Agenda No 10

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care and Health Overview and Scrutiny Committee**
Date of Committee	**13th April 2011**
Report Title	**Adult, Health & Community Services "Supporting Independence (Prevention) Strategy"**
Summary	The Supporting Independence (Prevention) Strategy expresses the approach that will be taken to reduce deterioration in the condition of those at substantial or critical level of social care need. In addition it highlights our approach to developing and facilitating community based services to respond to those with low and moderate needs to prevent their progression towards substantial or critical levels.
For further information please contact:	Andrew Sharp Service Manager, OPPD, Intelligence & Market Facilitation Tel: 01926 745610
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	O&S Briefing note – Prevention Strategy (February 2011)

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
Cabinet Member	☒	Councillor A Farnell, Councillor Mrs I Seccombe, Councillor H Timms
Chief Executive	☐	.....
Legal	☒	Alison Hallworth, Adult and Community Team

Warwickshire County Council

		Leader
Finance	☒	Chris Norton, Strategic Finance Manager
Other Chief Officers	☐	.....
District Councils	☐	.....
Health Authority	☒	Warwickshire PCT
Police	☐	.....
Other Bodies/Individuals	☒	Janet Purcell, Cabinet Manager Michelle McHugh, Overview and Scrutiny Manager

FINAL DECISION NO

SUGGESTED NEXT STEPS:		Details to be specified
Further consideration by this Committee	☐	.....
To Council	☐	.....
To Cabinet	☒	Cabinet – 12th May 2011
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Further Consultation	☐	.....

Adult Social Care and Health Overview and Scrutiny Committee – 13th April 2011

Adult, Health & Community Services "Supporting Independence (Prevention) Strategy"

Recommendation

It is recommended that the committee consider and comment on the content of the report and approve the Supporting Independence (Prevention) Strategy, attached as appendix A.

1. Background

1.1 Our strategic approach to supporting independence sets out the way in which we will promote and protect people's health and wellbeing through recovery, rehabilitation and reablement to increase independence and improve quality of life. The wider prevention and health inequalities agendas 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 in this strategy is upon working with health and housing colleagues to deal with issues related to our direct customer base.

1.2 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 this strategy is to clearly set out the vision, direction and principles of the approach to delaying those with high end moderate needs entering the social care system and reducing dependency and need for those already in the system through recovery, rehabilitation and reablement. In addition it also expresses our approach to building and facilitating community based approaches to support independence for those with low and moderate needs.

1.3 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 Clearly the development of this strategy is set against the context of reducing resources and central government funding for the provision of social care and health services alongside an 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. Moving towards more personalised approaches to service delivery and 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.

2.2 Our commitment to the Putting People First agenda and the associated delivery milestones is at the heart of this work and approach. Through the development of this strategic approach we have been clear that we are not recreating our existing commissioning strategies or redefining our approach to health inequalities, rather we are bringing these approaches together and confirming our joint commitment to a set of shared commissioning intentions which will deliver real and meaningful change across the health and social care sector.

2.3 The purpose of this strategy is to:

- Highlight the ways in which we can support independence to reduce deterioration for those with critical or substantial needs
- Consider the use of information and advice to signpost to community based services for those with low or moderate needs
- Reduce dependency and the need for ongoing support by using short term interventions to aid recovery, rehabilitation and reablement
- Encourage the development of a joined up approach to services which support independence

2.4 In developing the 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 confirms and expresses 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.

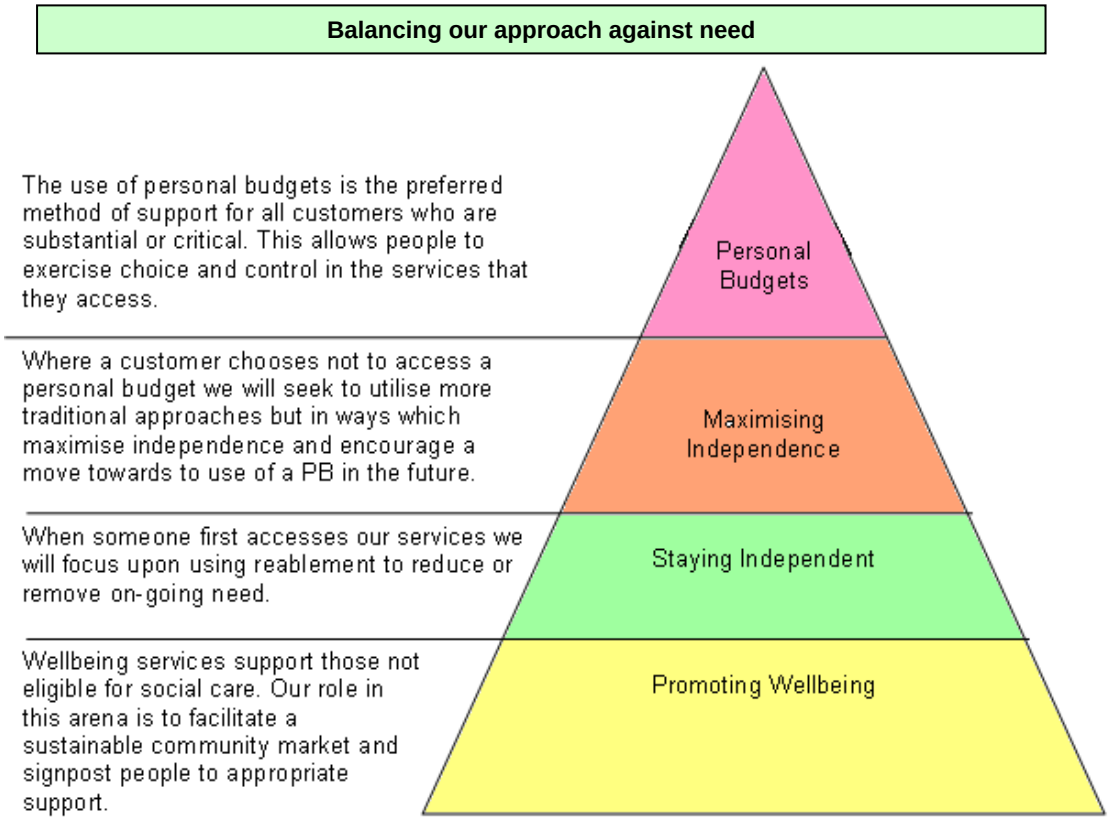
2.5 The strategy is designed to address services for all adults in Warwickshire supported by a variety of providers in the community, through adult social care and across health where arrangements overlap.

The strategy cuts across all of the client groups within which adult social care hold commissioning 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 specified low level non health or social care based support to maximise their independence.

2.6 From a delivery perspective the strategy sets 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).

2.7 In order to deliver against the vision and aspirations of this strategy, we will focus our efforts to deliver a set of services and interventions at appropriate levels of the social care spectrum. The following diagram shows the principles behind the approach and way in which specific interventions contribute to supporting independence across the FACS eligibility continuum.



2.8 In terms of activity delivered and commissioned by the Directorate the strategy expresses 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

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>

2.9 The approach outlined in this strategy document plays a key role in supporting the achievement of our ambitions and objectives as a corporate organisation. Within the Corporate Business Plan 2011/13 the Council has clearly stated its intentions around “Care & Independence” as part of which the Directorate is committed to working towards the following aims and associated outcomes for the residents of Warwickshire.

Delivery Aims:

- 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

Outcomes for Warwickshire:

- Warwickshire’s residents have more choice & control
- The number of home care packages is decreased
- Warwickshire’s vulnerable residents are supported at home
- Residents of Warwickshire have greater access to specialist residential care
- The successful transfer of the Public Health Service to the Local Authority

3. Next Steps

3.1 As part of the transfer of resources from the NHS to the County Council in support of the delivery of reablement services and implementation plan is being developed to express how these resources will be used. The focus of the activity contained within the Supporting Independence (Prevention) Strategy is intrinsically linked to this work and as a result once developed; the delivery plan will also act as the implementation plan for this strategy.

3.2 At the time of producing this strategy the development of the corporate and directorate based performance frameworks for 2011/12 is ongoing and as a result the measures and targets detailed in this section of the document remain subject to potential change. Further work will be taking place in the coming weeks to ensure effective management arrangements are in place linked to the governance framework and structure presented within the strategy.

