Appendices A & J are Not for Publication – exempt by virtue of paragraphs 3 and 9 of Schedule 12A

Agenda No.

AGENDA MANAGEMENT SHEET

Name of Committee	**Cabinet**
Date of Committee	**22nd May 2008**
Report Title	**Care & Choice: Delivering better care outcomes for older people [2008 – 2015]**
Summary	This report takes forward the vision for the Care and Choice programme first considered by Cabinet in 2007. The report is set against the context of demographic growth and the need to better understand care preferences. It builds on the local approach to more responsive provision of care against national guidelines and best practice within a financially realistic and affordable framework. The aim, in essence, is to make Warwickshire a place where people want to grow old. It is a programme about people and their lives not just buildings.
For further information please contact:	Graeme Betts Strategic Director Adult, Health & Community Services Tel: 01926 742950 Kim Harlock Head of Strategic Commissioning & Performance Tel: 01926 745101
Would the recommended decision be contrary to the Budget and Policy Framework? [please identify relevant plan/budget provision]	No.
Background papers ***Note: some of these are*** ***Exempt reports.***	LAC [DH] [2008] 1 – Transforming Social Care Guidance on Joint Strategic Needs Assessments, Department of Health, December 2007 Putting People First – [concordat] December 2007 Developing Adult, Health & Community Services – Cabinet June 2006 Cabinet Report May 2006 [Our Health Our Care Our Say] Our Health, Our Care Our Say [Cm 6737] January 2006. Transforming Social Care – putting people first, 13.03.08. Market Development/ site options – 7 June 2007, 6 September 2007 and 13 March 2008. Extra Care Housing Fund, Cabinet, April, 2008. Corporate Business Plan, 2008-2010

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	
Local Member(s)	☒	Not Applicable
Other Elected Members	☒	Councillor F McCarney, Councillor R Dodd, Councillor Mrs J Compton, Councillor Mrs J Dill-Russell
Cabinet Member	☒	Councillor C Hayfield, Councillor A Farnell
Chief Executive	☒	Jim Graham, Chief Executive
Legal	☒	Alison Hallworth, Adult and Community Team Leader
Finance	☒	Chris Norton, Financial Services Manager
Other Chief Officers	☒	David Clarke, Strategic Director, Resources David Carter, Strategic Director, Performance and Development
District Councils	☐	
Health Authority	☐	
Police	☐	
Other Bodies/Individuals	☒	Jane Pollard, Overview and Scrutiny Manager Janet Purcell, Cabinet Manager

FINAL DECISION NO

SUGGESTED NEXT STEPS:

Further consideration by this Committee	☒	Report back on consultations 2008, Progress review 2009
To Council	☐	
To Cabinet	☐	
To an O & S Committee	☒	Monitoring progress
To an Area Committee	☐	
Further Consultation	☒	Consultation on proposed Care Guarantee and approach to balance of care

CARE AND CHOICE PROGRAMME

CONTENTS

Item	Subject Matter
Covering Report	Overview, Vision and Recommendations
Appendix A	Previous Cabinet Decisions **[EXEMPT INFORMATION]**
Appendix B	Programme Governance
Appendix C	Social Care Transformation
Appendix D	Preferences Older People
Appendix E1	Needs Analysis [County & District]
Appendix E2	Supply Side [County and District]
Appendix E3	Balance of Care
Appendix F	Care Model – Extra Care
Appendix G	Care Guarantee
Appendix H	Consultation & Engagement
Appendix I	Risk Register
Appendix J	Developing the Care and Choice Programme [**EXEMPT INFORMATION**]
Appendix K	Criteria for Progression
Appendix L	Equality Impact Assessment
Appendix M	Programme Resource Issues
	NOTE: A detailed listing of references and sources used in the preparation of this report and balance of care analysis will be available together with more district material as part of the proposed consultation arrangements outlined in this report.

Appendices A & J contain exempt information by virtue of paragraphs 3 and 9 of Schedule 12A and are reproduced in the private portion of the agenda for Elected Members.

Agenda No

Cabinet – 22nd May 2008

Care & Choice: Delivering better care outcomes for older people [2008 – 2015]

["A programme about people and their lives – not just buildings"]

Joint Report of the Strategic Directors of Adult, Health and Community Services, Performance and Development and Resources

Recommendation:

It is recommended that Cabinet:

1. Endorse the whole care economy approach to stimulate the local care economy to secure strategic change; agree the programme's strategic objectives **[4.3];** and the shifts in the balance of care as outlined in this report.
2. Confirm that evidence on the needs and preferences of older people should be central to the local change process in shaping the balance of care.
3. Approve the commencement of formal consultation with health partners, District Councils, users, carers and the wider social care economy on needs, supply and the future balance of care and the development of extra care housing based on the evidence and findings in **Appendices D, E.1 – E.3.**
4. Approve the Care Guarantee [**Appendix G**] as an interim framework and for consultation with stakeholders, users and carers followed by final decision by Cabinet.
5. Note the outcome of consultation to date and approve the approach to consultation and engagement [**8.3 and Appendix H**]
6. Agree the outline criteria policy for project progression in relation to Council and Warwickshire Care Services' homes as set out in **Appendix K** for use as a gateway mechanism to bring individual schemes back for Cabinet decision.
7. Endorse the governance arrangements [**Appendix B**] together with the initial Equality Impact Assessment [**Appendix L**] and the Programme Risk Register [**Appendix I**]
8. Note the likely impact on direct provision of care of the social care reform agenda and the expected future balance of care and the need to reframe current resources as outlined in **Appendix J** subject to the outcome of ongoing consultation and engagement with stakeholders. **[NOTE: APPENDIX J is EXEMPT INFORMATION]**
9. Note the intention to use **Appendix J** as a basis for discussion with Warwickshire Care Services [WCS] and more generally on the content of this report.
10. Receive a further report on the development of a programme of change within direct provision and WCS services in response to the need for change; consider a phased plan of change as outlined in late Summer/Early Autumn 2008; and, keep under review.
11. Confirm that each scheme within the agreed Care and Choice Programme would be expected to be financially viable in its own right; and,
12. Agree to undertake a full and formal review of the programme in year three and invite Scrutiny to monitor progress and advise on any key issues on an annual basis.

1. Introduction

1.1 The Council's core vision involves putting customers first, improving services and leading communities. It is backed up by clear priorities for action and resources to deliver them. Consistent with the Council's overall approach, a specific vision for Adult Health and Communities has been developed. This is to:

"Maximise the quality of life of all communities in Warwickshire by working in partnership to reduce inequalities, improve well-being, promote individual independence and enrich people's lives through learning and culture."

1.2 Cabinet has received previous exempt reports on its care and accommodation services and on some initial schemes to effect change. These decisions of Cabinet are given at **Appendix A. [Exempt Information]**

1.3 This report draws together a wide range of material. The aim has been to create a coherent picture of local needs and supply within the local care economy. This is then used to arrive at specific conclusions about the future shape of care within Warwickshire that best meets local needs and expectations and offers care value.

1.4 Much of the detailed information on need and the balance of care appear in Appendices. There is a considerable amount of material. Where the content of appendices is for decision this has been highlighted in the recommendations for action.

1.5 The development of this work has been overseen by an Officer Programme Board, which has identified the areas for further decision. The overall governance arrangements are set out in **Appendix B.** In preparation for this meeting use has also been made of a Member's Seminar/Briefing to explore wider issues leading to its preparation.

1.6 The Council's vision guides the setting of priorities and policies. It acts as a reference point for the allocation of resources. Caring for older people is one of three top priorities drawn from seven longer term aims of which supporting older people to live independently is also one. The actions proposed in this report would contribute directly to the achievement these aims.

1.7 Strong partnerships are a key vehicle to tackling the wider issues facing Warwickshire. The proposals in the report are consistent with and should contribute to the development of healthier communities and healthy lifestyles work. The report will also contribute to joint action with health partners on the reduction of health inequalities.

1.8 The needs analysis and supply side mapping work will contribute to the Joint Strategic Needs Assessment, which has to be prepared. Material from this report will be used to inform strategic and operational commissioning activity that will be linked to the Local Area Agreement.

2. Impact of Social Care Reform

2.2 In March 2008 Cabinet received a report on the transformation of social care and the emphasis on approach in the Concordat ***"Putting People First"***. Cabinet gave support to the principle of personalisation, the need to translate this into change on the ground and the need to build into corporate business planning.

2.3 This decision was consistent with support given in 2007 for the reshaping of countywide provision of residential care options. The aim was to provide increased choice, promote independence and generate market development to meet five strategic commissioning priorities as follows:

- **Choice and Control:** We want to put older people in control of their own services, giving them more choice and a stronger voice
- **Services that are joined up:** We want older people to experience seamless services from health and social care and relevant partners.
- **More community based services:** We will commission services that will ensure that the independence of older people will be maintained and increased and that will support carers better.
- **Promoting independence:** We will commission more community-based services for older people.
- **Prevention and well-being:** we will commission more services that promote well being and prevent older people from needing more intensive health and social care services.

2.4 The national drivers of social care policy and priorities are summarized in **Appendix C.**

2.5 There are also local drivers for change that mirror the national agenda. They are:

- the need for accessible care alternatives closer to home; and,
- the long term viability of an ageing care home stock with high costs; and,
- the need for better care outcomes at lower cost; and,
- the continued impacts of social and demographic change; and
- the capacity to meet rising expectations around personalised care.

2.6 Delivering individual budgets and personalised care presents many challenges for commissioners and providers alike. The social care reform agenda will require a significant shift away from traditional models of care and the cultures that underpin them.

2.7 There are many challenges and potential obstacles to overcome. At the same time there are real opportunities to be grasped to reshape and grow care markets. This needs to happen in ways that make sense to those who use them and match with 21st Century standards and expectations around quality care and quality people to deliver this.

3. Preferences of Older People

3.1 What older people need, want, expect and are prepared to pay for has to be the starting point of the change agenda. Later life is still a time of growth and development. It is not about passive decline. Older people are often key to community life. This needs to be reflected in the overall approach to the improved local balance of care we are seeking.

3.2 There is good local and national evidence on the expectations surrounding care and accommodation needs in later life to guide what we might do in the future. This evidence needs to be supplemented by further work locally. The aim should be to secure ongoing engagement at every stage to help ensure continued relevance of action in response to needs. Recent national and local research on preferences is summarized in **Appendix D.** The key messages are that we should:

- accept that older people expect to have a real say and to remain as independent as possible for as long as possible;
- link extra care housing to wider considerations about quality of life, housing and the home;
- understand that staying at home, not going into a home, is the preference for the majority;
- respond to strong expectations around care at home support;
- understand the reasons for moving in later life;
- meet expectations on housing, the home, and extra care settings;
- recognise a willingness of some to consider extra care or sheltered housing as a positive choice in preference to care homes when needs reach a certain point;
- take account of the real need of schemes to meet expectations around location, space, convenience and daily living; and,
- respond to the wish for more information for decision making around care and to inform choice and control.
- understand that older people living in care homes represent a small proportion of people aged 65 and over.

3.3 Within these themes there is evidence that people want more options on housing and the home in later life. The vast majority of older people will live until the very end of their lives in general housing. Some may adapt their homes. Some sheltered housing, some of which has been in place for some time, reflects the space and facilities of the past rather than the future. Some remodelling may be needed and this would form part of the basis of discussions with Districts and other providers of sheltered/retirement accommodation for older people.

3.4 The development of housing with care/extra care schemes has the ability to fit in with and respond to that expectation. At the same time some people will still need care homes [with and without nursing]. A balance of care options and choices needs to be sustained and developed across the County. In general, future care home facilities need to be more consistent with the requirements of an older and more dependent population than in the past. Increasingly, potential residents will present very specific needs around higher physical dependency, dementia and related conditions.

4. Draft Programme Objectives

4.1 We all hope to grow old. This programme of transformational change is about older people and their lives, how we engage with them and how we respond to their needs and expectations. It is not just about buildings and care settings; although they are an important means to better individual outcomes. It is a response to our vision for adult social care and is a reflection on the value we ascribe to our own lives. The key elements are:

- People shape the services they use
- Service performance and quality are strengthened
- Capacity and capability within local care systems is improved
- Care markets are more responsive to and meet needs

4.2 This is a demanding agenda. Reforming social care to achieve personalisation for all will require a major cultural, transformational and transactional change in all parts of the care and support system and not just in social care. It will affect all sectors of provision and reshape commissioning of publicly funded care.

4.3 The care and choice agenda is about whole systems change and not just at the margins. It is about ambition for local people and delivery of change that makes real sense in terms of their daily lives, hopes and fears. Having considered the balance of care that is needed, the specific aims are:

- To **respond creatively to the impact of demographic change** between now and 2021 by better use of existing care capacity and better matching of service take up with needs identified through care assessment and advice.
- To **enable more older people to stay at home** and to live independently, with or without support or re-ablement inputs, for as long as it is reasonable, practicable and safe to do so.
- To **stimulate the local care economy to better meet care needs** and promote care solutions without recourse to significant public capital or health and social care revenue funding.
- To **enhance overall care value to purchasers of care** [includes people who self fund care] by generating care solutions through care markets that better meet needs and expectations, meet national minimum standards, assure quality care through quality people and deliver improved care outcomes.
- To **secure maximum affordable choice and fair care access by** older people that offers the best match to their needs, maximises their resources and improves the care value that they receive.
- To **reshape care accommodation provision** to better meet current and future specialist needs and preferences of older people and their supporters without significantly increasing total capacity within care homes.
- To **increase user, carer and community satisfaction with care services** and promote informed care choices that offer real control to people seeking care and support and treats people who self fund care on an equal basis.

5. Balancing Care [Need, Supply and Service use]

5.1 Some initial decisions about care services have been made. Further decisions are now needed to enable the Care and Choice programme to progress. To achieve this vision, we have to better match need, supply, demand and preferences in a way that makes sense to people who have care and support needs. We also have to be able to secure a measure of certainty and stability for care providers and carers at a time of change.

5.2 Detailed information of need and demand for care and support, demography and social factors are set out in **Appendix E [1].** Information on the supply side, services that respond to needs, is given in **Appendix E [2]. Appendix E [3]** sets out the balance of care, need, supply and a way of meeting preferences, we are trying to secure. Information is given, where possible, at county and district level. The aim has been to generate a picture of what we need, what we have, what is used and what people prefer. The intention is to work closely with health, Districts, providers, staff users and carers to inform how best we can respond to these challenges. In doing so we will be building on the real co-operation to date.

5.3 The key message from the balance of care, about the future, is that, committed as we and care staff are to good care, we cannot go on with what we have. Neither should we be seeking to replicate what we have now. We need to do something different that matches better to best practice, the changing needs and legitimate expectations and aspirations of older people and their relatives around personalisation and the diversity in care.

5.4 The key messages about the balance of care in **Appendix E [3]** are unlikely to come as a surprise. They match the experience of other councils, flow from data in earlier reports and are consistent with strategic priorities. They are:

- Existing supply and need are not in balance. There may be a shortfall in care and support availability for those with critical and substantial needs that may inhibit choice and responsive delivery.
- The evidence of potential demand in excess of supply suggests there may be specific areas where it is difficult to obtain care where intensive help is needed for people who are older and frailer than previously.
- Low intensity support services appear to be under developed.
- There appear to be gaps around intensive care for older people with mental health needs in need of 24 hour care. The need for more intensive options for this group is also evidenced by local commissioning experience around access to care and accommodation for older people with moderate and more severe levels of dementia.
- The ability to review and remodel existing care and accommodation services is closely linked to the ability to stimulate the local care economy and as a commissioner to try to increase capacity so as to create scope for choice and change.
- Action on service change needs to expand care system capacity at the same time as, or preferably in advance of, any re-modelling or re-balancing of care options within the care economy in order to minimise risk of disruption to existing service users and carers.
- Supply availability in relation to need varies within Warwickshire. Access

to local and convenient care services may need to develop more in some Districts than in others to ensure equality of access across the County.

