rachel Pearce, NHS Warwickshire Wendy Fabro, Strategic Director of Adult Social Care, WCC	To consider the Concordat agreed between NHS Warwickshire and WCC, regarding the transfer of funding to Adult Social Care			✓		High			

MEETING DATE	ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	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
22nd June 2011	Hospital Discharge and Reablement, Cllr Compton	Report and Recommendations of the Task and Finish Group			✓		High			
	Questions to the Portfolio Holder	Committee to put questions to the Portfolio Holder								
	Virtual Wards, NHS Warwickshire	To consider progress made in implementing virtual wards and outcomes achieved								
7TH Sept 2011	Questions to the Portfolio Holder	Committee to put questions to the Portfolio Holder								
	Care and Choice Programme, Ron Williamson	Progress Report on the Care and Choice Programme								
19th Oct 2011	Fairer Charging and Contributions, Ron Williamson	To consider impact of changes to charges and contributions	✓	✓			High			

BRIEFING NOTES		
Excess Winter Deaths and Fuel Poverty	Update on summit *(Cllr Clare Watson)*	
West Midlands Ambulance Service – re-modernisation	To receive an update on the implementation of the re-modernisation programme (requested at meeting on 12/10/10)	Requested by end of Jan 2011

Virtual Wards	General background and progress Reports on pilots (Rachel Pearce) (requested at meeting on 3/11/10)	Requested by end of Jan 2011
Waiting Times at the Eye Unit at Warwick Hospital	Briefing Note (Rachel Pearce)	Requested by the end of Jan 2011
Orthopaedic Surgery	To provide an update on the management of thresholds for Orthopaedic Surgery	Requested for end of Sept 2011
Flu Vaccine	To provide an update on the availability and take up of Flu Vaccines	Requested for the end of February 2011