Report Author: Andrew Sharp

Head(s) of Service:

Strategic Director(s): Wendy Fabbro

Portfolio Holder(s): Councillor Izzi Seccombe

March 2011

Warwickshire County Council

Warwickshire Adult Social Care & Health

Supporting Independence (prevention) Strategy

2011 – 2014

Working for Warwickshire

Contents

Foreword

We are delighted to present our Supporting Independence (prevention) strategy for Warwickshire which has been developed jointly across adult social care, health and other strategic partners, including district and borough councils. Through positive engagement and interaction with customers and their carers we are confident that this document maps out the direction of travel for the future as agreed by Cabinet to address and manage the demand placed upon adult social care.

The key purpose of this strategy is to respond to the aim expressed to us by customers and carers, that being that they want to be able to remain in their own home and to live healthy active lives for as long as possible. By delivering against the aims and objectives of this strategy we will be seeking to support this agenda to allow people to maintain their independence for as long as possible through a clear focus upon *recovery, rehabilitation and reablement* which represents the vision for adult social care in Warwickshire.

Our strategic approach to supporting independence sets out the way in which we will promote and protect people's health and wellbeing through recovery, rehabilitation and reablement to increase independence and improving quality of life. The wider prevention and health inequalities agendas 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 and housing 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. This will include a sharp focus upon the expansion of supported housing and the use of extra care across the County. 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. As this is a community based model we will work closely and positively with community and voluntary organisations with a focus on support and care for people in their own community.

The current model of 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 support 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 facilitating community based services and signposting to these 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. The production of this strategy recognises the value of targeting resources in ways which support independence for the wider population and prevent deterioration in those already needing social care.

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 an 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. Moving towards more personalised approaches to services 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.

Our commitment to the Putting People First agenda and the associated delivery milestones is also at the heart of this work and approach. Through the development of this document and strategic approach we have been clear that we are not recreating our existing commissioning strategies or redefining our approach to health inequalities, rather we are bringing these approaches together and confirming our joint commitment to a set of shared commissioning intentions which will deliver real and meaningful change across the health and social care sector.

The aim throughout this document and its development has also been to ensure a shared and common vision of the term ‘prevention’ and what this means in the local context of service delivery.

Wendy Fabbro
Strategic Director, Adult, Health & Community Services

Introduction & Purpose

Through the Putting People First agenda there is an increasing emphasis for public services to operate in ways which support people to retain their independence and to live full, active lives as part of the local community. In instances where people do require interaction with statutory services such as adult social care, the emphasis should be on the customer being able to exercise choice and control over the services that they receive and for agencies involved in working with them the main driver for intervention should be to support the individuals' independence. Within the public health agenda there has been a clear shift towards engagement with the public to ensure that people have access to the information and advice which allows them to make informed choices which improve and maintain health and wellbeing.

Developments in treatment and intervention in the medical sector have led to populations living longer. Although people are living longer there is clear evidence that these additional years are not necessarily healthy years and the level of health and social care interventions for people in the older age group are higher. However older people are now generally healthier and more active than previous generations and projects such as "active aging" show that where older people are supported to be independent the benefits on their general health and wellbeing are significant.

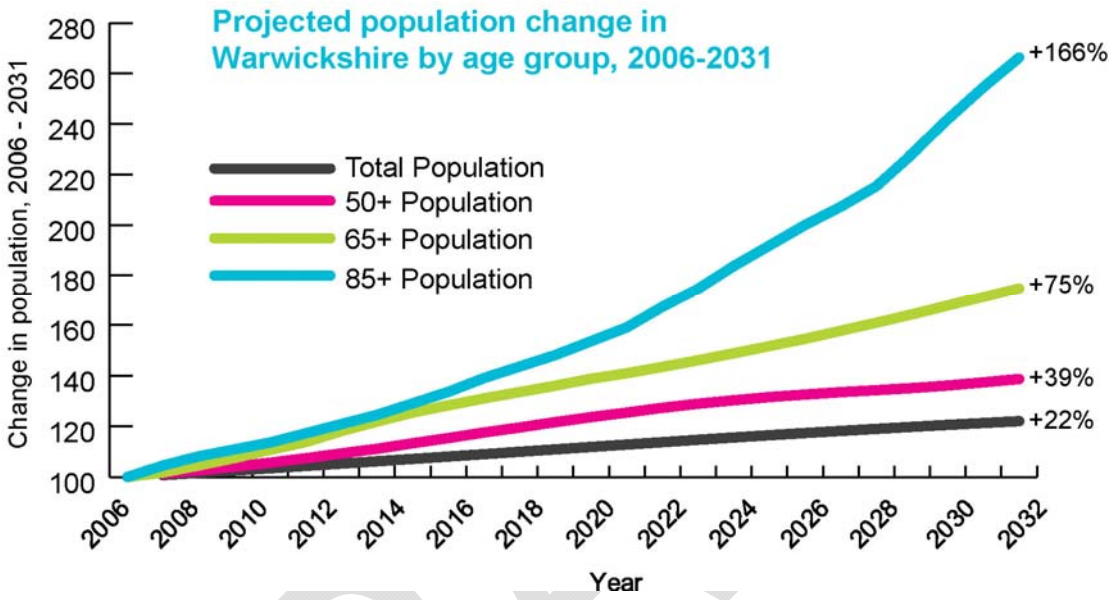
There are inequalities in life length and experience across the County; this is linked to a range of factors including economic status, educational attainment, housing and access to services. To combat these issues Warwickshire has already developed a health inequalities strategy and this document seeks to take full account of this agreed partnership approach to meet this agenda and aims to build on the commitments that we in the public sector have already made.

Demographic changes in Warwickshire mean that there is the potential for a significant increase in the numbers of people accessing social care and health services in the years to come. This is largely due to increases in the aging population but we are also anticipating an increase in demand for services to support people with disabilities and mental health issues. This increase in demand is clearly taking place alongside a reduction in the resources available to support people through social care and health services. National data suggests that if demand and current spend continue on the same trajectory then we would need to double our investment in care services by 2026. The issues faced around this are of significant national importance and in July 2011 central government will be presenting their vision to address this.

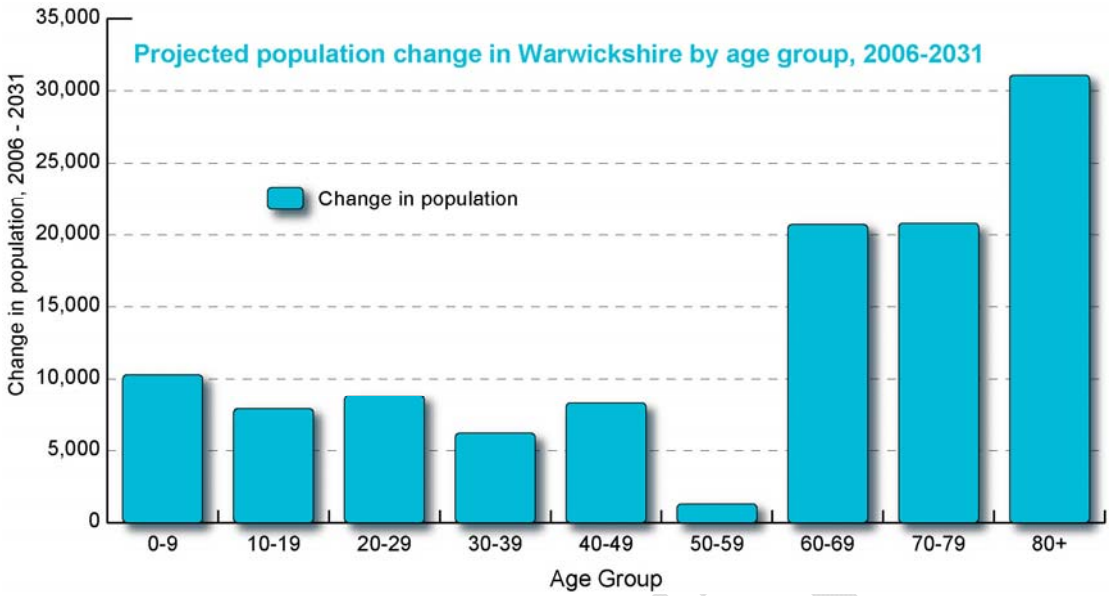
Clearly on a local level the level of investment suggested above is not an option and over the course of the next three to four years the amount of money available to provide services will reduce by around 20%, however we will still be spending significant sums on the provision of services (around £100M for adult social care) and the challenge for us is to use these resources more effectively.

In addition to using resources more wisely we also recognise the need to change our role from one of provider to commissioner and facilitator. Managing demographic demand is a key issue for social care and the potential increase in the customer base could place greater pressure on health and social care structures if we don't utilise alternative models of provision.

Data from the JSNA suggests that the number of people aged 85+ is projected to increase at a level of more than 166% by 2031.