- Demographic change will lead to a widening gap between existing supply and demand. This creates an opportunity to remodel the balance of care towards more care at home and extra care housing services and away from care homes offering personal care only.
- Sheltered housing is making a contribution which, if linked to the development of extra care accommodation with appropriate facilities and an appropriate mix of tenure types matching local circumstances, could make a vital contribution, together with Supporting People, to future care and choice options for older people.
- The development of extra care housing may need to be accompanied by some remodelling of existing sheltered provision and further mapping activity is needed in this area.
- As both a provider and a commissioner of care, the Council needs to consider how it can maximise its contribution to securing the best balance of care possible and determine how best its own directly provided care services can contribute to the care and choice vision.
- Attention needs to be given to the supply of human resources. The development of a more flexible, skilled and highly competent workforce across all sectors able to deliver care and support consistent with the principles of social care reform is needed.

6. Changing the Balance of Care

6.1 The key change in the local balance of care would be the development of extra care housing and the support of more people in their own homes. The aim would be that, overall, current provision of care and nursing homes should be at the around same level as now. It would be more focussed, however, on people with “critical” needs that cannot be met reasonably or practically in any other care and accommodation setting. A consequence of this would be an increasing dependency and an older and frailer population within these settings.

6.2 The aim is to meet part of the expected impact of demographic change by the development of extra care housing for people with substantial needs. This would be accompanied by action to develop overall capacity within the care economy. The generation of additional capacity can then be used as a lever to promote market change. In this way it should be possible to better match care and nursing home provision to the needs of the most dependent; with special reference to older people with dementias.

6.3 Properly co-ordinated, these shifts could become powerful drivers of better care outcomes at lower costs. This process of reframing and developing the local care economy would be undertaken within agreed and available resource parameters. It would involve continuing dialogue with care providers. The care and choice programme would be underpinned and reinforced by a continuing and developing close partnership working with health, housing, care providers, users and carers designed to secure :

- Provision of improved advice and support to better match care needs and settings with reduced use of care and nursing homes.

- Promotion of low intensity support, self directed care, direct payments together with improved support to carers and a focus on re-ablement as a means of generating care options and enhanced capacity for independent living.
- Commissioning of creative and personalised solutions for improved intensive care at home services making full use of direct payments, individual budgets, telecare, adaptations, carer support and night sitting services and contracting mechanisms to stimulate diversity and development within domiciliary care.
- Reframing of current direct care home provision to meet higher dependency needs and to help effect market shifts so that the vast majority of care and nursing home provision is within single rooms of 12m2, with en-suite facilities and consistent with preferences.
- Use of contracting mechanisms as a direct incentive to the phasing out of shared bedrooms for older people who are not related to one another and to stimulate market change to reframe total provision to modern standards and future expectations.
- Facilitating the development of care settings better able to meet the care requirements of people with special needs for dementia and nursing care and to deliver the right care in the right setting.

6.4 The inclusion of people who self fund their care is an essential element of the Care and Choice vision. Recent research has indicated that nearly a quarter of people who self fund their care may take up care home places through lack of awareness or access to alternatives. This results in higher expenditure on their part than might have been otherwise and results in a higher utilisation of limited care home places than is necessary. It may also lead to people turning to the Council, after a period of time, seeking financial support. This may then become costly to the Council. Less than a third of these people may have had previous contact with social services.

6.5 This research evidence supports our vision of more informed service take up; especially for people likely to be self-funding care on discharge from hospital. Improved assessment services at the time of discharge would provide a valuable opportunity to discuss alternatives and options; and, especially improved carer support, more intensive home care or extra care housing as these services are developed.

6.5 By including “self funders” and promoting better-informed care decisions we can maximise current capacity within the care economy. This will help to manage overall demand for care home provision. This better use of care homes could also help mitigate the impact of an ageing population.

6.6 In terms of accommodation the real change needed is in respect of extra care housing. What we want to see is a range of accommodation and care that ensures real options for:

- people in a range of personal and housing circumstances
- locations that provide a range of facilities and services
- settings that provide for actual and perceived security needs in a scheme and its surroundings
- services that recognise and provide for a diversity of lifestyle choices and cultural needs

- provision of flexible services based on positive contributions and images of life in later life.
- best care value on entry and for the future.

6.7 The model for extra care housing we are proposing reflects this. It is set out in **Appendix F.**

7. The Care Guarantee

7.1 It is likely that some projects relating to council care home provision within the Care and Choice [Older People] Programme will involve:

- development adjacent to existing care settings that may involve some disruption to amenity;
- change to the accommodation of older people within existing care homes or sheltered schemes; and,
- transfer of people to new and permanent or temporary care settings.

7.2 For residents and their relatives affected in this way the prospect of change is likely to be unsettling. The approach to engagement and consultation within the programme will support action to deliver:

- reassurance that rights will be respected and well being safeguarded;
- clear communication of the improved care and support outcomes for people that will result;
- robust project management designed to manage change as it affects people and minimise risk of adverse impacts on them;
- advocacy and support underpinned by social care assessments and care plans; and,
- ongoing and informed discussion with partners and stakeholders within the local care economy.

7.3 Reassurance on both the process and the products of change can be generated in wider consultation and more generally in programme progression. Each project will have its own engagement and care assessment programme. In this way we can ensure that people feel informed and secure about what is happening around or to where they live. Above all, it is vital, throughout the programme that we can demonstrate we understand, care and are committed to listening, learning and responding to what people have to say or are concerned about.

7.4 A proposed **"Care Guarantee"** is reproduced as **Appendix G**. The guarantee takes account of initial feedback. It should help mitigate anxiety around change and facilitate the outcomes for people that are being sought. At the same time, care must be taken not to:

- make promises that cannot be kept; or,
- might not reasonably be expected to be made in the first place; and
- ensure any costs are identified and managed within agreed funds.

7.5 The ability to meet the requirements of the care guarantee would be one of the criteria for project progression. **[Appendix K].** An important principle is

that the care guarantee would be available to all older people affected by change in a particular care setting. It would apply equally to people who fund their own care in any Council or Warwickshire Care Services care home affected by change. The three key elements are:

- **I**f someone has a place in a care home now they will have a place in the future: no one will be without a place to live.
- If someone has to move home permanently, they will not be asked to move more than once; but,
- If a care home is to be replaced, residents have a right to return to it following a temporary move, if that is what they want to do, provided the new setting can still meet their assessed care needs.

7.6 Any costs arising from the Care Guarantee would be met within the overall financial envelope for the Care and Choice programme. [See: Section 13]

8. Consultation and Engagement

8.1 The direction of change envisages people have choice and control over the support they need to live the lives they want. The challenges come in terms of the pace and scale of change expected over the next three years not just on the part of social care but also its partners. The reform agenda will challenge commissioners, providers and service users alike.

8.2 Strong local leadership will be required at all levels to convey the vision and to reach beyond the confines of social care. This will take time and requires an active programme of communication and engagement. Delivering the vision requires consultation and engagement with current service users, carers and supporters of older people and, at more general level, potential future users. It means engaging with people not receiving care/support but who may have expectations about the future.

8.3 Effective consultation and engagement are not only essential but are an indispensable part of the way the Council seeks to work and to improving quality of life. The Local Government and Public Involvement in Health Act, 2007, confers new duties to inform, consult and involve people. In March 2007 Cabinet approved an updated Corporate Consultation and Engagement Strategy. This has been used to frame the approach to consultation and engagement described in **Appendix H.** Consultation is a two way process. The key elements are:

- Continued general consultation on the overall direction we have been exploring following the Cabinet of June 2007.
- Continued and specific consultation at the formative stage with residents and relatives at homes identified for consideration for change prior to any decision about change by Cabinet.
- Ensure arrangements embrace not only what is being proposed [this is what we are thinking of doing] but also the reasoning behind proposals [this is why we are doing it].
- Ensure that prior to making decisions Cabinet has available to it information on the individual assessed needs of all residents and

having taken these into account be satisfied that the proposals would be consistent with those needs in the future.

- Facilitate a range of opportunities to find out about and to comment upon changes and that information is available in appropriate formats and through suitable mechanisms.
- Ensure sufficient time to permit collation of consultation results.
- Be clear that decisions on consultation feedback will be accompanied by reasons.
- Keep people informed of any changes in proposals or timeframes.
- Treat all residents equally and irrespective of whether they are publicly funded or not.

8.4 Homes likely to be affected by change would have equal time to comment on changes. The approach to consultation is intended to be inclusive, user friendly, open and transparent. People will be given sufficient information to be able to comment properly on proposals and have access to independent advice and support as necessary. The **Care Guarantee** is an essential part of the process. So, too, are up to date care assessments and dependency profiles of residents likely to be affected by change.

8.5 Finally, there are legal requirements on consultation that have to be met for residents. If not carried out fairly and properly would risk leaving the Council open to challenge. Effective arrangements for consultation will be a key part of programme development and progression and will be monitored by the officer Programme Board.

9. Staff Engagement and Consultation

9.1 Keeping our staff informed and involved is not only common sense but it will also help in provision of a greater sense of security on the part of residents. If staff, who are affected by change, feel confident and involved then not only is this consistent with their employment rights but also makes the management of change easier. It also removes a potential source of anxiety on the part of residents and relatives who will be concerned to know what will happen to the people who look after them.

9.2 The Information and Consultation of Employees Regulations, 2004, will apply as the need for change in relation to direct services comes within the definition of “recent and probable developments” within adult social care. Information has been shared already and meetings at homes have taken place along with initial consultation with trades unions.

9.3 The regulations allow significant flexibility in arrangements for engagement and consultation with employees The County Council fully supports the concept of collective representation and has established procedures for consulting with staff and unions. Over the last two years Adult Social Care has developed good partnership working unions and staff on effecting organisational change. This can be used and built upon within the Care and Choice programme.

9.4 In particular, the Directorate recognises its responsibility, as far as is reasonably practicable, to promote job security for employees. Where

changes are likely to arise that may affect staff the intention is to ensure that all staff are treated in a far and consistent manner whilst at the same time whilst continuing to ensure the highest standard of care service to residents and the local community.

9.5 Improving workforce mapping and identification of skills and competences across the various sectors of the local care economy required for the future is likely to be running in parallel with this work. The basic message to all staff will be that quality care requires quality people to deliver it and we remain committed to both.

10. Responding to the Balance of Care – Direct Services

10.1 The Council is both a commissioner and a provider of care homes. Cabinet has recognised a need for change. [**Appendix A**]. The approach to date has been to include all care homes provided through Warwickshire Care Services in this review of direct services. If a better balance of care, more appropriate to individual needs and consistent with the general principles of social care reform, is to be delivered the Council needs to influence overall provision and activity by:

- considering the care accommodation roles it could deliver; and
- developing a programme of change that reframes current provision to better meet current and expected future needs; and,
- assessing the extent to which existing design, location and facilities are consistent with expectations on accommodation in later life likely to be used by older people and their relatives when making decisions about future care; and,
- delivering change in a way that safeguards supply, protects rights and leads to a more specialist and specific role within the wider health and social care economy of which care at home, extra care housing and care homes are all a part.

10.2 The sequencing of such a programme would be critical to the delivery of change across the county and in minimising the potential for disruption to residents. There may be a need, initially at least, for additional sites to permit change. It is also possible an eventual programme may result scope for different site use. If so, this could be helpful with emerging work on reducing the need for out of area placements; the provision of care closer to home for adults with learning disabilities; and, by managing local whole service systems in a different way.

10.3 The Programme Board would examine these opportunities consistent with the proposed Agreed Criteria Policy. Given the potential scale of the programme, it would be prudent to provide for a full and formal review of the programme in its third year in 2011-12. The five key aims during this first three year period would be to :

- affirm the intention to remain a significant care home provider within the overall care economy; and,
- ensure the Council can be confident about its ability meet critical aspects of care needs qualifying for publicly funded care; and,
- remodel current provision of care homes to focus on high

dependency groups with special reference for older people with dementia with critical levels of need; and,

- identify locations for the development of extra care housing to help "kick start" wider processes of change necessary to meet the legitimate aspirations of older people now and in the future; and,
- continue to take account of care initiatives within the care economy as a whole and being able to respond to them consistent with the key objectives set down for the programme.

10.4 The proposed year three review would enable Cabinet to assess the how the Care and Choice change programme is progressing against its strategic aims; the reshaping of direct provision; and the extent to which the expected outcomes are being achieved. It would also enable Cabinet to assess future priorities, pacing and direction of travel in the context of latest estimates of need, supply side developments and feedback from older people and their relatives.

10.5 This approach would help ensure a supply of places to the council. It means that directly provided Care Homes for older people, principally those where all existing rooms have en suite facilities that include a toilet would have the certainty of knowing they would not be affected by change before 2013. This broad approach would reduce risk of home "blight" during the intervening period and enables the Council to undertake a full programme review in 2011 –12 to assess progress and shape further direction. It is also a useful signal of an intention to remain a care provider within the overall care economy in the future.

10.6 In general terms major extensions or significant adaptation to existing buildings will be avoided. The risks of disruption to services, noise, dust and general loss of amenity to residents are such, along with the greater risks around costs and loss of income, as to preclude this type of scheme.

10.7 The effects of rising dependency and need for dementia provision would be catered for. **Appendix E [1]** looks at the dependency profile of existing WCC homes. This indicates variations in levels of dependency between homes but a general upward movement between 1996 and 2006. These trends are expected to continue and need to be allowed for. They are likely to become more progressive as Extra Care housing and intensive home care services develop. Those admitted from 2010 onwards are likely to be older, have higher physical dependency and present greater needs around cognitive impairment [mental confusion]. This may have implications for staffing and facilities.

10.8 Services for people with a learning disability are not part of this programme. A new accommodation strategy will be developed consistent with the principles of ***"Valuing People"***. This would focus on care and support linked to person centred plans, provided locally, and maximising opportunities for independent and supported living. A further report for Cabinet decision will be prepared.

10.9 It should also be noted that two WCC/WCS Homes for "younger" people with disabilities are not included in this programme. They are:

- Newlands, Kenilworth

- Mill Green, Newbold on Avon

10.10 The table below sets out the likely future pattern of provision at the time of the year three review if projects progress as anticipated and receive Cabinet approval to proceed on meeting the requirements of the agreed criteria policy.

Table1: Council and Warwickshire Care Services Direct Provision of Care Homes for Older People [2008 and 2011-2012]

Care Homes & Extra Care Provision 2008	**Dependent Elderly**	**Elderly Mentally Infirm**	**Extra care**	**Nursing Care**	**Total Places**
WCC Places [capacity]	359	22	0	Ind sector	381
WCS Places [capacity]	264	67	0	0	331
Total	623	89	0	0	712
Care Homes & Extra Care Provision 2011/12	**Dependent Elderly**	**Elderly Mentally Infirm**	**Extra care**	**Nursing Care**	**Total Places**
Revised Capacity	504	225	192	72	993
Changes in direct capacity between 2008 & 2011/12	-119	+136	+192	+72	+ 281

10.11 It can be seen that there would be real improvements in the balance of care . In summary this would generate:

- Around 200 units of extra care housing of different tenure types
- Around 140 extra places in specialist care homes for older people with dementias
- Nearly 120 fewer places in traditional residential care homes that do not always meet modern spatial minimum standards
- Some 70 new nursing home places
- A solid foundation for dialogue and development pending the outcome of the year three review

10.12 Within the directorate's overall resource envelope the intention would also be to secure an enhancement in provision of intensive care at home support, numbers of supported carers and general delivery of low intensity support to people with moderate needs to help shape future care home provision.

10.13 A programme risk register has been developed and this is reproduced in full as **Appendix I**. The Care and Choice Programme Board will keep the programme risk register under review. The register will also be developed further in line with the Corporate Risk Management Strategy approved by Cabinet in December 2007.

10.4 More detailed, and exempt, information on the potential for reframing of direct provision over the next three years is given in **Appendix J.** This outline would

form the basis of detailed negotiations with Warwickshire Care Services and other partners. It would also be used for consultation and engagement with residents and staff consistent with the policy approach outlined in this report. **Appendix J** is not in the public portion of this agenda for the reasons outlined in the heading of this report.

11. Taking the Programme Forward – Criteria

11.1 The potential scope for change is considerable. It is clear not everything can or should be progressed in one go. Change needs to be managed. To facilitate this project progression criteria have been developed. The aim is for the officer Programme Management Team to use them as a "gateway review" mechanism prior to specific proposals coming to Cabinet for decision. The key criteria are seen as:

- Affordable
- Accessible
- Achievable
- Acceptable

11.2 The advantage of this arrangement is that it establishes a number of general tests that have to be met, and are known to have to be met, before a project can come forward for Cabinet decision on progression.

11.3 An agreed criteria policy is set out at **Appendix K.** The aim is to offer greater clarity and to reduce risk of abortive work and uncertainties around project progression and decision-making. It is inevitable; however, that there may be discrete aspects of individual projects that need to be considered on their merits at the time the project comes forward for decision. Bringing greater security to the process through the development of an agreed criteria policy would not restrict Member discretion in any way. Evidence to support criteria will be required and tested.

11.4 There also needs to be a good understanding, at all levels in all sectors of the care economy and within housing and health, about:

- What will be different [the outcomes]
- When outcomes are expected
- How we will know if they have been achieved.

11.5 The expected benefits or outcomes of the policy being put forward are:

- The likely care needs of older people are mapped and identified.
- Options for market development are identified and validated.
- Understanding of local markets and market influence is improved.
- Direction of travel is developed that is consistent with needs, preferences, priorities and resources.
- Older people who need long term care will have increased choice, receive good quality care and do so at reasonable cost.
- Person centred approaches will be promoted and delivered.
- Social isolation amongst older people will be reduced.
- More older people will live at home and independently within their local community with support of their social networks.

- Reduced reliance on care homes [with and without nursing].
- Funding of demographic change will be made more realisable.
- Care accommodation will be fit for purpose and based on the best possible needs analysis.
- Effective links are made and sustained with wider change agendas being pursued by the Council and its partners.

11.6 Progress in delivery will be monitored and reviewed. Targets for progress will be included within directorate annual business plans. This process monitoring will be supported by annual programme progress reporting to both Cabinet and Scrutiny. This will include information on user and carer feedback and will be publicly available.

12. Taking the Programme Forward – Equalities Impact Assessment [EIA]

12.1 This report focuses on services for all older people including those with dementia or other needs. All service users have their individual needs assessed to ensure their cultural, religious and all other personal needs are considered and planned for.

12.2 An initial equalities impact assessment has been prepared. It is reproduced at **Appendix L.** All the six main equality dimensions are covered. The impact assessment considers the ways in which this policy might affect some groups of people differently.

12.3 The potential of existing homes to discriminate against older people with major impairments [e.g., Incontinence, dementia] is identified. In particular people moving into care homes may become more dependent by virtue of home design and have limited choice about the services provided to them. Much existing care provision is located in buildings that now show the limitations of their design. Whilst dedicated staff add considerable value to the lives of residents, the pattern of care risks being inherently institutional. Home layouts and facilities need to change to be more responsive and reduce the risk of discrimination.

12.4 The general thrust of the policy is seen as respectful of human rights and seeking to promote equalities, health, independence, well-being and choice. The assessment confirms there are no significant adverse impacts on equalities. Arrangements are in place to monitor progress. The officer Programme Management Board would plan to undertake a further EIA in year three. The base year for this purpose will be 2008.

13. Taking the Programme Forward – Resource Parameters

13.1 The Care and Choice Programme contains a number of resource issues. Subject to the year three review, the Council could be looking at a programme with a potential capital investment in the region of £100 –150 million over an 8 – 10 year period.

13.2 The programme also has the potential to generate capital receipts in the region of £25 – £30 million depending on the eventual market balance and

future decisions on its scope. Use can be made of other available funding sources such as Extra Care Housing Grant and Housing Corporation funding to help effect change.

13.3 Each project within the programme would be expected to be financially viable in its own right and to meet the general affordability test outlined in **Appendix K**. As the programme progresses it is likely that some sites can be released and a capital receipt obtained. Whilst these capital receipts will not be ring-fenced to adult social care the source of capital receipts will be kept in mind when structuring Council Capital Programmes during the currency of the Care and Choice Programme.

13.4 In terms of revenue funding, a proportion of the expected annual provision for demographic change should be ring fenced to meet the revenue consequences of the programme. The programme should also be expected to contributed to efficiency gains and to demonstrate better care value overall, subject to any parameters the Council wishes, in policy terms, to set around the balance between direct and independent sector provision. A business case would be needed for any additional resources.

13.5 Stimulation of the independent sector may lead to increased expectations for public funding. At the same time, whilst the national funding regime for social care in England continues, the approach may lead to more people securing care within the independent sector and reduced demand for care through the local authority.

13.6 Equally, stimulation of the independent sector may reduce the need for continued direct provision in some areas. Since the commencement of the needs analysis information on new schemes, within the independent sector, have come to the attention of officers. Significant expansion of relevant services by the independent sector would need to be allowed for. This could, for example, release council resources [capital and revenue] for other social care priorities.

13.7 Costs associated with the care services we have now also need to be taken into account. All the council's homes, including those now with Warwickshire Care Services were originally purpose built. Most were designed for a different level of dependency.

13.8 All have needed improvement over the years to deliver facilities that are consistent with improved access by users. A planned programme of maintenance is in place. Not all homes have all rooms with en suite facilities. Room sizes, layouts and facilities also vary across all the homes.

13.9 There are likely to be transitional costs around the change process. This includes the proposed Care Guarantee. It is intended that these should be met by the setting up of a specific revenue reserve fund able to exist over a number of financial years. The advantage of this model is that it enables costs to be managed and tracked. There would be a single budget manager to ensure effective control.

13.9 In summary, the programme would be progressed and delivered within

agreed resource parameters set by the Council with effective use made of external funding as appropriate. Further information on potential types of cost, sources of funding, cost savings and high level financial risks is set out in **Appendix M.**

14. Recommendations

It is recommended that Cabinet:

- Endorse the whole care economy approach to stimulate the local care economy to secure strategic change; agree the programme's strategic objectives **[4.3];** and the shifts in the balance of care as outlined in this report.
- Confirm that evidence on the needs and preferences of older people should be central to the local change process in shaping the balance of care.
- Approve the commencement of formal consultation with health partners, District Councils, users, carers and the whole social care economy on needs, supply and the future balance of care and the development of extra care housing based on the evidence and findings in **Appendices E.1 – E.3.**
- Approve the Care Guarantee [**Appendix G**] as an interim framework and for consultation with stakeholders, users and carers followed by final decision by Cabinet.
- Note the outcome of consultation to date and approve the approach to consultation and engagement [**8.3 and Appendix H**]
- Agree the outline criteria policy for project progression in relation to Council and Warwickshire Care Services' homes as set out in **Appendix K** for use as a gateway mechanism to bring individual schemes back for Cabinet decision.
- Endorse the governance arrangements [**Appendix B**] together with the initial Equality Impact Assessment [**Appendix L**] and the Programme Risk Register [**Appendix I**]
- Note the likely impact on direct provision of care of the social care reform agenda and the expected future balance of care and the need to reframe current resources as outlined in **Appendix J** subject to the outcome of ongoing consultation and engagement with stakeholders. **[NOTE: APPENDIX J is EXEMPT INFORMATION]**
- Note the intention to use **Appendix J** as a basis for discussion with Warwickshire Care Services [WCS] and more generally on the content of this report.
- Receive a further report on the development of a programme of change within direct provision and WCS services in response to the need for change; consider a phased plan of change as outlined in late Summer/Early Autumn 2008; and, keep under review.
- Confirm that each scheme within the agreed Care and Choice Programme would be expected to be financially viable in its own right; and,
- Agree to undertake a full and formal review of the programme in year three and invite Scrutiny to monitor progress and advise on any key issues on an annual basis.

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Strategic Director of Adult,
Health and Community Services

DAVID CLARKE
Strategic Director of Resources

DAVID CARTER
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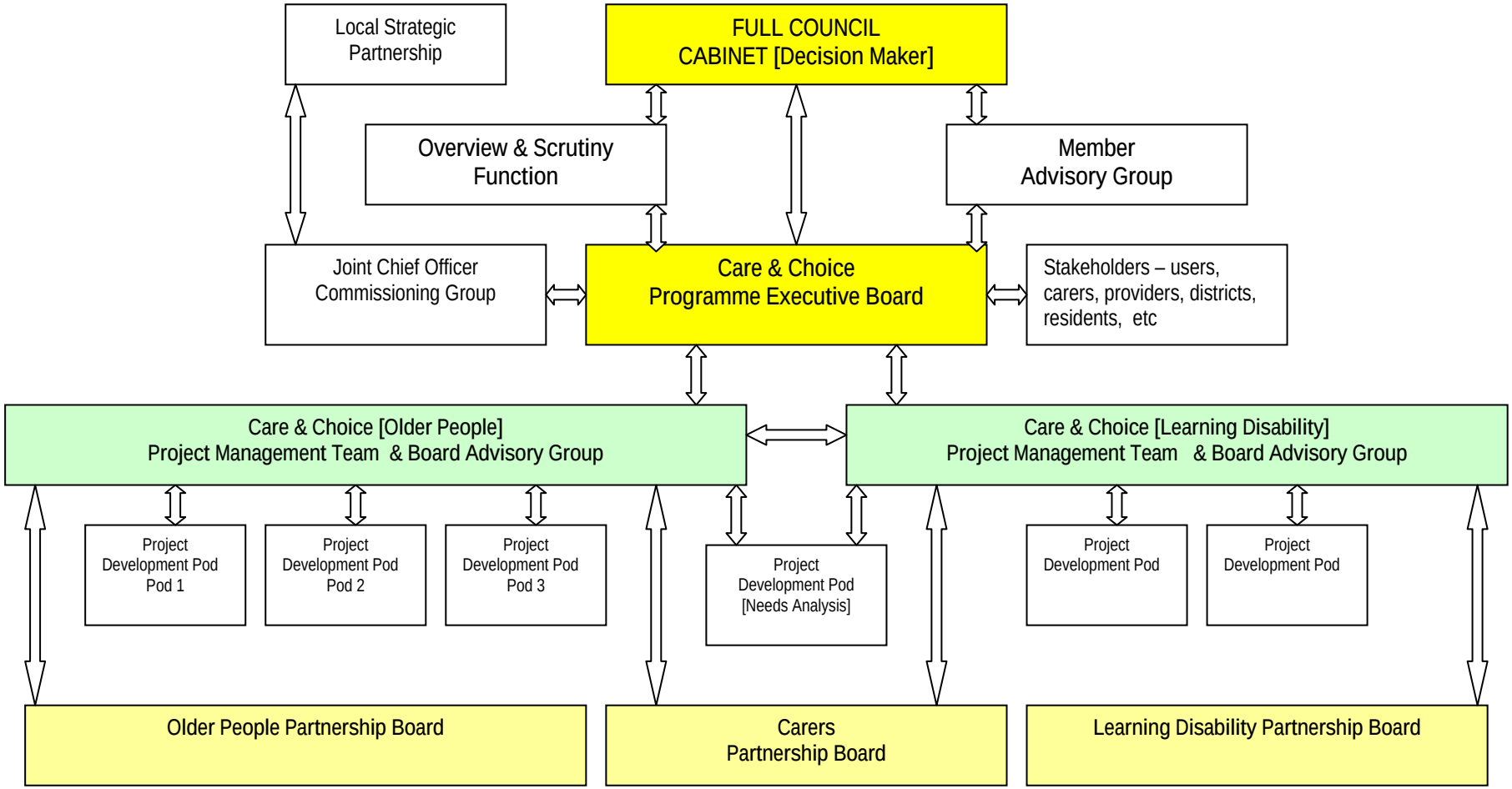
April 2008

APPENDIX B – PROGRAMME GOVERNANCE

CARE & CHOICE PROGRAMME
ACCOUNTABILITY FRAMEWORK [2008]



Note: All project development pods are time limited with memberships specific to issue and led by a project management team member.

APPENDIX C

TRANSFORMING SOCIAL CARE LOCALLY

1. The Local Context

1.1 The Council's core vision matches well with the 2006 White Paper ***"Our Health, Our Care, Our Say"***. This outlined Government's intention to achieve four main goals:

- Provide better prevention services and earlier intervention
- Give people more choice and a louder voice
- Do more on tackling inequalities, social exclusion and improving access to community services
- Give more support for people with long-term needs.

1.2 Consistent with the Council's overall approach, a specific vision for Adult Health and Communities has been developed. This is to:

"Maximise the quality of life of all communities in Warwickshire by working in partnership to reduce inequalities, improve well-being, promote individual independence and enrich people's lives through learning and culture."

1.3 The vision for adult services within the Council has been articulated and shared widely. The focus has been on four principal themes

- Putting people who use services in the driving seat
- Increasing Preventive Services
- Effective Partnerships
- Improving Performance

1.4 Good progress has been made in delivering these themes and in turning the vision into a reality. This progress has been recognised in the improved external annual assessment of performance for adult social care and in two inspections in 2007 covering services for older people and the Supporting People programme.

1.5 At national level the reform agenda continues. Services need to respond to the challenges of demographic change, rising expectations and the increased emphasis on user and carer choice, voice and control. All are linked to the principle of care closer to home and whenever possible and practicable support for independent living within the community. These concepts underpin the approach to strategic commissioning of care and accommodation for older people outlined and approved in reports to Cabinet in 2007.

2. The Impact of "Putting People First"

2.1 The Department of Health wants to see real transformational change within social care over the next three years. Local care systems are to be reframed to deliver support tailored to individuals and local populations irrespective of their circumstances and levels of need. Personalisation and early intervention are seen as key issues for the whole of local government and not just for adult social services.