Not only would this place pressure upon traditional public sector services if everyone of 85 and over needed to access social care but also upon carers whose contribution to supporting individuals with care needs is currently under recognised on a national basis. Hidden and informal carers within the community have been identified through local and national work as a critical issue for the future and the cost of this group not being recognised is of real concern for the future of both social care and health. Without the continued support of this regularly under recognised group the levels of increased pressure on social care and health services would be of a level which would leave both organisations unable to cope with increased demand. One of the key issues related to this is the increase in the numbers of people over the age of 80 who are likely to be cared for, formally or informally and the reduction in numbers of people in the 50-59 age range who traditionally act as carers.



As well as the ongoing growth in the older population the level 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 support we provide to both the carer and the cared for will need to change. In addition to this community based responses to increases in people with dementia will also be critical in maintaining people at lower levels of need. The dementia strategy for Warwickshire, which has recently been published, expresses our partnership approach in this arena in greater detail. When working with carers and service providers both groups highlight the difference in the type of support and care that is required for people with dementia and it will be a real challenge to ensure that the social care market and the community is developed and mature enough to respond to these expectations in ways which prevent deterioration for the carer and cared for.

Within adult social care we have taken the strategic decision to focus our interventions and service provision towards those with the greatest need. To do this we will be using the national framework of Fair Access to Care Services (FACS) to define our delivery model. It is important to note at this point that our intention to focus on those in the greatest need does not represent a change in policy in Warwickshire, our eligibility criteria remains as it has for the past few years but we are intending to tighten our application of this policy as agreed by Cabinet in July 2010.

There are four levels of FACS which can be described as:

Critical – There are significant risks to independence through an inability to carry out **vital** personal care and/or domestic tasks and **vital** relationships or responsibilities are threatened.

A persons needs are deemed critical when it is assessed that if support was not provided, then this would lead to the individual being admitted to hospital or 24 hour care within two weeks.

Substantial – There are significant risks to independence through an inability to carry out the **majority** of personal care and/or domestic tasks and the **majority** of relationships and responsibilities are threatened.

Moderate – There is a risk to independence through an inability to carry out **several** personal care and/or domestic tasks, **several** relationships and responsibilities are threatened. A persons needs are deemed moderate if support was not provided leading to a hospital or 24 hour care admission.

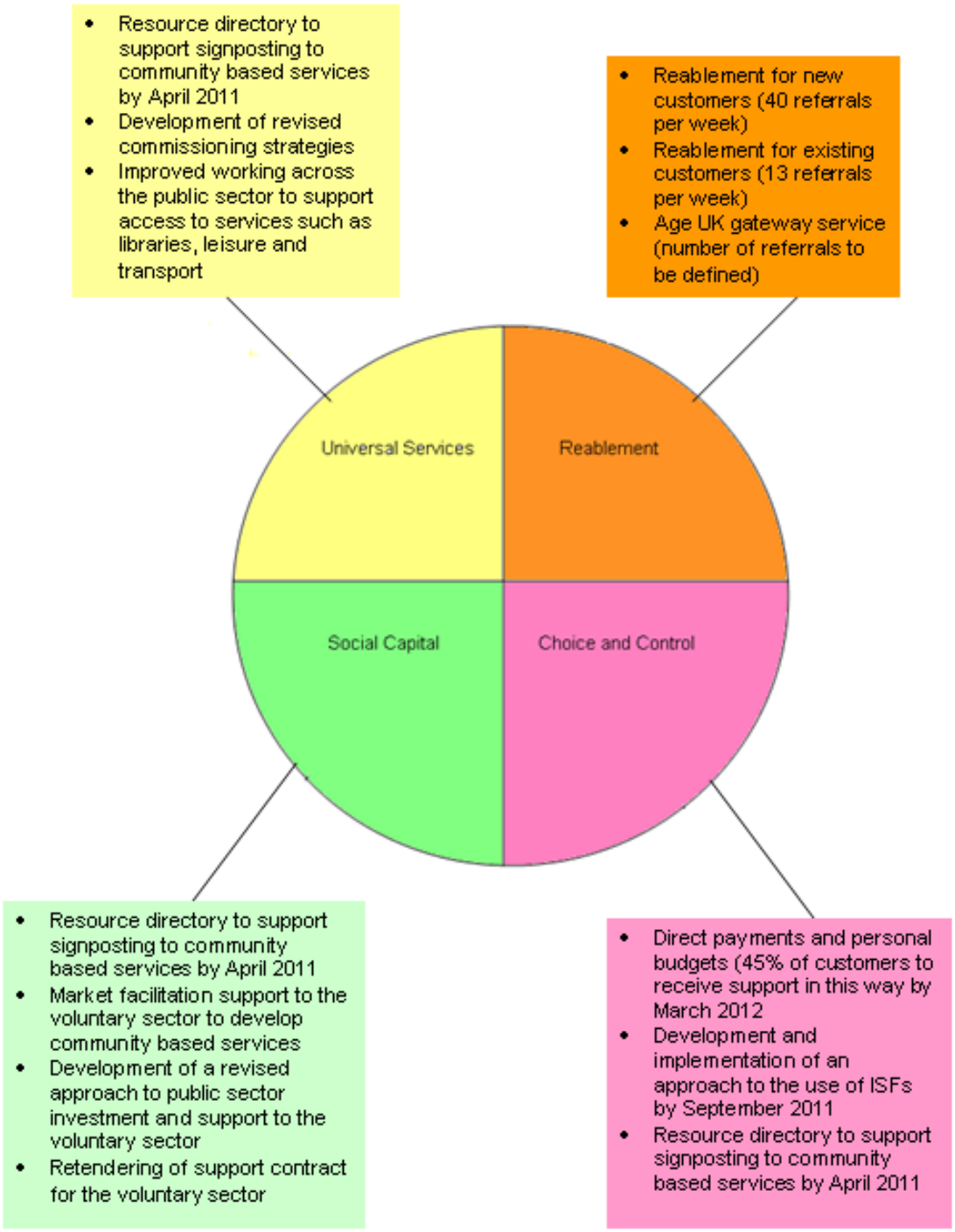
Low – There is a risk to independence through an inability to carry out **one or two** personal c are and/or domestic tasks, **one or two** relationships and responsibilities are threatened. A persons needs are deemed low if support was not provided leading to a hospital or 24 hour care admission.

The purpose of this strategy is to:

- Highlight the ways in which we can support independence to reduce deterioration for those with critical or substantial needs
- Consider the use of information and advice to signpost to community based services for those with low or moderate needs
- Reduce dependency and the need for ongoing support by using short term interventions to aid recovery, rehabilitation and reablement
- Encourage the development of a joined up approach to services which support independence

As part of our approach there is a need to highlight the way in which the community sector and statutory services can work together in ways which reduce deterioration for those with substantial or critical needs. In addition to this, there is also a need for these sectors to work together in the provision of information, advice and low level community based interventions.

Clearly statutory services such as adult social care play a critical part in this but the picture is completed by other agencies and sectors. Increasingly the role of the local authority will be one of a facilitator offering advice and business support to community organisations with the aim of encouraging them to grow in ways which will better support the wider community. The following diagram illustrates the cross-over between these arrangements.



This strategy is linked to a range of other activities taking place across the public sector and as a result there is no intention to replicate information presented elsewhere, instead the focus will be on bringing this activity together and highlighting additional specific approaches that will need to take place to ensure that we deliver against this agenda.

Through all of the work that we have undertaken to date in support of the transformation of social care services to meet the expectations of Putting People First there has been a clear message from customers and carers that one size doesn't fit all in the services that we provide and commission. To ensure that people are able to exercise real choice and control in the services that they access we need to act as a facilitator to shape the social care market to ensure that a menu of flexible options are available to those who require support.

In particular there is a clear need for people to be able to access services early to prevent bigger problems in the future, for the most part these early intervention services are not part of the social care or statutory sector market so our role in this will be to signpost and inform people as to the options available to them through the local community. To deliver this we have committed to the development of a resource directory, which will identify the services that are available and how they can be accessed. In addition to this, through our market facilitation function we will offer business development advice and support to voluntary sector organisations to encourage and grow them to be self sufficient.

Delivering and driving improvements in our approach to supporting independence within social care services must be seen in the context of the wider preventative agenda. Much of the work we do in this area is underpinned and supported by our existing health inequalities strategy which will continue to act as the framework for our wider contribution which will not be replicated in this document. The wider approach within the health inequalities strategy recognises that taking steps to address issues of prevention from a health inequalities cuts across the whole of society and public services. Actions to address healthy lifestyle and the determinants of health through changes in behaviour can result in better health in the longer term, reduction in disease and limiting conditions and an associated reduction in demand for health and social care services.