2.2 On 10 December 2007the first concordat signed by adult social care and health providers across all sectors, the NHS Executive, central and local government, professional bodies and regulations was published. Entitled ***"Putting People First",*** the key elements included:

- giving most people who receive funded care their own personal budgets;
- much closer collaboration between NHS and local government;
- a focus on early intervention and prevention;
- investing in support that tackles loneliness and isolation; and,
- Joint Strategic Needs Assessments undertaken by Councils, PCTs and NHS providers

2.3 Central to the reformed system is local authority leadership and partnership working with the local NHS, other statutory agencies, independent sector organisations, users, carers and the wider community. Shared outcomes are expected to be agreed so that, irrespective of illness or disability, people are able to:

- Live independently
- Stay healthy, recover quickly from illness
- Exercise the maximum control over their own lives
- Sustain family units and age appropriate caring roles
- Participate as active and equal citizens
- Have the best possible quality of life
- Retain maximum dignity and respect.

2.4 All Councils will be allocated Social Care Reform Specific Grant to support delivery. Department of Health Circular LAC [2008] 1, issued in January 2008, sets out the allocations and grant conditions. A bidding process is not involved. The grant funding has to be used to redesign systems, process and transactions to transform service delivery. It has to be used for a range of process re-engineering, capability and capacity building activities required to design an entire system including work by the County Council to:

- Move from traditional service provision focussed on inputs and processes towards more flexible and efficient ways of working that focus on outcomes people want and need and promotes their independence, well-being and dignity.
- Generate a shift from a culture of crisis intervention towards more early intervention focused on independence and well being in line with needs of the local population.
- Engage people more in the design, commissioning, evaluation of service and how their needs are met; ensuring choice and control in every setting at every stage.
- Remodel systems and processes to be more efficient and equitable and recognise the ability of people to spot cost effective personalised solutions.
- Join up services to provide easy to recognise access points with no wrong front doors and an ability to connect with hard to reach people.
- Raise the skills of the workforce and promote new ways of working and new types of worker along with cultural change to deliver new ways or working.
- Generate leadership at all levels of local government and communities to support change.

2.5 Councils are expected to develop their own monitoring plans and delivery arrangements. These are expected to be consistent with the analysis flowing from the local Joint Strategic Needs Assessment on which guidance has been issued. Councils are also expected to work with regional consortia and improvement agencies now and to start to develop and identify local actions needed for service transformation. This includes engaging with other partners, service users and carers, user led organisations and to ensure this work is properly represented in discussions on Local Area Agreements.

2.6 Success will be monitored through improved outcome based indicators, the Care Quality Commissions performance assessment process and under the new arrangements for comprehensive performance assessment [CAA]. In practice what this means is that by 2011 all councils will be expected to have made significant steps towards redesign and reshaping of their adult social care services, having regard to the strategic needs assessments. The key components expected to be in place include:

- Everyone eligible for statutory support should have a personal budget, a clear and transparent allocation of resources, with many more people having the opportunity to take all or part of this budget as a direct payment.

- A strategic balance, based on local needs, between enablement, early intervention and prevention and provision for intensive care support for those with high-level complex need.

- A common assessment framework across health and social care to deliver a more diverse range of local services and solutions, with greater use of self-assessment, supported decision making and appropriate safeguarding arrangements.

- Robust arrangements to ensure that views and experiences of users, carers, user led organisations and other stakeholders are central to every aspect of the reform programme.

- A market development and stimulation strategy with evidence of action to deliver change and meet local needs.

- A workforce, across all sectors, with the capacity, capability and culture needed to deliver choice and support control; with staff trained and empowered to work in support of users to managing risks and resources.

2.7 Any local programme for change needs to be consistent with the social care reform agenda. This suggests that the Care and Choice programme of change should be about generating a new balance of care within which care accommodation services would be located. In doing so the following have to be kept firmly in mind:

1. People Shape Services

- Meet local care and accommodation needs, demographic change, and expectations.
- Sustain and promote independent living and the ability for people to remain in their own homes within supportive communities
- Ensure increased choice and individual control
- Maximise the well-being, dignity, respect and safety of older people

2. Strengthened Performance & Quality

- Raise standards of service and ensure are self sustaining
- Develop a balance of care that promotes independence and meets needs
- Deliver requirements for enhanced care value for those who use services and those who fund or provide them.
- Ensure effective risk management and assurance on care delivery

3. Increased Capability

- Underpin with workforce development and training
- Promote cultural change to support social care reform
- Generate innovative, high quality and flexible care options

4. Shape and Build the Market

- Engage local communities
- Challenge inequalities and narrow the gap of inequality
- Share commissioning intentions with people and providers
- Work in partnership with all sectors to deliver change
- Use local knowledge and experience of services
- Identify priorities and deliver them

2.8 On 13 March 2008 Cabinet supported the principle of personalising care, the need to translate this vision into practical change on the ground and the intention to integrate the reform agenda into social care business planning and service delivery.

APPENDIX D

PREFERENCES OF OLDER PEOPLE

1. Introduction

1.1 The preferences and supports available to older people will have a significant impact on levels of service take up. So, too, will the perception of individuals around the following:

- Basic knowledge that the service exists
- Understanding of extent to which they are able to meet own needs
- Likelihood that they are eligible for the service
- Usefulness if the service in meeting their needs
- Beliefs about likely overall benefits and costs of service take up
- Extent to which their situation in unlikely to change

1.2 It is essential than any approach to market management takes account of these factors along with the likely preferences of older people. There is now a reasonable body of evidence, at national and local level, about preferences for housing, care and support in later life. This can be used, along with data on supply and need, to help shape the approach to future provision.

2. Information from Local Studies

2.1 Locally, discussions have taken place through an Accommodation Strategy focus group. A short questionnaire about future accommodation preferences was circulated through the Warwickshire Older People's Forums Annual Event in October 2006. Whilst remaining to be published formally, the material indicated that the choices for living older people would like to have in the future, when more support is needed, were as follows:

Options	**Responses**
Support to stay in own home:	74
Extra care housing with on-site care	31
Sheltered Housing – with call system	30
Care Village – socially active with care available	37
Care Home – with own room	4

2.2 Knowledge or experience of different options and the descriptors used may have been a factor shaping responses. The balance of preferences between staying at home, specialist housing options and care homes, however, broadly follow the results from other studies most older people preferred to stay where they were.

2.3 Views within the focus group on care villages were interesting. They tended to reflect the findings of the London survey. Having your own front door, flexibility, choice and being affordable were all considered essential. Having a mix of people was also a focus for discussion. This local material suggests that other national and local studies may be helpful guides on needs and expectations around housing in later life pending further local work to shape development of housing with care options. The key words from this work also seem to link to national evidence on: "options", "choice", "control" "social activity", "company" and "independence".

2.4 These local findings match well with those from national and other local councils within the West Midlands Region. The largest of these studies was undertaken by Coventry. Coventry City Council approved an older people's housing strategy in November 2005. As part of this approach, consultation was held with older peoples groups and a lifestyle survey was undertaken.] The focus of their strategy was to:

- Enable older people to maintain their independence by remaining in their own home.
- Make active and informed choices where necessary or desired for suitable housing, care and support while maximising independence and quality of life.

2.5 The Coventry priorities included:

- Developing schemes for older people to live independently in their own homes with support [including floating support] telemedicine, assistive technology and personal care and encouraging use of direct payments.
- Working in partnership with private developers, registered social landlords and others to develop affordable assisted living accommodation including sheltered and extra care housing schemes.
- Enable older people who wish to move to a housing with care and support setting to do so.

2.6 Feedback from the older people's groups confirmed a broad understanding of differences between sheltered schemes, housing with care, residential and nursing care. All groups, however, indicated a need for more information to inform decision-making. The majority wanted to live at home for as long as possible. They would only consider moving to a scheme if there were a particular need. If there was a need for more care and support where they lived now, most wanted to stay in their home *"no matter what"*. Groups felt strongly that they did not want to move into a care home.

2.7 The positives about sheltered type schemes were seen as:

- Improved quality of life
- Social activities
- Safety and security
- Facilities on one level

2.8 Negatives included:

- Leaving own home, neighbours and friends
- Unable to visit usual places
- Loss of independence
- Relying on others for support and care
- Room sizes and space
- Design issues: noise, layout, potential isolation

2.9 Nearly a 1000 people took part in the Coventry older people's lifestyle survey. Around three quarters owned their own home. The majority of these had lived in the same home for over 20 years. Just over half lived on their own. Their preferences about a new home, if they had to move, were:

- Relocate within Coventry 64%
- All on one level 42%
- Near to amenities 36%
- Support and care available 32%
- Easy to heat 32%

2.10 In terms of housing schemes for older people just over half of respondents were aware of sheltered housing in Coventry. The key benefits of such schemes were seen as:

- 67% safety and security
- 51% personal support
- 51% independent living
- 40% facilities on site or nearby

2.11 If respondents needed to move into a housing scheme nearly two in five preferred sheltered housing and a third housing with care schemes. Two thirds indicated a need for two bedrooms. Only 15% indicated preference for a care home. People from black and minority ethnic groups were more likely to want to live with relatives if they needed to move somewhere with care. There were clear locality preferences about where people would wish to live.

3. National Studies

3.1 This information coheres well with other material from national studies. ***Public Services for Tomorrow's Older Citizens [2005],*** produced and agreed by key organisations in 2005 was concerned with the commissioning, provision and performance review of public services for older people. It brings together the research messages from a number of sources. This wide ranging paper identified eight building blocks to meet the challenge an ageing population presents:

- Vision and culture to underpin a quality of life and well being approach
- Addressing ageism and discrimination
- Addressing poverty and the legal and financial architecture that underpins income in retirement
- Information and resources for choice and control
- Addressing the failure of the market to deliver the type of products and services that older people want
- Promoting a quality of life and well being approach
- Developing a broader set of housing and support options
- A stronger and more comprehensive strategic, resourcing and commissioning framework.

3.2 The key message around housing was the wish for a broader set of options. The circumstances of individual older people, of course, are very varied. ***"Planning for the Majority" [2002]*** emphasises that most older people do not require specialised housing and that their choices are shaped more by lifestyle preferences than by frailty.

3.3 The complexities surrounding what "extra care" housing represents and offers tend to be reflected in the understanding older people have of the term. This understanding has to be considered in the wider context of their needs and aspirations around their quality of life and its enhancement. ***"Adding Quality to Quantity"[2002]*** suggested a number of main themes:

- Having good social relationships – family, friends, neighbours
- Having social roles and activities
- Having good health and functional ability
- Living in a good home and neighbourhood
- Having a positive outlook and sense of well being
- Maintaining independence and control
- Having an adequate income

3.5 These themes have been picked up in a number of other national surveys. As people get older their housing situation becomes inextricably linked to their financial, practical, social, health and care needs. ***"Quality and Choice for Older People's Housing" [2001]*** considered attitudes to "staying put – moving on" options. It referred to an Anchor survey that suggested:

- 66% of older home owners wished to stay in their existing homes
- 30% would consider moving on options, mainly to smaller accommodation

3.6 Whilst it is suggested there is potentially a serious unmet demand for suitable small accommodation other research also affirms a preference for living at home with assistance over other options. There is also strong evidence of preference for sheltered housing over care homes in ***"What do they really think***" [1996].

3.7 Some research has also sought to examine whether there may be differences between people who might be called the 'pre 1948 grateful' generation and the 'baby boomer' generation, that is people who are 50 today. The interest is whether the latter group may have a different view about how things should be for them, as they get older. The indications are that they may expect and even demand more and not accept poor standards: voice, choice and control are likely to be key elements. On the issues of staying at home, retaining independence views tend to be much the same as for older people now.

3.8 ***"Looking Forward to Old Age"***, ***[2005]*** outlined the results of a study by the King's Fund undertaken in London in 2004, involving people in their 50's. The findings from this study in London suggest that the following issues meant something to a group of people in their fifties:

- Care provision was seen as a right that had been earned and expectation of services was higher.
- Age discrimination and ageism were seen as impeding access to good quality services for older people.
- Choice and maintaining independence were key aspects of quality services and respecting individuality.
- Ability to secure assistance that helped sustain independence, social contact and involved them rather than did things for them.
- Staying in one's own home was generally desired as was the ability to keep up social networks, interests.
- Access to information for decision-making and choice.
- Information, advice and advocacy services were seen as important.
- Services should be dependable, reliable, offer continuity, be safe, and undertaken by competent staff who were valued and in turn displayed positive attitudes towards older people.
- Security
- Transport
- Prospect of residential care was disliked in terms of loss of independence and perceived quality of what was available now.

3.9 Within this King's Fund study, housing and environment issues were very important. Key themes to emerge were:

- Staying at home for as long as possible was generally desired.
- Respondents disliked the idea of residential care because of a perceived loss of independence and concern about standards.

- Perceptions of "retirement communities" varied with a preference for mixed communities over those just for older people.
- Most saw sheltered housing as an acceptable option if people needed care
- Location, accessibility, and space are likely to be issues; but
- When to move was a difficult issue – moving to sheltered housing was still a big step
- Feeling safe and secure was important in later life.

3.10 ***"When I Get Older"[2004]***] was a survey of just over 1000 people by the Commission for Social Care Inspection (CSCI). This paper sends a key message: above all else, people under 60 preferred to stay in their own homes as they get older and need social care or support. People would choose to receive social care in their own homes or move to a smaller house before considering other options such as sheltered housing or residential care. Preferences were expressed as follows:

- 62% preferred to stay in their own home and receive support from friends and family
- 56% preferred to stay at home with care and support from trained care workers
- 39% would consider moving to a smaller home of their own to make it easier to retain their independence.
- 27% would consider some kind of sheltered accommodation with a warden
- 25% would consider sheltered housing with a warden and other social care services and social activities
- Women were more likely than men to prefer sheltered accommodation with other social care services
- 11% would move to live in a care home with only 7% being prepared to consider a council run home.
- In terms of care support where they are now living, the desire for independence, choice and control is strong: own room, allowed to come and go freely, access to transport, visitors and feeling safe.

3.11 Hopes and concerns can change over time. Concerns about having enough to live on in the approach to retirement may be replaced by fears about losing independence and becoming a burden later on. Issues older people face will relate closely to how they are getting older.

3.12 Approaches to accommodation issues in later life need to respond to the hopes and concerns people have. Older people are very clear that independence is about more than being able to do things for themselves. It is equally about choice, control and fulfilling lives. The information available nationally suggests approaches to accommodation need to be located within a move from the traditional agenda of prevention and support associated with health and social care to a much broader one around quality of life of which housing and the home is an integral part.

3.13 **Securing Good Care for Older People [Wanless] 2006** brought together evidence on people's preferences should they need care. In terms of service mix, most people preferred to receive care at or close to home. Despite preferences, many older people still found themselves in a care home. Family members were often influential in the decision making. Most would prefer prevention rather than cure. The report considered preferences from a range of sources in addition to those above.

3.14 A national survey of older people published in 1994 found that after the onset of significant disability more than four fifths of older people wished to remain in their present homes. Another study at around the same time found similar results but with some being prepared to consider sheltered housing.

3.15 In the event of disability three quarters of older people surveyed in 1999 indicated they would rather stay in their own home and have them adapted rather than move. Another study, published in 2000, indicated that 92% were against the residential care option.

3.16 There are critical, and the main generally consistent messages here for the development of accommodation strategies for older people: staying at home, being supported to remain independent, remaining in control and having services and accommodation that meet needs and preferences.

APPENDIX E [1]

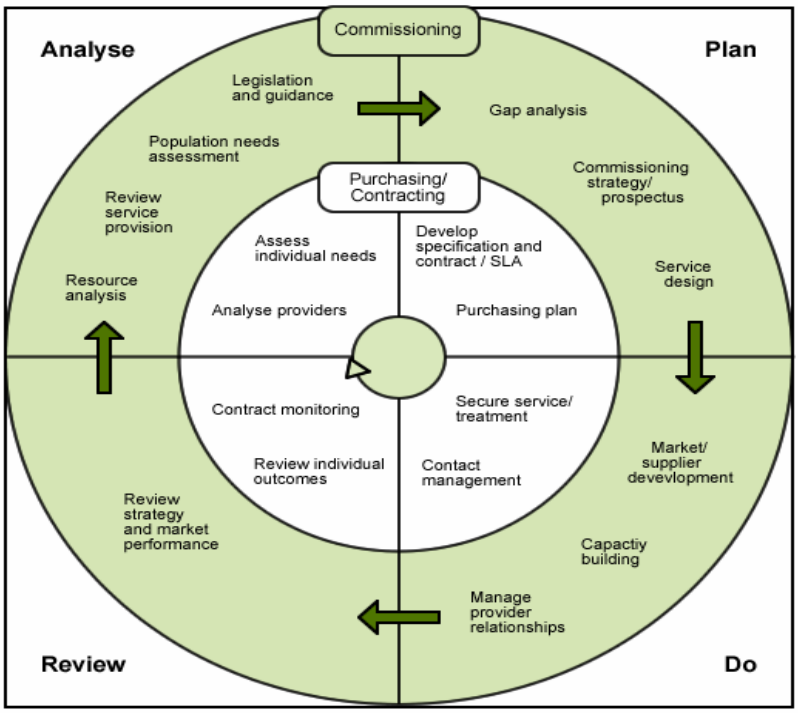
STRATEGIC NEEDS ANALYSIS

OLDER PEOPLE: CARE, SUPPORT & ACCOMMODATION

1. Introduction

1.1 Matching need for accommodation, support and care with the supply of such services and ability to meet demand and expectations for them is a key function of commissioning bodies. A diagram showing the model used for operational and strategic commissioning is reproduced below:

Diagram 1 – Joint Commissioning for Public Care



Source: IPC

1.2 This model makes clear that we have to bring a number of factors together at strategic level [the green ring] before we can get into operational commissioning activity. They are:

- Need: Potential need for care, support and accommodation services
- Supply: Current provision of care, support and accommodation services
- Demand: Factors affecting take up and likely user and carer preferences and impact on existing and future supply
- Market Gaps: Mapping the difference between what we have, what we do and what we will need in future.

1.3 These issues have to be understood, also, across the whole care economy and not just that of publicly funded care. One reason for this is that there is a lot of informal care. Another is that a significant number of people commission their own care through use of benefits and their own resources. Not to include people who self commission care [often call self funders] also risks overstating need in relation to supply and demand for care and support within the balance of care model we will be using.

1.4 This appendix deals with need. Care supply is considered in Appendix **E [2**] and **Appendix D**] looks at preferences. **Appendix E.3** looks at gaps and proposes the future balance of care.

1.5 Feedback from local commissioning and evidence about the expectations and preferences of older people who use services now or might do so in future are essential components to ensuring continued relevance of the Care and Choice Programme that is being developed. Mechanisms need to be in place to capture and analyse this information. Strengthening capacity in this area would be helpful and at national level there are additional tools that would assist.

1.6 What the model in Diagram 1 also confirms is that before commissioning care, support and accommodation we need to understand the health, social and demographic factors that underpin demand for care and support. These drivers of demand for health, housing and social care support in later life include:

- Demographic change and increased numbers of older people
- Disability and dependency
- Mental disorders [Dementia and Depression]
- Living Alone, Loneliness and social isolation
- Low Incomes and economic disadvantage

2. Demographic Change

2.1 The most significant impact on the likely demand for future care and support will come from demographic change. Warwickshire's population has been growing for the past three decades. The rate of growth has exceeded regional and national levels. Population projections suggest that the largest proportionate population increase will occur in the older age groups.

2.2 The past ten years have seen older people make up a proportionately larger share of the population of Warwickshire. This increase is expected to continue with the proportion of over 65 year olds increasing from 16% in 2006 to 22% in 2028. **Tables 1-3** below give data for the years 2001, 2011 and 2021. They indicate that all districts will experience an increase in the number of older people. The highest rate of increase is likely to occur in Stratford on Avon and the lowest in Warwick.

2.3 Generally speaking for most, but not all, the years between 65 and 74 are those of active "retirement". Above this age the need for assistance with activities for daily living as a result of increasing frailty and onset of disability increases steadily. In the 85 and over age group women will outnumber men. These aspects are covered in more detail in later sections of this needs analysis.

Table1: Number of Older People by District, 2001

District	65 - 74	75-84	85+	Total
North Warwickshire	5,204	3,134	951	9,289
Nuneaton & Bedworth	9,848	6,121	1,708	17,677
Rugby	7,272	5,068	1,710	14,050
Stratford on Avon	10,680	6,907	2,621	20,208
Warwick	10,537	7,496	2,609	20,642
Warwickshire [Total]	43,541	28,726	9,599	81,866

Source: 2001 Census

APPENDIX E [1]

Table 2: Estimated Number of Older People 2011

District	65 - 74	75-84	85+	Total
North Warwickshire	6,600	3,700	1,300	11,600
Nuneaton & Bedworth	11,900	6,700	2,400	21,000
Rugby	10,000	5,900	2,500	18,400
Stratford on Avon	14,300	8,400	3,300	26,000
Warwick	12,300	8,000	3,400	23,700
Warwickshire [Total]	54,100	32,500	12,700	99,300

Table 3: Estimated Number of Older People 2021

District	65 - 74	75-84	85+	Total
North Warwickshire	7,700	5,000	1,700	14,400
Nuneaton & Bedworth	13,800	9,000	3,300	26,100
Rugby	10,000	7,400	3,000	20,400
Stratford on Avon	16,900	11,900	4,600	33,400
Warwick	14,100	10,000	4,400	28,500
Warwickshire [Total]	62,500	43,400	17,000	122,900

Source Tables 2 & 3 – 2004 ONS Population Estimates

2.4 The real impact on health, social care and housing will be the increases in the numbers of older people aged over 75 and 85. Take up of care and support is highest in these age groups. **Table 4** below shows the percentage changes we might expect using 2001 as the base year. The 85-plus age group is expected to increase by approximately 77% between 2001 and 2021. The highest percentage change would be in Nuneaton and Bedworth.

Table 4: Percentage Change on 2001, populations of older people 2001 and 2021

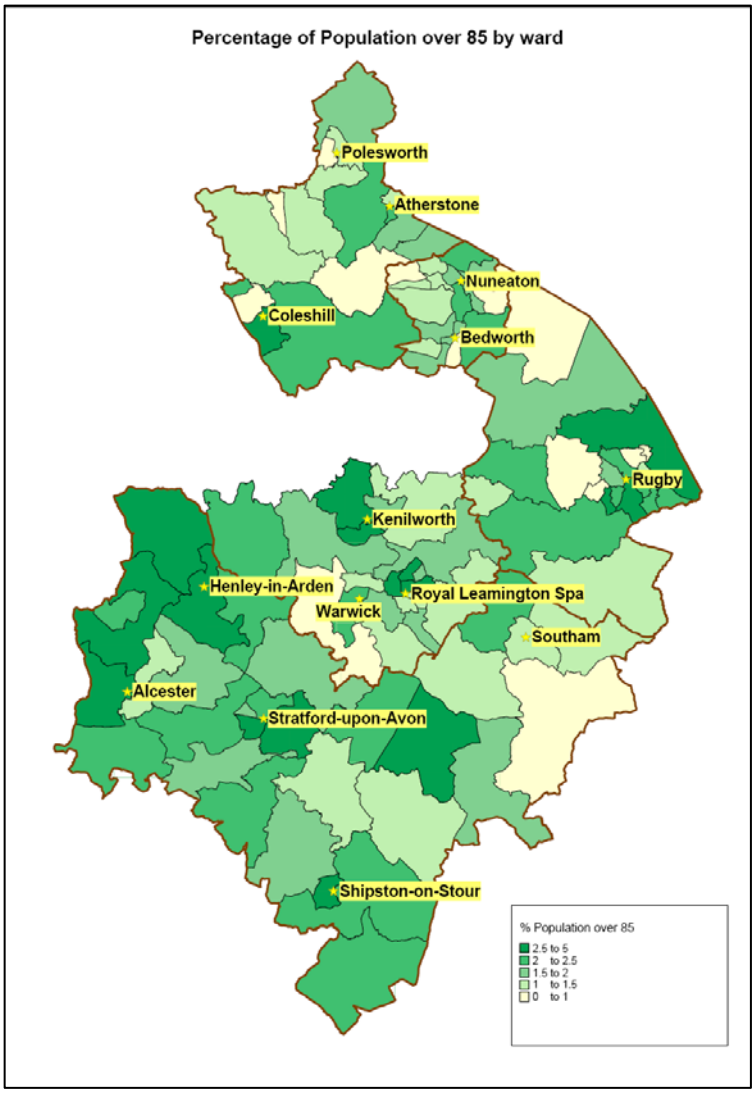
District	65 – 74 % change on 2001	75-84 % change on 2001	85+ %change on 2001	Total % change on 2001
North Warwickshire	48%	60%	79%	55%
Nuneaton & Bedworth	40%	47%	93%	48%
Rugby	38%	46%	75%	45%
Stratford on Avon	58%	72%	76%	65%
Warwick	34%	33%	69%	38%
Warwickshire [Total]	44%	51%	77%	50%

APPENDIX E [1]

3. Where Older People Live

3.1 Map 1 below shows the percentage of older people by Wards at the time of the 2001 Census who were aged 85 and over. It shows that some parts of the County contain more older people than others but does include institutional populations. Knowing where these relative concentrations of older people are now and having an idea of where they are likely to be in the future will help in thinking about where convenient and accessible services might best be located. Further work is needed on this aspect. It will form part of ongoing modelling work within the strategic commissioning process and as the local Joint Strategic Needs Assessment develops.

Map 1 – Ward distribution of people aged 85 and over [2001 Census]



4. Black and Minority Ethnic Elders

4.1 Older people are not a homogenous group. It is important that advice and support services are sensitive to a range of factors. One of these is diversity. The importance of culturally sensitive services has been recognised by the Council. At the time of the 2001 census there were nearly 4,200 people from black and minority ethnic groups aged 65 and over within the County. The number of elders from black and minority ethnic groups is likely to increase and a provisional estimate has been made.

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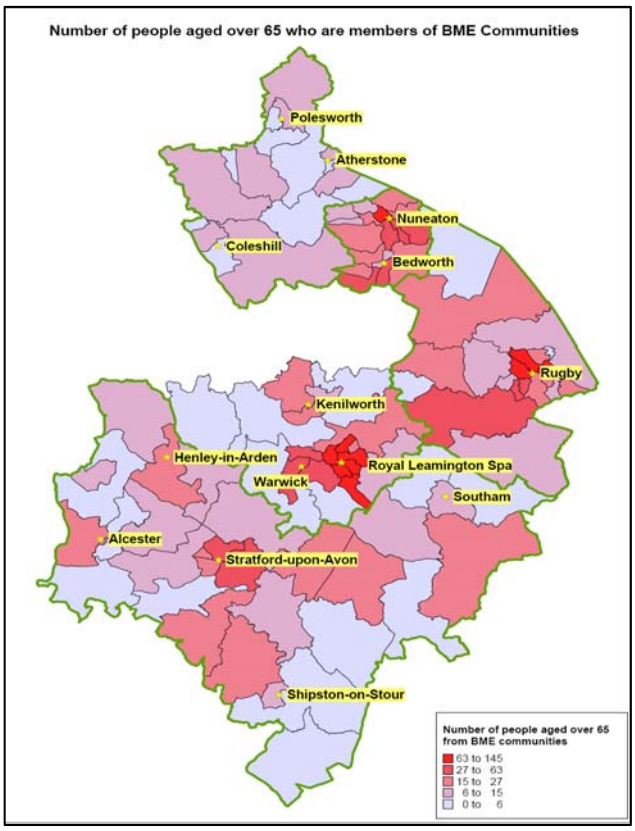
Table5: Older People from Black and Minority Ethnic Groups 2001, 2011 & 2021.

District	Year	BME 65-74	BME 75+	Total
North Warwickshire	2001	136	101	237
	2011	173	123	296
	2021	201	165	366
Nuneaton & Bedworth	2001	480	258	738
	2011	579	300	879
	2021	672	405	1077
Rugby	2001	600	379	979
	2011	825	469	1294
	2021	825	581	1406
Stratford on Avon	2001	320	273	593
	2011	429	335	764
	2021	507	473	980
Warwick	2001	1014	619	1633
	2011	1184	700	1884
	2021	1358	884	2242
Warwickshire [Total]	2001	2550	1630	4180
	2011	3190	1927	5117
	2021	3563	2508	6071

Note: BME includes White Irish and White Other due to recognised specific needs. The predictions for numbers of BME in 2011 and 2021 are based on the percentage of older people who are BME remaining constant.
Data Source: 2001 Census and 2004 population estimates/commissioning

4.2 The population of people from black and minority ethnic [BME] groups is distributed unevenly. Rates per 1000 population tend to be higher in urban areas as shown in the map [Diagram 2] below. This helps to identify areas where specialist services may be relevant. It also confirms the complexity of responding to needs across a wide area with few major concentrations of black and minority ethnic elders.

Diagram 2 – People aged 65 and over [2001] from BME groups



APPENDIX E [1]

4.3 Within adult social care information is collected on self perceived ethnicity as a matter of good practice. Care records indicate that take up of adult social care services generally follows this pattern. Further work is to be undertaken to assess over or under representation at District level. The number of service users in each district and as a percentage of services users in that district are shown in the tables below:

Table 6a: Adult Social Care - Number of BME Service Users

	60-74	75-84	85+	Total
North Warwickshire	2	10	3	**15**
Nuneaton and Bedworth	91	67	14	**172**
Rugby	31	47	31	**109**
Stratford	9	18	25	**52**
Warwick	37	68	52	**157**
Warwickshire	**170**	**210**	**125**	**505**

Source: Strategic Commissioning, Care First

Table 6b: Adult Social Care - Percentage of BME Service Users

	60-74	75-84	85+	Total
North Warwickshire	1%	3%	1%	**2%**
Nuneaton and Bedworth	20%	10%	2%	**10%**
Rugby	14%	12%	6%	**10%**
Stratford	3%	3%	3%	**3%**
Warwick	11%	12%	6%	**9%**
Warwickshire	**12%**	**8%**	**4%**	**7%**

Source: as above

5. Disability and dependency in later life

5.1 An increase in the number of older people does not of itself mean that more services are needed. Older people are as much a resource as they are a potential source of demand for care, accommodation and support. Many voluntary groups and communities would struggle without the support of older people. Keeping fit, active, healthy and engaged in local communities helps sustain morale and capacity for independence. Sustaining these aspects through low intensity support and wider approaches to healthy living and active citizenship can make a real difference to the point at which need for care and support arises. They are essential elements of independence, well being and choice.