Adopting a universal approach to this type of prevention across all sectors can help to reduce levels of need and the associated pressure that this places upon the health and social care sector as well as improving life experience and chances for those people who live in Warwickshire. However it is clear that much of the activity to deal with the wider prevention operates over a significant length of time and the outcomes of such interventions are not always clear. For this reason the focus of our approach in the short term must compliment this by working in ways which support independence within the services that people access.

On a national level the commitment to developing integrated approaches across social care and health and the intention to bring services closer to the customer couldn't be clearer. The Government have set out their expectation around a preventative approach through a range of strategic documents including the Darzi review, Transforming Community Services and the NHS Quality, Innovation, Productivity and Prevention Challenge.

The advent of the white paper “Liberating the NHS” further demonstrates this direction of travel with the move to establish Health and Wellbeing Boards and GP consortia. As part of this shift in approach the creation of the new national body Public Health England and the change in the way that resources are allocated across health and social care further underline the significance of this approach.

In addition to these strategic changes recent legislation means that funding will be transferred from the NHS to social care in the form of ringfenced funding.

This funding will be used to support the development of reablement services and approaches as well as interventions which target support for carers. This resource transfer forms a critical component of our approach to supporting independence for people in Warwickshire and the delivery plan for this strategy will be built upon the actions that we will take to deliver against these expectations.

The agenda for change that we are currently working towards on a national level provides a challenge but also real opportunity to local areas and communities such as Warwickshire. On a local level we are already committed to a significant transformation of our adult social care services which will mean radical change in the way that we deliver all of our services. Our transformation approach, which is based upon a portfolio approach to change, is built around the following structure:

- Review of residential care and increased community charges
- Learning disability services
- Older people and physical disability community services
- Mental Health
- Adult Customer Journey (the social care pathway)

The portfolios of work cover the full range of traditional services provided through social care and contain within them activity to expand our use of supported housing and extra care and telecare. In developing modern approaches to delivering services for the future issues of safeguarding are at the core of our delivery models. By linking our work through the transformation programme to the supporting independence agenda we will be well placed to ensure a sustainable social care structure and market both now and in the future.

The purpose of this strategy is therefore to ensure a joined up approach to delivering services which are focused upon the preventative agenda across the customer base of adult social care and health. By delivering this approach we will build a stronger community infrastructure and develop clear access channels underpinned by an approach to information and advice which is focused towards reducing health inequalities, delaying or preventing social exclusion and the need for intensive, costly support from social care and health agencies.

To develop the strategy we have taken full account of the data within the Joint Strategic Needs Analysis (JSNA) which defines and describes the future local health and social care needs across the County.

Scope of the Strategy

Defining the scope of this strategy is critical to its potential for success; the prevention agenda in its widest sense can be seen to encompass all of the services that are accessed by a local community. To ensure that the development and delivery of this strategy is manageable it has been vital to define a shared understanding of the prevention agenda for Warwickshire and the associated boundaries within which this strategy will operate. For this reason the strategy is focused upon supporting independence which includes our contribution to the prevention agenda rather than seeking to be a "prevention strategy".

This strategy is designed to address services for all adults in Warwickshire supported by a variety of providers in the community, 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 commissioning 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 health or social care based support to maximise their independence

Throughout the development of the strategy we have made clear reference to the wider prevention agenda and have ensured that the actions we propose to take are supportive of this agenda but our focus must be upon our existing and potentially imminent customer base. In addition to this the basic tenant of the development of the strategy has been upon the agreed need to focus upon recovery, rehabilitation and reablement as the key to reducing dependency and mitigating the need for ongoing support through social care and health services.

Vision & Key Principles

Our vision for social care 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. This combined with NHS Warwickshire's vision "Best Health for Everyone" is summarised in the following set of priorities which also illustrates the key principles of transformation underpinning our vision developed through the use of intelligence collected within the JSNA:

- We will move from a focus on treating illness and ill health to a system of promoting health, wellbeing and independence where this is seen to be as important as commissioning for ill health and high dependency care

- We will move away from doing things to or for people and will instead focus on enabling people to do things for themselves for example through reductions in on-going homecare packages and residential placements as an outcome from the use of re-ablement

- There will be a shift from one size fits all approaches to structures which reduce inequalities and promote equality in ways which give everyone the chance to live healthy lives and access services at the right time

- Rather than commissioning in block and on a volume and price basis we will seek to grow a market which allows individuals to access or commission services to meet their needs in the way that they choose, which will support health, wellbeing and independence

- We have traditionally used national and historical data and trends to inform commissioning decisions, which has led to replication of existing service models, this will be replaced with the use of local, real time data and analysis to inform decision making

- We will move away from traditional long term residential provision wherever possible to be replaced with more flexible options such as extra care with a focus on preventing deterioration and aiding recovery to reduce the need for on-going support.

- As opposed to seeing the health and social care economy as separate entities we will focus on joined up approaches and services to deliver seamless transition across agencies with the customer individual retaining control

- Intrinsic to the joint approach is a recognition that we are working across one service economy with the need to plan together and be flexible about the way we use our resources

- Traditional models of social care placed the practitioner in control of decision making with minimal choice for the individual, through our personalised approach to commissioning we will invert this relationship to allow flexibility and choice for the individual supported by professional advice

- Over the past few years our approach and service models have been driven by national targets and initiatives, this will be replaced by an emphasis on local priorities and activity to address need in the local population informed by effective engagement

By delivering against this strategic vision and key principles we will expect to ensure a range of positive outcomes for the people of Warwickshire. As expressed in the Corporate Business Plan for 2011/14 the Council is committed to:

- **Residents having more choice & control**

- **On going home care packages being decreased (because reablement has enabled people to become more independent)**

- **Vulnerable residents being supported at home wherever this is appropriate or;**

- **Ensuring greater access to specialist residential care when support at home is no longer practical or safe with an emphasis on the expansion of Extra Care Housing as an option**

When developing this strategy we have clearly needed to take account of changes in the way that health and social care will be delivered on a national level and responding to the white paper “Liberating the NHS” is central to the development of our strategic approach to prevention. To support this we have developed a shared vision for health and social care which will be used to inform the development and implementation of the health and wellbeing board, a new cross agency body which is designed to take oversight of health responsibilities across the local area. Our approach to the use of this board and the way that this will link to our other governance structures is explored later in this document.

There are clear links between prevention in a social care sense and the public health agenda and the changes proposed to the way in which public health is delivered following the white paper will mean new ways of working across the public sector. One of the key elements of the white paper is the proposal that elements of the public health service and infrastructure transfer to the Local Authority.

The County Council has a lead role to play in supporting, facilitating and leading this change programme. As part of this commitment we have developed a shared vision for public health in Warwickshire

The vision has been developed with the Faculty of Public Health definition of public health in mind which states that:

The science and art of promoting and protecting health and well being, preventing ill health and prolonging life through the efforts of society.

Outline vision for Warwickshire

The public's health is our priority, where wellness and tackling health inequalities will be central to all we do. We will work collaboratively with all on outcomes that will reduce the preventable causes of ill-health, use the least intrusive approaches necessary to achieve the desired effect, and focus on enabling and guiding people towards life prolonging choices wherever possible.

In Warwickshire we will:

- Improve and protect peoples' health and well-being, improve the health of the poorest fastest

- Integrate expertise, action, advice and influence through a strong and protected public health system (Public Health England) to ensure world-leading health protection, and set challenging local objectives with clarity over our aims.

- Aim to use the least intrusive approach necessary to achieve the desired effect, seeking to use approaches that focus on enabling and guiding people to live healthier lifestyles and make healthy choices.

- Effectively bring together all the interests of NHS, social care, education, transport and environment and effect a positive impact on our public health

- Adopt a new and collaborative approach to fighting health inequalities**,** rooted in local communities and with the wider determinants of health including economic status, education opportunity, employment, housing and environment – integral to our efforts.

- Use the proposed health premium to reward progress on specific public health outcomes.

- Work with businesses to make them aware of their responsibility for tackling the rising burden of preventable ill-health in order to deliver the improvements we wish to see and empower local communities to come together to tackle the challenges they face involving more work being done by the voluntary sector, rather than the state

- Work in partnership with all, including businesses and the voluntary sector through the Public Health Responsibility Deal to create an environment that supports informed, balanced, health-improving choices about what we eat and drink and our level of physical activity.

- Use the five national networks focusing on food, alcohol, physical activity, health in the workplace and the role of behaviour change recognising that all of society influences our health decisions.

- Work together to tackle our public health challenges, using the best new insights of social psychology and behavioral economics to achieve real improvements in public health healthy living.