5.2 Generally speaking, however, dependency increases with age. Just under a third of older people have some form of disability. Of those aged 75 and over some two thirds may be expected to have disabilities. In terms of care and support what we need to understand is:

- the prevalence and the severity of disability; and
- the impact of disability on functioning either at home or in care homes

5.3 There are a number of sources of information that can be used to estimate levels of dependency amongst older people. They are:

- 2001 census provides information on self reported limiting long term illness.
- Health Survey for England [2000]
- Health Survey England [2005]
- OPCS surveys of disability in Great Britain Report 1, 1989
- Dementia UK [2007]

APPENDIX E [1]

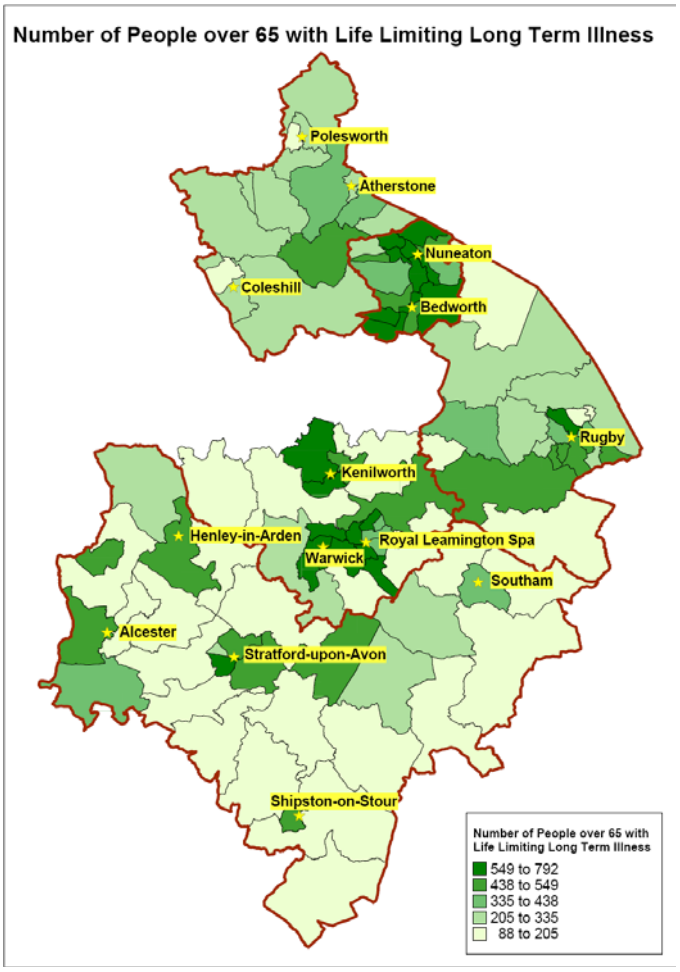
Table 7: Older people reporting limiting long term illness and as percentage of age group

District	Limiting Long Term Illness 65+	% of population 65+
North Warwickshire	4,698	51%
Nuneaton & Bedworth	9,349	53%
Rugby	6,332	45%
Stratford on Avon	8,283	41%
Warwick	9,063	44%
Warwickshire [Total]	37,725	46%

Source: 2001 Census

5.4 There were some clusters of older people who said they had a life limiting long term illness (LLLTI) in the 2001 census. These concentrations were in the urban areas, particularly Nuneaton, Bedworth, Warwick, Leamington and Kenilworth. This is not unexpected as there are correlations between deprivation and life limiting long term illness. Information for the county as a whole is shown in the Map below. Data include institutional populations.

Map 3: Number of people over 65 with Life Limiting Long Term Illness



Source: 2001 Census

APPENDIX E [1]

6. Assessing the Prevalence and Severity of Disability

6.1 Whilst the information on limiting long term illnesses is helpful, what is critical in terms of social care and support is an understanding of the relationship between impairment, disability and handicap. Disability can exist along on a continuum across a number of dimensions. It may range from slight to very severe in terms of ability to do things.

6.2 Earlier work by OPCS has been used to estimate numbers of older people with different levels of severity of disability in terms of the restriction or lack of ability to perform normal activities as a result of some physical, mental or sensory impairment. Whilst this study is some 20 years old, it remains one of the largest undertaken and a recent literature review has pointed to its continued relevance. This OPCS study uses a ten point scale with 10 being the highest and 1 the lowest.

6.3 The tables below provide estimates of numbers of older people with disabilities according to the severity of that disability. Many disabilities arise as a consequence of the ageing process. Almost 70% of adults with disabilities are estimated to be aged 60 and over with nearly half being aged 70 or over. It confirms there are more women with disabilities than men partly because women live longer than men.

6.4 The very elderly predominate in categories 9 and 10. The rate of disability at this level of severity was shown not to rise steeply until age 70 and then rose very steeply after 80. This matches with local experience in the take up of care and support services. Of those in category 10 half were estimated to live in communal establishments. The majority had more than one type of disability. The most common was locomotor, followed by hearing and personal care disabilities.

6.5 In the tables that follow, the severity categories used by OPCS have been mapped to the Fair Access Criteria used for the allocation of resources. It is not a perfect match as the table shows. It does offer an approximate framework, however, with which to assess likely need and to relate this to supply and take up to identify gaps both now and in the future. It also helps in making sense of the categories in terms of the appropriate balance of care and support to respond to the different levels of need.

Table 8: Warwickshire Estimated Number Older People with disabilities 2006/07

OPCS Severity Category	Fair Access Category	60 – 74 men	60 – 74 women	75+ men	75+ women	Total Prevalence
10	**4**	192	161	344	1134	1831
9	**4/3**	460	563	705	1436	3164
8	**3**	536	523	705	1310	3074
7	**3/2**	575	764	705	1764	3808
6	**2**	613	925	672	1739	3949
5	**2**	958	1327	968	1915	5168
4	**1**	1149	1206	968	1562	4885
3	**1**	1455	1447	984	1613	5499
2	**1**	1992	1648	1197	1663	6500
1	**1**	2911	2050	1492	1764	8217
All categories		10841	10614	8740	15900	46095

Source [All tables] OPCS survey data 1989,using 2006 ONS mid year estimates.

APPENDIX E [1]

Table 8a: North Warwickshire Estimated Number Older People with disabilities 2006/07

OPCS Severity Category	Fair Access Category	60 – 74 men	60 – 74 women	75+ men	75+ women	Total Prevalence
10	**4**	24	19	38	108	189
9	**4/3**	58	67	77	137	339
8	**3**	67	62	77	125	331
7	**3/2**	72	91	77	168	408
6	**2**	77	110	74	166	427
5	**2**	120	158	106	182	566
4	**1**	144	144	106	149	543
3	**1**	182	173	108	154	617
2	**1**	250	197	131	158	736
1	**1**	365	245	164	168	942
All Categories		1359	1266	958	1515	5098

Table 8b: Nuneaton & Bedworth Estimated Number Older People with disabilities 2006/07

OPCS Severity Category	Fair Access Category	60 – 74 men	60 – 74 women	75+ men	75+ women	Total Prevalence
10	**4**	42	36	69	230	377
9	**4/3**	100	126	142	291	659
8	**3**	116	117	142	265	640
7	**3/2**	125	171	142	357	795
6	**2**	133	207	135	352	827
5	**2**	208	297	195	388	1088
4	**1**	249	270	195	316	1030
3	**1**	315	324	198	326	1163
2	**1**	432	369	241	337	1379
1	**1**	631	459	300	357	1747
All Categories		2351	2376	1759	3219	9705

Table 8c: Rugby Estimated Number Older People with disabilities 2006/07

OPCS Severity Category	Fair Access Category	60 – 74 men	60 – 74 women	75+ men	75+ women	Total Prevalence
10	**4**	33	27	61	194	315
9	**4/3**	79	94	125	245	543
8	**3**	92	87	125	224	528
7	**3/2**	99	127	125	301	652
6	**2**	106	154	119	297	676
5	**2**	165	221	171	327	884
4	**1**	198	201	171	267	837
3	**1**	251	241	174	275	941
2	**1**	343	275	212	284	1114
1	**1**	502	342	264	301	1409
All Categories		1868	1769	1547	2715	7899

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Table 8d: Stratford on Avon Estimated Number Older People with disabilities 2006/07

OPCS Severity Category	Fair Access Category	60 – 74 men	60 – 74 women	75+ men	75+ women	Total Prevalence
10	**4**	50	41	84	297	472
9	**4/3**	119	144	172	376	811
8	**3**	139	134	172	343	788
7	**3/2**	149	196	172	462	979
6	**2**	158	237	164	455	1014
5	**2**	248	340	236	502	1326
4	**1**	297	309	236	409	1251
3	**1**	376	371	240	422	1409
2	**1**	515	422	292	436	1665
1	**1**	752	525	364	462	2103
All Categories		2803	2719	2132	4164	11818

Table 8e: Warwick Estimated Number Older People with disabilities 2006/07

Severity Category	Fair Access Category	60 – 74 men	60 – 74 women	75+ men	75+ women	Total Prevalence
10	**4**	44	37	90	297	468
9	**4/3**	104	130	185	376	795
8	**3**	122	121	185	343	771
7	**3/2**	131	177	185	462	955
6	**2**	139	214	176	455	984
5	**2**	218	307	254	502	1281
4	**1**	261	279	254	409	1203
3	**1**	331	335	258	422	1346
2	**1**	452	381	314	436	1583
1	**1**	661	474	391	462	1988
All Categories		2463	2455	2292	4164	11374

Source all tables: 2006 mid year estimate, ONS and 1989 OPCS estimates of Prevalence

6.6 The Health Survey for England has looked directly at health needs of older people in 2000 and again in 2005. The 2000 survey compared populations in care homes with those living at home. It confirmed that people living in care homes had, roughly, double the prevalence of long standing illness and at least one disability compared with people in private households:

- Three in four residents in care homes were severely disabled with one or more disability.
- Women had higher rates of disability than men.

6.7 Three quarters of care home residents were women. The main domains of functional activities for daily living were locomotor, seeing, hearing, communication and daily living. Information on four domains is given below:

Domain	Care Homes		Private Households	
	M %	F%	M%	F%
Locomotor	76	81	30	33
Personal care	58	66	14	14
Hearing 80+ years	31	36	24	21
Seeing 80+ years	27	31	15	11

Source: Health Survey for England, 2000

APPENDIX E [1]

6.8 The prevalence and severity of the various different types of locomotor and personal care disability were examined. Some 71% of men and 74% of women aged 65 and over in care homes were reported to gave difficulty in walking 200 meters. Among these, 40% of men and 46% of women had experienced difficulty in walking even a few steps [classified as severe disability].58% of men and 66% of women in care homes reported that they could not walk up a flight of steps at all [severe disability] compared with only 7% of men and 8% of women in private households.

6.9 The most common personal care needs reported by those in care homes were with dressing and undressing and getting in and out of bed. Levels of disability tended to be severe with 44% of men and 50% of women unable to get dress/undressed without help and 25% of men and 42% of women unable to get in and out of bed unaided. A further Health Survey England report for 2005 confirmed:

- More than half of those over 65 said their health was good or very good.
- Some 71% reported longstanding illness and some 42% of men and 46% of women said that their illness limited their activities in some way.
- Prevalence of functional limitation increased with age with some 17% of men and 19% of women aged over 85 reporting three or more limitations.
- Some 21% of men and 22% of women over 65 said they had bladder problems.
- By the age of 85, over 35% of men and 56% of women were walking impaired.
- The ability to balance declined with age for both men and women.
- Some 23% of men and 29% of women over 65 had fallen in the last 12 months.
- The proportion of women requiring treatment following a fall rose from 29% for those aged 65-69 to 42% of those aged 85 and over.
- Cardiovascular disease was the more common chronic disease reported by men aged 65 and over. Prevalence increased with age with 43% of men and 45% of women aged 85 and over reporting CVD.
- Some 13% of men and 10 % of women over 65 reported having diabetes.
- Arthritis was the most prevalent chronic disease and was reported by 37% or men and 47% of women. Prevalence increased with age.
- Some 62% of men and 64% of women over 65 were hypertensive with prevalence reaching a peak for the 80-84 age group.
- The annual GP contact was just under 7 visits a year.

6.10 Locally, periodic dependency studies have been undertaken of residents at Council owned care homes for older people. The Crichton scale was used to assess this. The tables below use material from two surveys. One was undertaken in 1996 and the most recent in 2006. The results are summarized in the two tables below.

Table 10 [a]: Dependency of residents in Warwickshire Care Homes - 1996

	Dependency Category						
	1	**2**	**3**	**4**	**5**	**6**	**7**
Home A	46%	62%	96%	19%	35%	54%	77%
Home B	38%	55%	93%	24%	45%	76%	79%
Home C	33%	50%	88%	13%	50%	63%	63%
Home D	29%	38%	86%	14%	38%	38%	57%
Home E	27%	62%	92%	23%	62%	73%	77%
Home F	36%	33%	70%	6%	15%	61%	67%
Home G	39%	65%	87%	30%	61%	43%	43%
Home H	29%	54%	92%	21%	63%	83%	88%
Home I	50%	46%	86%	18%	50%	54%	54%
Home J	24%	48%	83%	28%	34%	79%	62%

APPENDIX E [1]

Table 10 [b] - Dependency of residents in Warwickshire Care Homes - 2006

	Dependency Category						
	1	**2**	**3**	**4**	**5**	**6**	**7**
Home A	22%	63%	91%	9%	44%	47%	66%
Home B	40%	60%	93%	3%	53%	63%	83%
Home C	33%	55%	88%	3%	39%	24%	52%
Home D	31%	57%	89%	20%	20%	37%	49%
Home E	15%	35%	91%	6%	6%	21%	38%
Home F	30%	42%	79%	18%	21%	18%	52%
Home G	19%	32%	90%	3%	26%	48%	61%
Home H	27%	73%	100%	80%	70%	60%	80%
Home I	17%	29%	89%	0%	20%	57%	49%
Home J	11%	46%	86%	11%	40%	40%	60%

Source: Commissioning /Local Provider data [Crichton Scales]

1 Percentage of residents fully ambulant or usually independent
2 Percentage of residents able to dress correctly or with minimum supervision
3 Percentage able to feed themselves or with minimum supervision
4 Percentage of residents able to bathe with minimal supervision
5 Percentage of residents with full control of continence
6 Percentage of residents with complete memory or only occasionally forgetful
7 Percentage of residents fully oriented or oriented in home – identifies people correctly.

6.11 The two surveys were undertaken by different people and the most recent is approaching two years old. There is therefore the possibility that there may be some variations in completion and further shifts in dependency arising from disability. On the whole the data appear to have a measure of consistency with other data within this Appendix. Only in one case does there appear to be variation that might require some further review. In general terms, however, it does seem possible to draw some general conclusions from these exercises. They are:

- There has been a general increase in dependency
- There is a degree of variation between homes but a general consistency for individual homes over time.
- A general deterioration in locomotor ability which suggests more people need assistance when walking
- Roughly the same proportion of residents can dress correctly
- Most residents can feed themselves with minimum supervision
- Fewer residents, with the exception of one home, can bathe independently
- The proportion of residents in full control of continence has reduced
- There is a much lower proportion of residents with complete memory
- Rather more residents may need assistance finding there way about.

6.12 It might reasonably be expected as community care and extra care services develop that these trends will continue and may accelerate. Issues around continence and mobility have implications for home design and other factors for staff ratios and care arrangements.