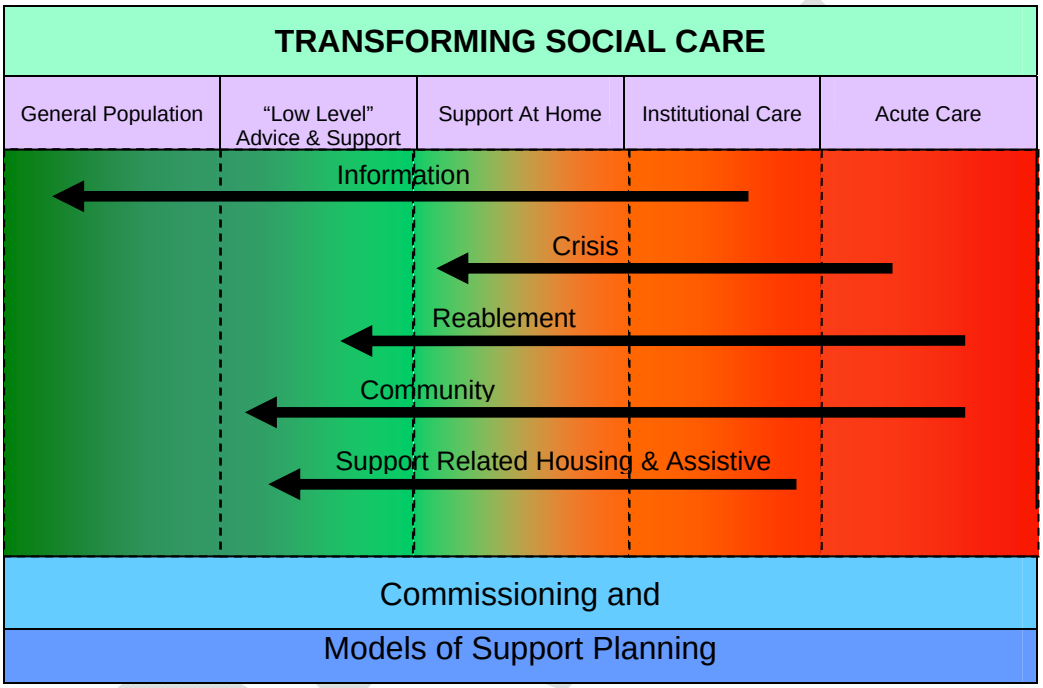
- Ensure the public health priorities and actions tackle the preventable causes of ill-health.

- Protect people from major health emergencies and serious harm to health through our control role in Health protection and resilience planning.

- Tackle the wider determinant of ill health through combined efforts of all public services.

Defining Prevention

The concept of prevention can be understood in a variety of ways which is why it is important to define what we mean by the term in the context of this strategy. As part of the Transformation Programme within adult social care for Warwickshire we have adopted a model which builds upon the work undertaken by ADASS in 2003 around "Inverting the triangle of care". This work highlighted the need to shift the focus of delivery for health and social care services away from high end acute and critical interventions and more towards lower level and early intervention. The model below expresses our local approach in more detail:



Through this model we have defined the need to move away from high end care and support by targeting our interventions, this can be categorised as:

Critical level needs

Reablement and on-going support as with customers who have substantial needs we would seek to use our reablement service to mitigate or reduce the need for on-going social care support. However we recognise that for people with this level of need it is likely that a proportion will still require support of some kind after going through reablement. Current data suggests that around 43% of those who leave reablement require a service but at a lower level of intensity than would have been required without an intervention of this nature.

In order to ensure that we provide appropriate options and levels of support or choice customers will still have the option to be supported through traditional forms of provision such as residential care and domiciliary care; however we would seek to use new modes of support where possible and where this is financially sustainable.

Extra care is being developed as our longer term replacement to residential provision and where possible customers will be encouraged to use personal budgets to identify and commission their own support to meet their needs in ways which are outside of the scope of traditional services.

Substantial level needs

Reablement and Maximising Independence services to help those who already have an illness or disability to live as active and full a life as possible and to be safe in the services that they access. These services could be traditional social care and health based interventions but they need to be tailored to give people the right sort of support and help so that they can do more for themselves and remain independent for longer. As a policy intention we would be seeking to support customers with this type of need through Direct Payments or Personal Budgets wherever possible. In addition to this the use of telecare and telehealth equipment for this group will reduce dependency on traditional provision. Where possible interventions will be for a short term defined period rather than on-going.

Moderate level needs

Staying Independent services focused on people who need some support to stop their condition getting worse. As with wellbeing services these should be provided outside of the traditional health and social care economy within the community.

Low level needs

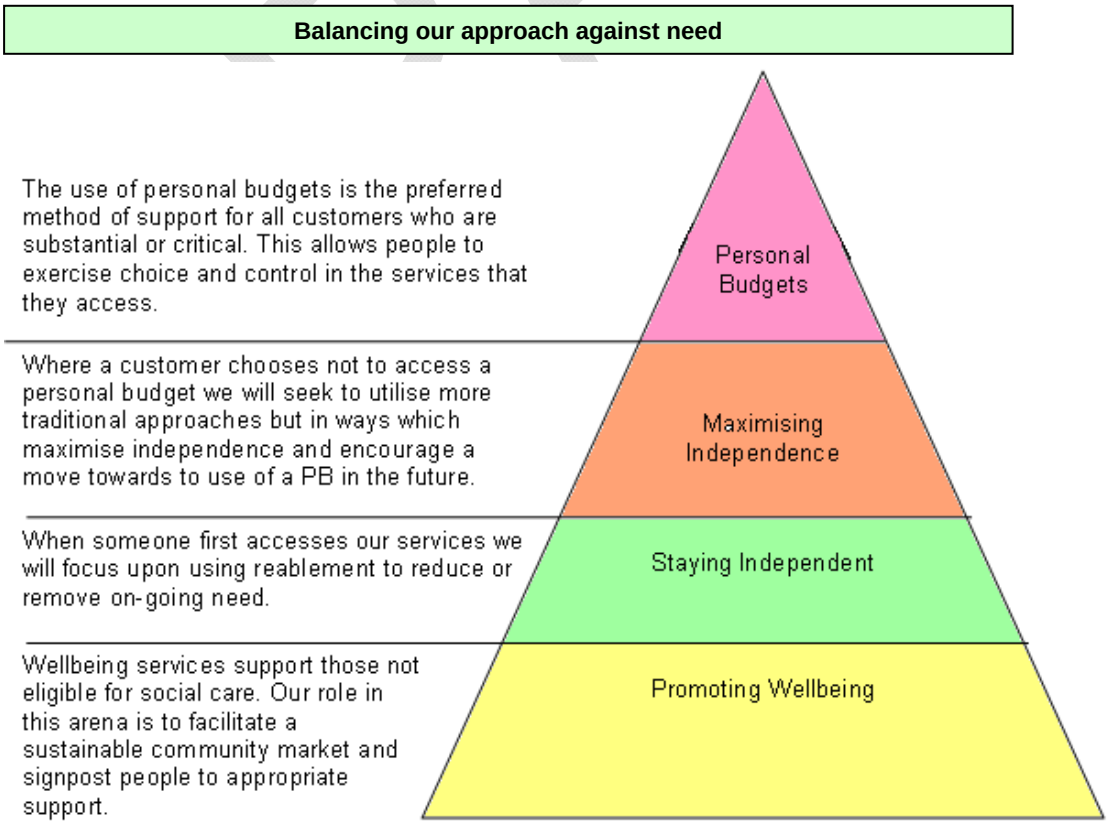
Promoting Wellbeing services which are provided outside of the scope of traditional health and social care settings and provided in the community through voluntary groups or not for profit organisations. These services are focused towards people who are basically healthy but require some for of low level support or intervention to maintain their health, to be safe or get the most out of their lives

Current Position & Initiatives – Building Effective Interventions

There is already a large amount of work going on across the County which aims to support independence and much of this is innovative in nature. However as part of our transformation programme it is clear that much of this work is taking place in pockets and lacks a co-ordinated focus. This Strategy sets out and clarifies as part of the transformation framework the models of service in the future and the methods of access that will be available. There are clearly opportunities to build on existing good practice to improve access to services which support independence for all people across the County regardless of how these services are provided.

Whilst this strategy is focused on adults of all ages where they have need to interface with adult social care services, the evidence base for work to support independence is founded in research largely undertaken with older people. However there is learning based on this evidence as good practice to inform our approach across the wider customer base that we work with, including Learning Disabilities, Physical Disabilities and Mental Health.