7. Older People with Mental Health Needs [Dementias]

7.1 Dementia is a term for a range of progressive, terminal organic brain diseases. It includes decline in memory, reasoning and communication skills, the ability to carry out daily activities and loss of control of basic bodily functions. The emotional impact on people with dementia and their families can be enormous. There is a wide range of front line service to which people can access.

7.2 Advanced dementia, difficulties at night and the breakdown of social support are often triggers for admission to care homes. The prognosis for continued independence of people with dementia who suffer a fractured neck of femur is often poor. A National Dementia Strategy is in development. This will focus on raising awareness, early diagnosis and improving the quality of care.

7.3 The prevalence rates for dementia are higher in the older age groups. The number of people in these groups is predicted to increase. Moderate or severe dementia is often a trigger for more intensive social care support. There is an increasing body of evidence that enables us to estimate likely prevalence and so identify gross need in this area.

Table 11: Consensus prevalence for people aged 65+ with dementia as a percentage of the population

Age Group	Female	Male	Total
65-69	1.0	1.5	1.3
70-74	2.4	3.1	2.9
75-79	6.5	5.1	5.9
80-84	13.3	10.2	12.2
85-89	22.2	16.7	20.3
90-94	29.6	27.5	28.6
95+	34.4	30.0	32.5

Source – Dementia UK, A report by Kings College London and the London School of Economics for the Alzheimer's Society on the prevalence of Dementia in the UK

7.4 Using these prevalence rates it is possible to estimate the number of people likely to have dementia and to project this forward using local trend based data. By 2021 the estimated number of people with dementia will have increased by 62% on the 2001 Census baseline figure. The annual increase is estimated to be at around 180 people per annum. The result is shown in **Table: 12** below.

Table 12: Older People with Dementia in Warwickshire – Estimates 2001, 2011 & 2021

District	Year	65 - 74	75 - 79	80+	Total
North Warwickshire	2001	107	111	395	613
	2011	128	124	514	765
	2021	163	177	689	1029
Nuneaton & Bedworth	2001	203	219	728	1149
	2011	238	230	977	1445
	2021	297	325	1291	1913
Rugby	2001	150	174	694	1019
	2011	181	177	878	1235
	2021	212	254	1103	1569
Stratford on Avon	2001	219	242	1007	1469
	2011	289	283	1278	1851
	2021	360	419	1718	2497
Warwick	2001	219	265	1027	1511
	2011	276	260	1291	1827
	2021	332	384	1642	2358
Warwickshire [Total]	2001	898	1010	3855	5764
	2011	1108	1080	4950	7138
	2021	1362	1558	6444	9363

Source: Strategic Commissioning using prevalence data above, 2001 Census and ONS 2004 population projections.

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8. Older People with Mental Health Needs [Depression in later life]

8.1 Good mental health and well being is as important for older people as any other age group. It may also bring benefits. Depression is the most common mental disorder in later life but its prevalence is harder to estimate. Depression amongst older people often goes unreported or undiagnosed. Older people's sadness can have a major impact on independence and quality of life.

8.2 The NSF, older people, [2001] estimates prevalence rates of depression at between 3 - 5 % of older people. Some studies have shown that 10-15% of people aged 65 or more suffer with significant depressive symptoms. Depression in later life has a poor prognosis. Severe depression can have a major impact on social functioning and the ability to sustain social engagement. Depression and disability are often associated but most older people with disabilities are not depressed and neither do all people who become depressed stay depressed. That is not to say living with a disability is not without its difficulties and that older people do not face obstacles to engaging on an equal basis within their local community.

8.3 The association between poor health and depression appears to be greater for those aged 75 and over and for men than for younger older people and for women. As noted elsewhere poor health, loss of mobility and depression are linked with loneliness and social isolation. In the face of role losses people can benefit from substitute roles or activities. Activity correlates well with subjective well being.

8.4 Programmes and initiatives that target depression and its impact on morbidity and mortality are especially relevant in later life. Social support has been show to be effective in countering depression. Telephone based support and emerging telecare has been shown to be moderately effective in responding to depression, social isolation and unmet needs. Combating social isolation and loneliness aimed at specific groups with a element of participant control can make a useful contribution.

8.5 This is seen as an important area for further an joint work with health partners as part of the joint commissioning of services for older people and in the development of a full Joint Strategic Needs Assessment. Estimated numbers are given in the table below.

Table 13: Estimates of number of older people [severe depression] 3% - 5%

District	2001	2011	2021
North Warwickshire	279 - 464	348 – 580	432 - 720
Nuneaton & Bedworth	530 – 884	630 – 1050	783 – 1305
Rugby	422 – 703	552 – 920	612 - 1020
Stratford on Avon	606 - 1010	780 - 1300	1002 - 1670
Warwick	619 - 1032	711 - 1185	855 – 1425
Warwickshire [Total]	2456 - 4093	2979 - 4965	3687 - 6145

Source: Commissioning using 2001 Census data, 2004 projections and prevalence data as stated above.

9. Living Alone, Loneliness & Isolation

9.1 The social situation of older people can be equally important in terms predisposition to mental health problems and ability to sustain community involvement.

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9.2 The 2001 Census indicated that almost a quarter of households in England and Wales consist of pensioners only. Of all pensioner households, some 61% were single person and 38% were a couple or family. The remainder contained people not all of whom were a couple. The figures for Warwickshire reflect this pattern and are given below.

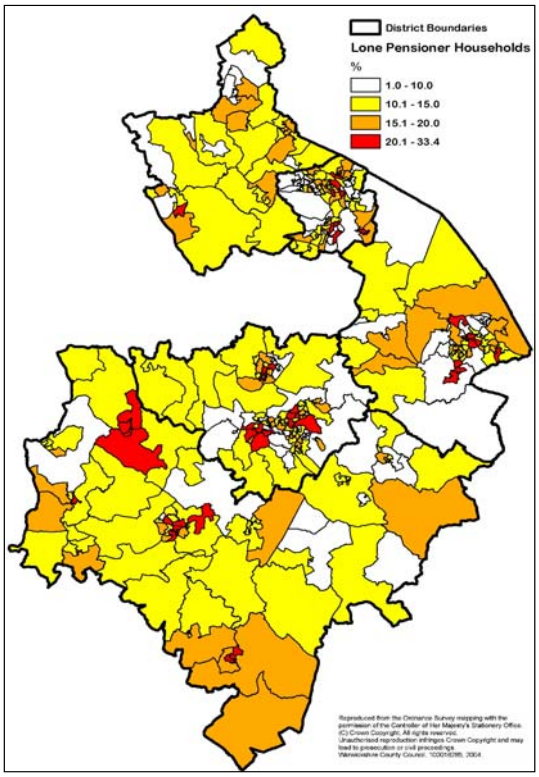
Table14: Pensioner Households, 2001.

District	Lone Pensioner Households	All Pensioner Households	Other Pensioner Households	All Households	% Households with Lone Pensioners
North Warwickshire	3187	2273	106	25173	12.6%
Nuneaton & Bedworth	6480	4445	122	48683	13.3%
Rugby	5027	3499	113	36483	13.8%
Stratford on Avon	6962	5225	208	47202	14.7%
Warwick	7695	4967	188	53356	14.4%
Warwickshire [Total]	29351	20415	738	210898	13.9%

Source: 2001 Census

9.2 There were over 50,000 pensioner households in 2001 of different types and made up nearly a quarter of all households. The highest percentage of lone pensioner households was to be found in the southern part of the County: Stratford on Avon and Warwick districts. Those living in lone pensioner households are likely to be older and will contain a higher proportion of women. Map 4 below shows relative concentrations of lone pensioner households across the county.

Map 4: Lone pensioner households as % of households 2001 Census.



Source: 2001 Census

9.3 By identifying concentrations of lone pensioner households it may be possible to pinpoint areas where older people may be at risk of social isolation [although this does not necessarily follow]. Similarly, there may be those who wish to access care and support services of varying degrees of intensity should dependency increase or in the potential absence of an informal carer. In making these points, however, it is important to distinguish between living alone, social isolation and loneliness. The relationships between loneliness, social isolation and living alone are complex and are not simply determined by household type.

9.4 Work by Agenet indicates many older people demonstrate high levels of social engagement. Loneliness and isolation affects only a minority. Reduced social contact, being alone, isolation and feelings of loneliness are consistently associated, however, with reduced quality of older people's lives. The vulnerability factors of increased isolation, which can also lead to a sense of being trapped at home, are:

- Increased age/being over 75 or 80
- Widowed
- Poor health/health worse than expected
- Restricted mobility – no access to car/not use public transport
- Living alone, having no living children
- Low income/ benefits as main source of income
- No access to telephone
- Adult children living more than 50 miles away
- No close relatives living nearby
- Not knowing neighbours.

9.5 Data from the English Longitudinal Study of Ageing [ELSA] on the social exclusion of older people confirmed that whilst there were connections between different forms of exclusion there was no simple domino effect. That is to say, changing one factor does not necessarily result in changes in other dimensions of exclusion. What is clear, is that living alone in later life does not of itself necessarily generate a need for accommodation; although it may lead to consideration of living somewhere smaller. Fear associated with being alone [e.g. falling, alone at night, personal safety, repairs etc] may be a more significant factor.

9.6 Different types of loneliness and isolation involve different strategies and interventions to alleviate them. Older people need to be involved in finding solutions that would enable them to exercise greater control over their own lives and ensure that services were geared to their needs. The expectation is that future responses need to be framed around quality of life approaches designed to promote independence and well being where people live.

9.7 Work by Help the Aged, for example, with a specific group of older people suggests that those older people who used day services valued them but many older people preferred access to meaningful activities within the wider community. This shift is now part of the challenge of the social care reform agenda: personalisation and normalisation of support.

10. Low Incomes in later life

10.1 Having enough to live on is important at every stage of life. Living on a low income does not help as people become more dependant. There were some 26,220 people in Warwickshire, some 22% of all people aged over 60 in Warwickshire, receiving pension credit in 2007. The proportion of households receiving Pension credit is lower than for the West Midlands as a whole.

10.2 There is some evidence to suggest non take up of benefits. Improving levels of take up of pension credit [and attendance allowance] could make a significant contribution to independent living within the community. It may also reduce need for more intensive help or accommodation and could help sustain the work of informal care networks.

Table15: Number of pensioners in Warwickshire with pension credit [May 2007]

District	People Receiving Pension Credit	Population 60+	% with Pension Credit
North Warwickshire	3,570	14,200	25.1
Nuneaton & Bedworth	7,290	25,800	28.3
Rugby	4,210	20,500	20.5
Stratford on Avon	5,480	30,800	17.8
Warwick	5,670	28,900	19.6
Warwickshire [Total]	26,220	120,200	21.8
West Midlands	347,610	1,066,300	32.6

Source: Quality of Life in Warwickshire, 2007.

11. Attendance Allowance

11.1 Attendance allowance is a state benefit paid to people aged 65 and over that helps with the extra costs of long-term illness or disability. It is paid to the person who has the illness or disability, which can be physical, sensory or mental. Attendance Allowance is not means tested and is available irrespective of income, savings or national insurance contribution record. It is tax- free, does not reduce other benefits and can help obtain other benefits. The benefit is paid at two rates: higher and lower.

11.2 The care conditions for attendance allowance are the same as for the middle and higher rates of Disability Living Allowance which is payable to people under 65. Attendance Allowance has an importance role in enabling people to meet increased costs and to exercise more choice and control over the help they need.

11.3 Information on benefit take up can also help in assessing the distribution of older people with disability needs within Warwickshire. This information also has the potential to help identify areas of low take up that can be used in awareness campaigns. The tables below give information on the number of recipients in 2007.

Table 16a: Attendance Allowance Recipients [May 2007]

	65-74	75+	Total
Warwickshire	**1665**	**13155**	**14820**
North Warwickshire	275	1730	2005
Nuneaton and Bedworth	500	3060	3560
Rugby	250	2225	2475
Stratford-on-Avon	350	3085	3435
Warwick	290	3055	3345

Source: Strategic Commissioning/dwp

Table 16 b: Attendance Allowance (May 2007) – Rates Per Thousand

	65-74	75+	Total
Warwickshire	**36.3**	**315.5**	**169.2**
North Warwickshire	50.0	376.1	198.5
Nuneaton and Bedworth	49.0	364.3	191.4
Rugby	32.5	313.4	167.2
Stratford-on-Avon	29.7	288.3	152.7
Warwick	26.9	282.9	154.9

Source: Strategic Commissioning/dwp

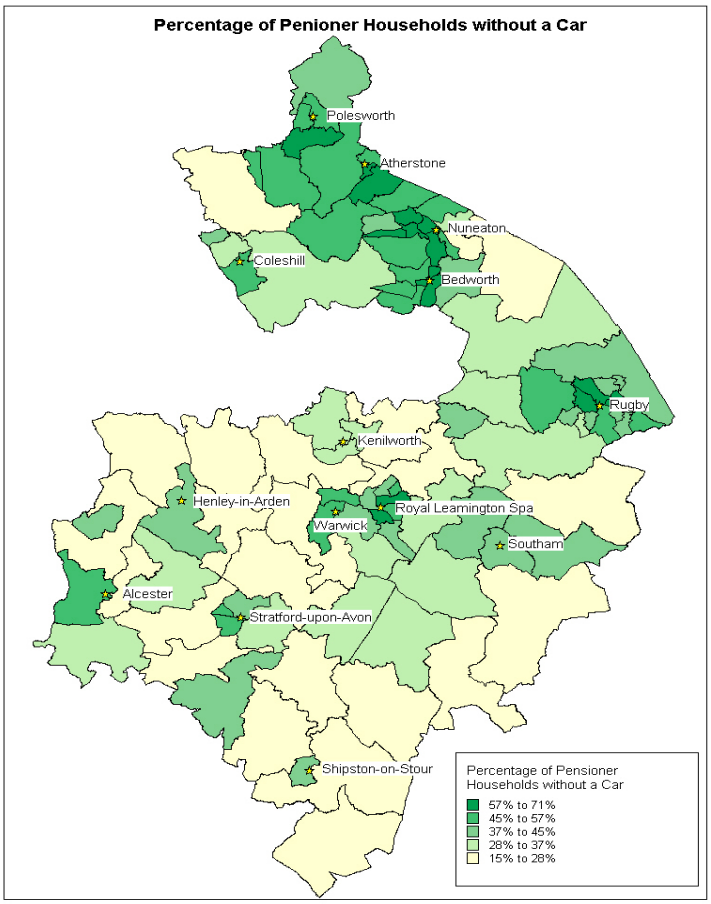
11.4 Compared with prevalence data there may be some low take-up of this benefit. The data show a higher rate of take up in North Warwickshire and Nuneaton and Bedworth. The degree of variation is narrower for people aged 75 and over. These variations may reflect higher levels of morbidity in the populations in North Warwickshire. At the same time it suggests there may be an element of non take-up in Stratford on Avon and Warwick Districts. This might usefully be explored as part of wider approaches to the promotion of independence and well-being.

12. No Central Heating or No car

12.1 Not having central heating or a car can be used as a proxy indicator for disadvantage. The ability to get out and about is important in terms of maintaining social contacts and inclusion in community life and activity. Many older people tend to see no longer having access to a car or being unable to drive any longer as a major change. Being able to get out and about is closely linked to ability to stay at home and live independently. Limited income may also restrict the ability to run a car or to use some forms of transport or at peak times. Whilst we do not have local data, a report by an adjacent council indicates:

- Just over half of older people use cars to get to the shops, post office, doctor etc..
- Nearly two in five relied on transport, which was not their own, to get out and about.
- A higher proportion of those aged 75 and over rely on others to get out and about with driving of their own car falling considerably

Map 5: – Percentage of Pensioner Households without a car



Source: 2001 Census

Not having central heating has a relevance to health and social care. Keeping warm and well in winter is a major factor in reducing risk of excess winter deaths and respiratory illnesses.