In order to deliver against the vision and aspirations of this strategy against the defined areas of focus that have been identified, we will focus our efforts to deliver a set of services and interventions at appropriate levels of the social care spectrum. The following diagram shows the principles behind the approach and way in which specific interventions contribute to supporting independence across the FACS eligibility continuum.



<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>

Services to promote wellbeing

Issues of healthy lifestyle and public health interventions such as vaccination are recognised as an important part of the wider prevention agenda but are led and facilitated through other structures outside of the core business of this strategy. Those areas which are the direct responsibility of adult social care are described further in the following section which also sets the context for the implementation plan which will sit alongside this strategy. There is a broad range of activity taking place around wellbeing and health promotion, some examples of which are:

- Social inclusion
- Healthy living
- Community safety
- Drugs & Alcohol
- Housing and housing related support (excluding extra care)
- Transport
- Welfare rights
- Lunch clubs
- Community and faith based groups

Much of this provision is available through the third sector and is aimed at those with low or moderate levels of need. Traditionally services of this nature have been supported through funding made available by adult social care but as we move towards a model of focusing our interventions at those with higher levels of need this is no longer sustainable. Over the course of the financial year 2010/11 we have been reviewing the impact of services that we support in this arena and in 2011/12 we will be decommissioning and disinvesting from many of these services.

There is a clear recognition that these services are still required and that they offer a level of value to those with lower level needs that should not be lost. Through our market facilitation and management roles we will be working with the third sector and specifically the agencies that we have historically funded to ensure that we support their sustainability as we disinvest.

Information, advice & signposting

Everyone who has reason to be in contact with adult social care, regardless of their level of need required access to high quality information and advice to help them navigate through the range of services that are available to them. The interaction with customers through our access channels and the provision of information and advice will differ based upon eligibility the basic principle cuts across all levels of need. To facilitate and support access to social care services and community based alternatives, we have committed to the development of revised access channels as part of the corporate one front door project and our revised access model.

The Council's One Front Door programme is focused on giving customers access and resolution to services at the first point of contact whether online, face to face or via the telephone. For Adult Social Care this means in addition to handling queries relating to County Council services the One Front Door will act as a signposting service for non eligible customers helping them gain support that will not only give them choice but help them maintain their independence outside of social care.

Alongside this commitment to the development of an access model which is focused upon provision of information and advice we are developing a resource directory which will be a repository of services that can be accessed by those who require support. The directory will include a comprehensive range of community based services which can be accessed by both practitioners and the public. The majority of the services within the directory will not be funded or commissioned by adult social care, but are available to be accessed by those who wish to purchase additional support themselves. The directory will be available on the council's website and will go live in April 2011. The directory will be regularly updated to ensure accurate information is available on a timely basis.

In addition to this, we have commissioned Age UK to provide a gateway service targeted specifically at customers with higher moderate needs. This service will work to identify community based solutions which will halt or slow progression to substantial or critical need. To support this service, we will be investing £100,000 through contract reshaping. The effectiveness of the service and the number of referrals will be monitored on an ongoing basis as, for 2011/12, this will be a pilot service. If the service is successful, we will tender for ongoing provision from 2012/13 onwards. This service is joint funded with the PCT who have invested £33,000 into the service.

Reablement

Reablement can be described as a service for potential customers who present with poor physical or mental health following a period of crisis, hospital admission or deterioration of health. The purpose of the service is to help them people in these circumstances to manage their illness or condition by learning or re-learning the skills necessary for daily living. We have a reablement service in place across the County and data shows that of those who access the service around 57% require no on-going package of support at the end of their six week support.

Based on the positive results of this approach we will expand this service to existing customers at hospital discharge or where their review suggests an increase in the level of support they require. This expansion will see the level of referrals to reablement increase from 40 to 63 on a weekly basis. As well expanding to existing customers, we will also begin to develop reablement for specialist services and additional client groups such as learning and physical disabilities. The timescale for the development of specialist services is to be defined but it is likely that they will commence during the financial year 2011/12.

To support the expansion of the service, we will be using funding from the winter pressures resources which are currently being transferred from the PCT to the local authority. It is likely that funding arrangements will be finalised by May 2011. In order to assess the effectiveness of the delivery of these services and the use of the winter pressures funding, we are currently developing a range of additional performance measures which will be included in our regular monitoring.

Intermediate Care

Comprehensive intermediate care services are vital to improving the outcomes for older people and reducing the demand on health and social care services. There are clear and close links between intermediate care and reablement with the key features of intermediate care focusing on rapid response to address issues of crises to avert or reduce levels of emergency admission to hospital or residential care home. The service also acts as a mechanism to support, encourage and facilitate timely discharge from Hospital.

Intermediate care services are provided through the health service rather than the local authority but there is a close relationship between these services and social care practitioners. In addition as legislation around responsibility for readmission following discharge from hospital there is an increased emphasis on joining together health and social care interventions of this nature.

Over the course of the coming months we will be working with colleagues in the PCT to link our reablement and intermediate care services, this may result in a joint service or separate services with complimentary pathways of care.

As part of the realignment of resources between the PCT and the local authority, we will be working to develop a joint or complimentary reablement and intermediate care service. This service will focus upon shared or complimentary pathways of care to support recovery, rehabilitation and reablement at an early stage. The level of financial resource and the scope of this service is currently being defined and is likely to be agreed in May 2011.

As part of the gateway service with Age UK, we are seeking to use signposting and access to equipment as a mechanism to support recovery in the local community following discharge from hospital or a contact with social care which does not lead to an ongoing service.

Long term conditions

People with complex health and social care needs, largely associated with long term conditions, benefit greatly from joint health and social care assessment and care management. The benefits include improving outcomes for individuals and evidence strongly suggests that joint approaches reduce demand on both health and social care systems. The benefits are particularly strong where jointly delivered rapid and flexible response services targeted at older people with mental health needs are in place.

Hospitals and institutional care are not healthy places to be. People in these settings have an increased risk of their condition worsening or secondary conditions taking hold. Currently patients with long-term conditions account for 60% of hospital bed days across the acute sector, and 80% of these patients at any given time do not actually need to be in hospital. By placing people in hospital we increase the risk of the need for greater intervention from health and social care services following discharge.

By developing our approach to supporting the management of long-term conditions, we can reduce the need for hospital admission and reduce pressure upon the social care economy. Many long-term conditions can be self-managed, particularly through the use of technology and, as we develop our approach to telecare and telehealth, this will need to be a significant focus.

Specialist Residential & Extra Care Housing

Despite the move to enable more people to remain living in their own homes, residential care homes will always remain the appropriate and positive choice for some people. This is particularly relevant for those who require specialist support for example in relation to dementia. There is however a need to ensure that the use of residential provision is not seen as a permanent solution and that we seek to ensure that where possible we work more proactively with people in these settings to improve their general health and wellbeing with a view to moving them on.

Part of the approach to reducing need within a residential setting is the shift away form the traditional model of care and a move towards Extra Care Provision. Our Care & Choice Accommodation Programme is focused upon progressing work in this area and a limited amount of this type of provision is already available in the County.

Falls Prevention

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

Approximately 30% of the population over-65, 50% of the population over 85s and 60% of nursing home residents in England will fall each year and 20-30% of these falls will cause injury, with 30% of admissions to hospital for hip fracture being from patients in care home.

Falls are the most common reason for A&E attendance and hospital admission in the elderly and fractures represent one of the most serious consequences of a falls and osteoporosis; hip fractures in particular. Following osteoporotic hip fracture 50% of people will no longer be able to live independently, with fewer than half returning to their initial place of residence and10% of people sustaining a hip fracture die within a month of admission, and 30% will have died at 1 year following admission.

In Warwickshire admission rates for fractured neck of femur are rising year on year, and although these changes are not statistically significant there were 551 admissions for fractured neck of femur in 2008/9 compared with 483 in 2005/6.

Recent systematic reviews have shown little evidence to support the effectiveness of multi-factorial interventions to prevent falls and injuries in older people in community and emergency settings. Based on this evidence the PCT have agreed that there are five effective, interventions that will be progressed and these are:

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

The development of the falls strategy is PCT led and considered to be one of their highest priorities. Investment in this area is significant and in the millions as the PCT seek to reduce the pressure placed on elective surgery as a result of falls.

Although the strategy is PCT led, as is the investment in the service, adult social care services also play a role in supporting the delivery of these priorities. Arrangements will be developed to ensure integrated approaches are in place which enhances the ability to address the causes of falls.

Currently it is acknowledged that services across the county are not proportionate and a key intention of the strategy is to ensure alignment in service provision by the PCT.

Telecare

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. To support this we have completed a strategic review of our telecare service and are re modelling the adult social care service to provide the three elements of a telecare service across the county; equipment and installation, monitoring and telephone response and a physical response service for those customers without key holders.

As part of the expansion of the telecare service, we will be implementing ADL Smartcare which provides an evidence based self-assessment service linked to equipment solutions. Following the completion of the self-assessment, a customer is advised of the types of equipment that can meet their need and how this can be accessed. The use of this approach will support those who wish to purchase telecare equipment, who are not FACS eligible, to access cost effective solutions. ADL are developing this approach with us over the next six months (up to September 2011) and this work is being funded as part of the transfer of resources from the PCT linked to winter pressure funding. In addition to the self-assessment identifying equipment solutions, it also provides signposting to other services as and when appropriate.

Aids & Adaptations

Demand for adaptations is rising as a result of a range of demographic pressures and the grant fund available to satisfy this demand is like many other funding streams, under pressure.

There is no longer a requirement for local authorities to match fund 60:40 the grant income and the grant ceiling has now been increased to £30,000 per grant, this will impact on the numbers of grants that can be completed.

There is some evidence at a national level that Housing Associations adaptation budgets are coming under pressure. Residents in need of adaptations are therefore seeking DFG's placing additional burdens on local authority budgets. Additionally there has been a rise in the number of low income owner occupiers and the general demographic pressures noted above, creating increasing demand[1].

As at 31 October 2010 total of 844 people had been waiting for an adaptation at some stage during the year and the average waiting time between assessment and work beginning was 29 weeks (2009/10 average 31 weeks).

ICES

Since 2004 we have had a joint community equipment service in Warwickshire delivered by the County Council and the PCT with the Council acting as the Lead for the service with a pooled budget manager being responsible for day to day operations. Since 2005 these services have been delivered through a contract with Nottingham Rehab Supplies (NRS). Over the past 3 years we have been working closely with NRS to improve the delivery of the service specification to ensure that the service is timely and effective with particular focus being given to communication between the prescribers and the distribution centre. Over the last 4 years items of equipment and adaptations provided through the service have increased by 62% and in 2009/10 82,572 items of equipment were delivered to customers in Warwickshire.

To further develop the service and to build on the success to date our intention is to move to the use of a “hybrid” retail model incorporating the Putting People First principles. The new service will be designed to support Warwickshire residents to purchase equipment when they need it, quickly, easily and in a way that fits into their lives. The service is a strategic shift towards providing residents with an early intervention service at the same time as controlling the increase in the volumes of funded equipment.

The purpose of the model is to act as a preventative service aimed at residents with low to moderate needs to reduce the number of residents who move to the statutory service at a substantial or critical level. The self-assessment or supported assessment process within the new service reduces the element of risk of people purchasing the wrong equipment and encourage self-funding in a risk free manner.

Benefits Realisation and Resource Arrangements

In order to manage and monitor the effectiveness of our use of resources to support independence and contribute to the prevention agenda linked to our transformation programme, we have developed a benefits realisation model to assess our customer flow and financial allocation. The benefits realisation model is still being refined but as part of its development we have identified that, as a directorate, we currently spend £2 million on services and support which relate to the issues addressed within the strategy. This level of spend equates to 1.3% of our current budget.

Within the prevention element of the benefits realisation model, we have identified the following services as contributing to this agenda.

- Age UK
- Alzheimer's Society Home Respite
- Alzheimer's Society one-to-one support
- Warwickshire Association for the Blind Rehab Service
- Independent Advocacy – Professional Advocacy
- Kenilworth Helping Hands
- Friendship Care and Housing – Bedworth Wellbeing Resource Café
- Friendship Care and Housing – North Warwickshire Resource Centre
- Mid Warwickshire MIND Resource Café
- Rethink Carer Information and Support Service
- Rethink The Old Bank Resource Café
- Springfield MIND Wellbeing Exchange
- Age UK Home Safety Checks
- Independent Advocacy – Financial Support
- Guidepost Services for Carers
- South Warwickshire Carers
- Senior People's Forum
- Lunch Clubs (detail expressed at appendix A)
- BME Low Level Services (detail expressed at appendix A)
- Older People Low Level Services (detail expressed at appendix A)
- Older People Mental Health Low Level Services (detail expressed at appendix A)

As part of the transformation programme, within the low level services portfolio, we are currently seeking to reshape the services that we commission and fund which contribute to the supporting independence agenda.

Outcomes & Headline Measures

The approach outlined in this strategy document plays a key role in supporting the achievement of our ambitions and objectives as a corporate organisation. Within the Corporate Business Plan 2011/13 the Council has clearly stated its intentions around “Care & Independence” as part of which the Directorate is committed to working towards the following aims and associated outcomes for the residents of Warwickshire.

Delivery Aims:

- 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

Outcomes for Warwickshire:

- Warwickshire’s residents have more choice & control
- The number of home care packages is decreased
- Warwickshire’s vulnerable residents are supported at home
- Residents of Warwickshire have greater access to specialist residential care
- The successful transfer of the Public Health Service to the Local Authority

To assess our delivery of these aims and outcomes the following headline measures and associated targets have been developed*, which will be performance managed through officer and member structures over the course of the year.

Warwickshire's residents have more choice & control				
Title	**Definition**	**Target 11/12**	**Target 12/13**	**Target 13/14**
Emergency readmissions	Emergency readmissions within 28 days of discharge from hospital (low is good)	New measure	New measure	New measure
Enhancing independence & control over own support	(NI136 derivative) The proportion of those using social care who have control over their daily life (high is good)	New measure	New measure	New measure
Enhancing quality of life for carers	Carer reported quality of life (survey based – high is good))	New measure	New measure	New measure
Enhancing quality of life for people with learning disabilities	(NI146 exact match) Proportion of adults with a learning disability in employment (high is good)	11%	13%	TBC
Enhancing quality of life for people with mental illness	(NI150 exact match) Proportion of adults in contact with secondary mental health services in employment (high is good)	28%	31%	TBC
Improving access to information about care and support	The proportion of people using social car and carers who express difficulty in finding information and advice about local services (survey based – low is good)	New measure	New measure	New measure
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 (survey based – high is good)	New measure	New measure	New measure

Title	Definition	Target 11/12	Target 12/13	Target 13/14
Ensuring a safe environment for people with mental illness	(NI149 exact match) Proportion of adults in contact with secondary mental health services in settled accommodation (high is good)	92%	93%	TBC
Ensuring a safe environment for people with learning disabilities	(NI145 exact match) Proportion of adults in with a learning disability in settled accommodation (high is good)	70%	75%	TBC
Providing effective safeguarding	The proportion of referrals to adult safeguarding services which are repeat referrals (low is good)	New measure	New measure	New measure

On going home care packages are decreased				
Title	**Definition**	**Target 11/12**	**Target 12/13**	**Target 13/14**
Helping older people to recover independence	Proportion of older people (65+) who are still at home after 91 days following discharge from hospital (high is good)	New measure	New measure	New measure
Protecting from avoidable falls and related injuries	Acute hospital admissions as a result of falls or injuries for over 65s (low is good)	New measure	New measure	New measure

Warwickshire's vulnerable residents are supported at home				
Title	**Definition**	**Target 11/12**	**Target 12/13**	**Target 13/14**
Admissions to residential care	Admissions to residential care homes per 1,000 population (low is good)	54.0	50.0	TBC
Preventing deterioration and emergency admissions	(NI134 derivative) Emergency bed days associated with multiple (two or more in a year) acute hospital admissions for over 75s (low is good)	Health Indicator, we were never able to access information on this indicator as health were working to a different definition		
Improving recovery from falls and falls injuries	The proportion of people suffering fragility fractures who recover to their previous levels of mobility at 120 days (high is good)	New measure	New measure	New measure
Promoting personalisation	(NI130 exact match) Proportion of people using social care who receive self directed support (high is good)	45%	60%	75%
Ensuring people feel supported to manage their own condition	(NI124 derivative) Proportion of people with long term conditions feeling supported to be independent and manage their condition (high is good)	PCT Indicator, we don't set the targets		
Delivering efficient services which prevent dependency	Proportion of Council spend on residential care (low is good)	No Target Previously Set		

Residents of Warwickshire have greater access to specialist residential care				
Title	**Definition**	**Target 11/12**	**Target 12/13**	**Target 13/14**
Supporting recovery at the most appropriate place	(NI131 exact match) Delayed transfers of care (low is good)	15.0	10.0	TBC

*At the time of producing this draft strategy the development of the corporate and directorate based performance frameworks is ongoing and as a result the measures and targets detailed in this section of the document remain subject to potential change.

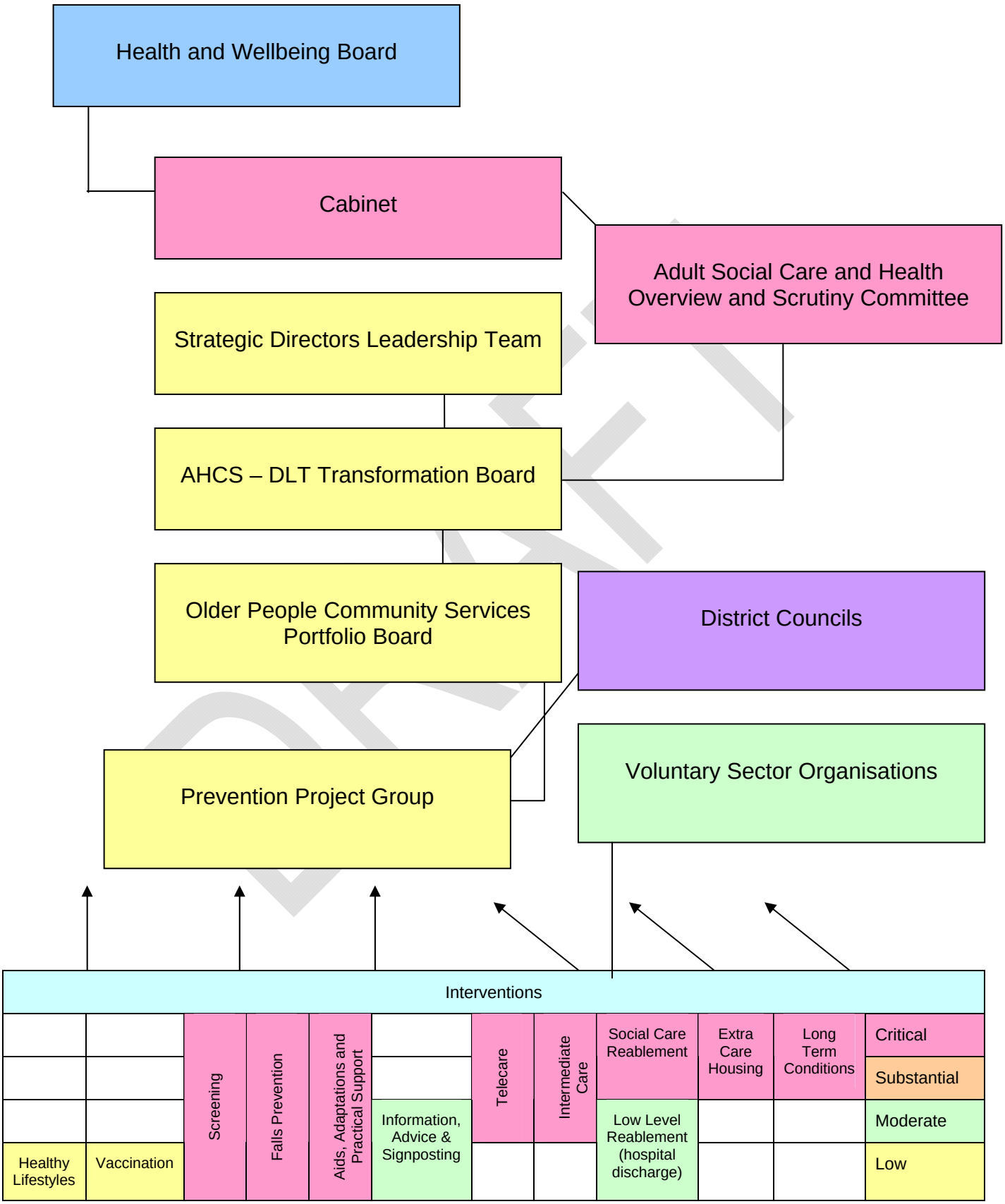
Governance Framework

Delivery of the prevention strategy and the services that support it are intrinsically linked to the transformation programme for adult social care. In addition work is currently being undertaken in conjunction with the PCT to develop a response to the Governments expectations around shifting resources from the PCT to the local authority in support of reablement and preventative services. Based upon this it is anticipated that the plan of work to utilise reablement funding resources will become the delivery plan which underpins this prevention strategy.

From a governance perspective the Older People and Community Services Portfolio of the transformation programme is responsible for the management of the delivery of the strategy on behalf of the transformation board. To support this arrangement a prevention steering group has been developed which it is intended will meet on a quarterly basis to review progress and to challenge the effectiveness of the interventions that have been put into place.

In the longer term there will be a need to ensure that the prevention strategy and approach reports to the Health & Wellbeing board which is being developed in response to the white paper “Liberating the NHS” but as these arrangements are not yet in place the interim governance structure described above will be responsible for the management of delivery. The following diagram seeks to express the structural arrangement within the framework.

Governance Framework – Supporting Independence (Prevention) Strategy



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Appendix A – Low Level Services Contractual Arrangements

Lunch Clubs

- Nuneaton Caribbean Association
- Whitestone Luncheon and Over 60's Club
- Water Orton Parish Church
- Bedworth Civic Hall Lunch Club
- Conifer Court Lunch Club
- The Grove Lunch Club
- New Town Centre Lunch Club
- St Mary's Youth
- Harbury Village Lunch Club
- Mancetter Lunch Club
- Water Orton Lunch Club
- Watten's Lodge Lunch Club
- Overslade Lunch Club
- Dell Court Lunch Club
- Lawrence Mackie Lunch Club
- Rainbow Fields Lunch Club
- Earlswood Lunch Club
- Burley Lunch Club
- Wilmcote Lunch Club
- Jubilee Court Lunch Club
- Stour Court Lunch Club
- Malt Lane Lunch Club
- Mulberry Street Lunch Club
- Osprey House Lunch Club
- Snitterfield Lunch Club
- Iris Lees Lunch Club
- Dale Street Lunch Club
- Chandos Court Lunch Club
- Lowsonford Lunch Club
- Fillongley Village Lunch Club
- Cubbington Lunch Club

All of these lunch clubs were decommissioned by the local authority in 2010/11, releasing a saving of £38,687. During the decommissioning process, short-term funding was made available to support these lunch clubs to become self-sustaining without funding from the directorate.

BME Groups

- African Caribbean Friendly Association
- Sikh Mission
- Anmol
- Guru Nanak
- Rugby Sikh Association
- Pakistan Welfare Association
- Sikh Social and Welfare Association
- Rugby West Indian Association
- Rugby Indian Association
- Rugby Chinese Society
- Milan Multi-Cultural Society
- Sikh Community Centre
- South African Caribbean Project

To support these groups, Warwickshire County Council currently provides £125,976 across the organisations on an annual basis. In 2011/12 these organisations will be decommissioned by the directorate and, as a result, will not receive further financial support. Three months notice has been served to these organisations as at 1 April 2011, however there is an option to extend the notice period by a further three months which would result in financial support being provided up to 30 September 2011.

As we decommission from these organisations we will be working with them to support them in becoming self-sustaining organisations. The market facilitation team are currently undertaking visits with the organisations to discuss their business planning and development options for the future. In addition to this, they may receive ongoing funding where FACS eligible individuals supported by the directorate choose to purchase support from them directly utilising a personal budget or direct payment.

Older People Low Level Services

- Iris Lees
- Waverley Day Care Centre
- Waverley Drop-In Centre
- Age UK – Rugby Day Care
- Age UK – Hospital Discharge Home Support
- Age UK – Daily Living Support
- Age UK – Abbey Green Day Care
- Age UK – Digby Road Specialist Club
- Age UK – Atherstone 55's Club
- Age UK – Daily Living Support North

To support these groups, Warwickshire County Council currently provides £289,627 across the organisations on an annual basis. During 2011/12 we will be decommissioning or reshaping some of these services. As a result of this work we will be reducing our financial commitment to £263,627 and will be

amending the types of service that we commission. We will no longer be providing financial support to Age UK in relation to their hospital discharge, daily living support, and 55's club, but will be commissioning a gateway service focused on providing tailored support to customers who are not FACS eligible for social care but are rated as having high-end moderate social care needs.

Older People Mental Health Low Level Services

- Alzheimer's Society – Victor Hodges (Day Care)
- Alzheimer's Society – Information and Advice Stratford
- Alzheimer's Society – Information and Advice Warwick
- Alzheimer's Society – Dell Court (Day Care)
- Alzheimer's Society – Alz's Café
- Age UK Daybreak Services
- Age UK Independent Support for Over 55's

To support these groups, Warwickshire County Council currently provides £465,131 across the organisations on an annual basis.