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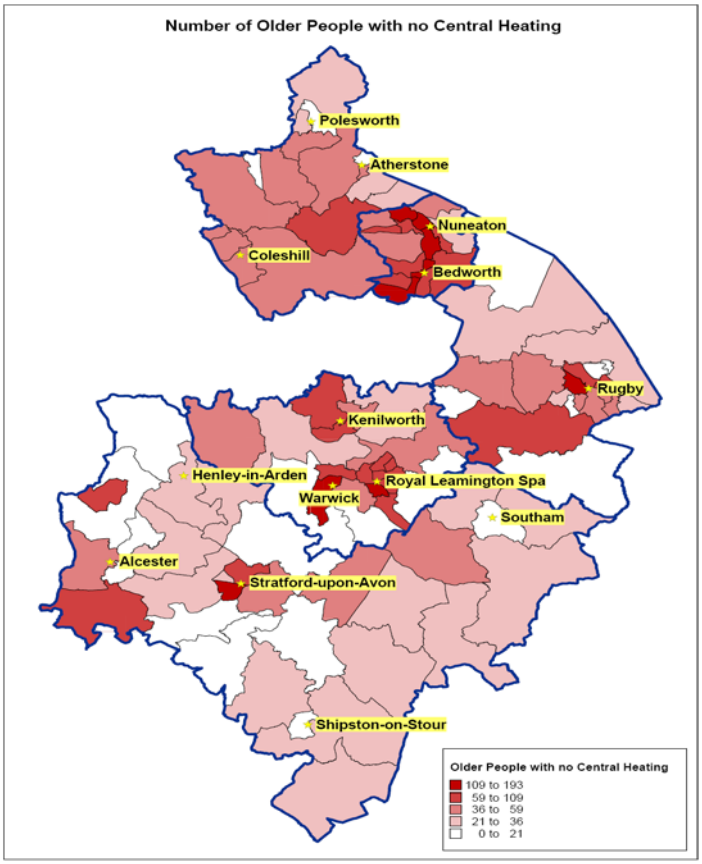
The map below gives information from the 2001 census about pensioner households without central heating.

Map 6 – Older People – No central heating



Source: 2001 Census

13. Excess Winter Deaths 1981 - 2003

13.1 This is a complex area. To assess whether or not there are excess deaths in the winter period, the year was broken into 3 seasons. If there was no true excess in the number of winter deaths it would be expected that 33.3% of deaths in the year occurred in the winter. Between 1981 and 2004 the winter death percentage in Warwickshire was 37.5%, which is an excess of 4.2%. The greatest cause of this excess appears to be respiratory and related conditions.

Figure 1: Excess winter deaths in Warwickshire

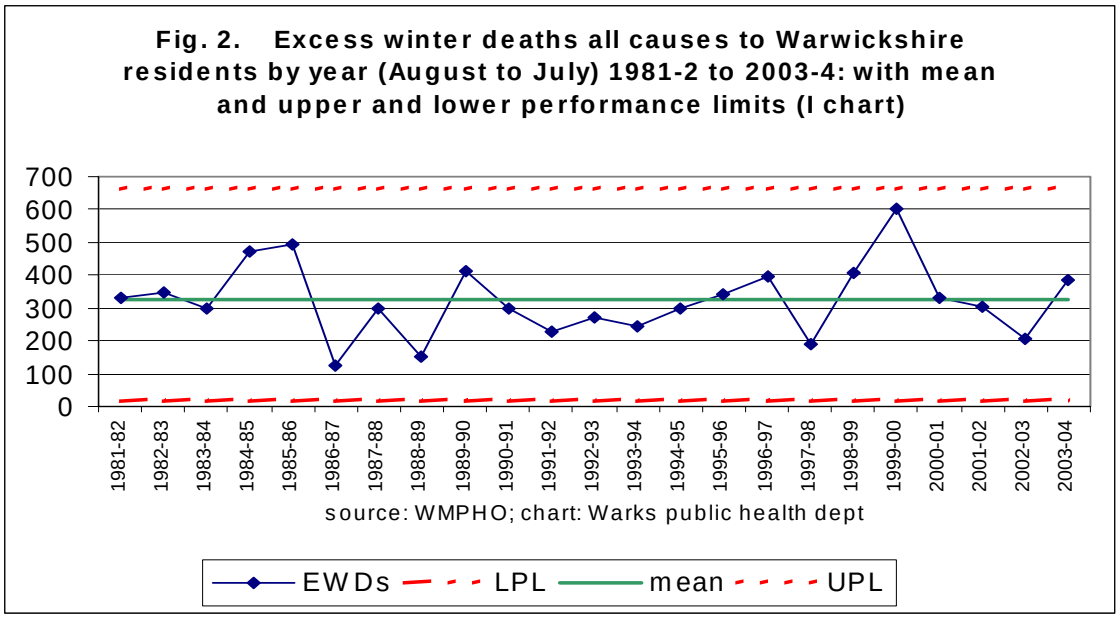


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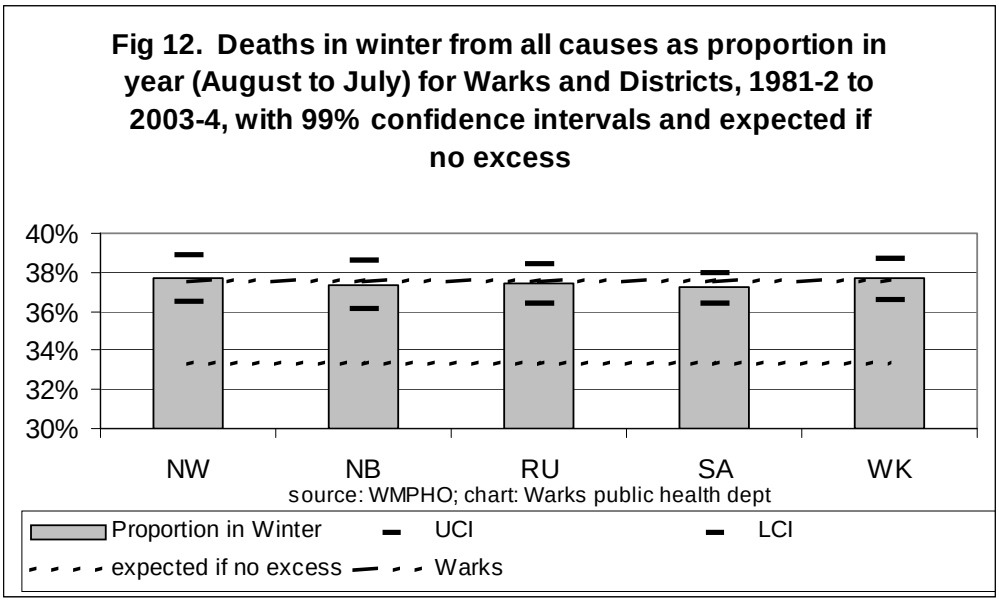
Figure 2: Excess winter deaths by district



Source: Warwickshire PCT

13.2 Figure 2 suggests marginally higher rates of average excess in winter deaths occur in North Warwickshire and Warwick Districts. Nuneaton and Bedworth and Stratford are below the county average. This suggests further work may be helpful as part of the development of a Joint Strategic Needs Assessment in partnership with the local NHS.

14. CARER SUPPORT SERVICES:

14.1 As well as being an important part of the provision of care and support within the community, carers are also entitled to receive information, advice and assessment and support services from the Council. The Council, with its partners, has developed a local vision for services for carers. This Joint Commissioning strategy for Carers is a first step towards improving services and support and to secure better outcomes. The current types of carer support service are shown in the table below.

Table 17: Services received by carers* 2006-2007

Service	Service Users*	%
Community Alarm	2	0%
Carers Emergency Plan	274	12%
Day Care	302	13%
Direct Payment	105	5%
Equipment	8	0%
Home support	726	32%
Lunch Club	1	0%
Meals on Wheels	31	1%
Practical Assistance	37	2%
Respite	760	34%
Day Services	3	0%
Total	**2249**	

Source: Care First- JA *Some carers have more than one service. The number of carers was 1496.

14.2 This table, along with identification of separate assessments for carers, probably underestimates the number of carers worked with. In some cases this support and

assessment are part of the services for the individual cared for. Improved data capture would be helpful. Greater use of separate assessments would facilitate identification and recognition. It would also be more consistent with the increasing emphasis on carer recognition, individualised care and person centred planning.

14.3 Current thresholds for carer support mean that scope for low intensity support to prevent breakdown in informal care or reduce need for more intensive social care inputs should be an area of development. Nationally there is a review of the working of fair access criteria. Locally, some two thirds of services are accounted for by home care and respite support. CSCI has indicated, however, that provision of equipment or day care and home care to the person cared for may significantly ease the burden on the carer.

14.4 A number of carers have an emergency plan in place. These plans represent a pro-active approach to needs, can raise confidence and coping capacity by identifying contingency arrangements that can be put into place should there be an interruption in the availability of carer support which may trigger a need for more intensive care.

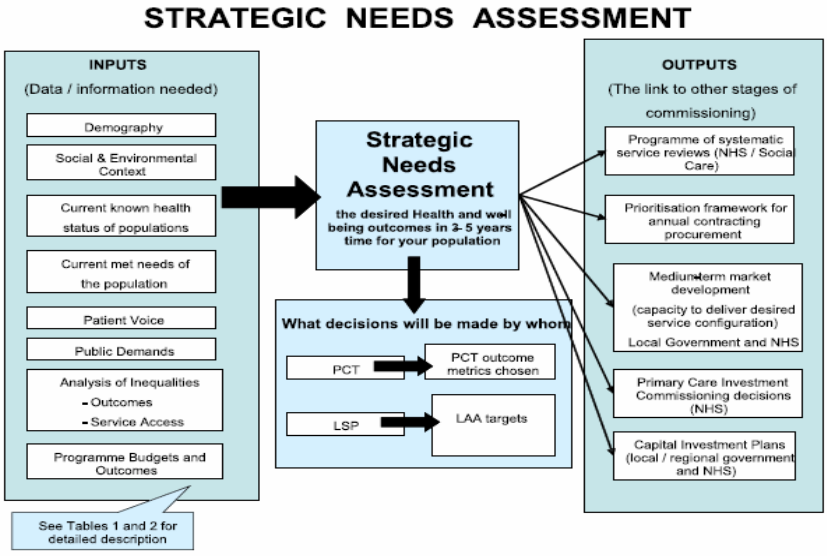
15. Link to Joint Strategic Needs Assessments

15.1 In March 2007 the Department of Health published a commissioning framework aimed at commissioners and providers of services in health and Social Care. Responses to that consultation called for greater clarity surrounding Joint Strategic Needs Assessments. This was followed in December 2007 by the publication of further guidance. The Local Government and Public Involvement in Health Act, 2007, places a duty on Councils and Primary Care trusts to undertake a joint strategic needs assessment. This assessment is expected to:

- identify current and future health and well being needs of the local population; and,
- Inform priorities and targets set by Local Area Agreements; and
- Lead to agreed commissioning priorities to improve outcomes and reduce health inequalities.

15.2 The approach to this work is summarized in Diagram 2 below:

Diagram 2 – Joint Strategic Needs Assessments [Source: CSIP]



15.3 Work has commenced on the development of a Joint Strategic Needs Assessment for Warwickshire. It is intended that the first core dataset, analysis and report should be

compiled by September 2008. The products of this work would then be available for use in the 2009/10 financial and business process.

15.4 This needs analysis will contribute to the development of the Joint Strategic Needs Analysis and will also be developed further within it .This will be done as part of any ongoing commitment to the development of intelligent information to inform and direct joint strategic commissioning of services and partnership working with all sectors within the local health and social care economy. A community engagement strategy will ensure involvement of users and carers in the development of the needs assessment.

APPENDIX E [2]

THE SUPPLY SIDE OF THE CARE ECONOMY

1. Introduction

1.1 This Appendix looks at the supply side of the care equation within the strategic commissioning process. It sets out to map the distribution of current community and care home service provision within the County.

1.2 It begins with carers who, whilst they receive services and support (See **Appendix E[1]**), are also the major source of community care for older people. Without carers local health and social care systems would struggle to cope. Supporting and sustaining carers in their caring role, if that is what they wish, is therefore a key strategic task. It will be delivered through the implementation of the recently prepared Joint Commissioning Strategy.

1.3 The appendix then goes on to map the amount of care home and sheltered housing provision across all sectors. This has been done on a district basis to ensure consistency with needs data. Having information about the spatial distribution of facilities also helps identify local issues around access and choice.

1.4 Consideration is then given to supply side issues around service quality. The quality of care provision has been receiving increasing attention from care regulators. Compliance with standards, convenience and consistency of care in line with user and carer expectations are important dimensions of quality. There are a number of factors that can be considered. This paper focuses on five of them:

- Balance of single and shared rooms
- Rooms with en suite facilities
- Rooms not less than 10 sq.m [National Minimum standard – existing]
- Rooms of 12 sq.m [National Minimum Standard new build]
- Proportion of care staff with NVQs [National Minimum Standard]

1.5 The information on care quality is not as extensive as we would wish. A key task over the next three months will be to map these aspects better . This will be done as part of the process of consultation that is proposed with the local care economy. This will include reinforcing the information we have from users and carers about what we have now, might need in the future and would be more in tune with needs and expectations. **Appendix D** deals with this aspect in more detail.

1.6 From May 2008, the Commission for Social Care Inspection will publish ratings for all care homes. The aim in doing so is to provide an incentive to homes to improve above the basic level. The ratings will be given according to the calibre of care given as well as the quality and condition of equipment and accommodation.

1.7 The continued willingness of people to use homes whose provision of care struggles to meet national minimum standards is something we intend to change. A key aim of any future approach to market management will be the generation of more informed choice and greater access to quality care at a reasonable price. This can only be achieved by a strong focus on personalisation, care outcomes and working in partnership with all sectors of provision, users and carers.

1.8 Finally, in mapping the local care economy and in commenting upon it is not intended in any way to detract from the commitment and caring of those who work within it. We hope very much that care staff will contribute to the debate we wish to generate around quality care services for the future and quality staff to deliver it.

2. Carer Support

2.1 A Joint Commissioning Strategy for Carers for the period 2008 - 2011 was approved by Cabinet in March 2008. It defines carers as:

"Carers look after family, partners or friends in need of help because they are disabled, ill or frail. The care they provide is unpaid."

2.2 The purpose of the strategy is to improve the lives of carers by working with partners and carers to deliver improved outcomes around recognition, support, information, involvement, breaks and their economic well being. Treating Carers and the people they care for with dignity and respect and ensuring their wishes are at the centre of plans and services to support them are central to the strategy.

2.3 The strategy takes account of all relevant national policy and the expected roll out of the New Deal for Carers. It is not intended here to reproduce in full the needs analysis underpinning the carers' strategy. Rather the aim is to identify some of the key messages around carers and older people. The 2001 Census indicated there were some 53,221 carers in the county in 2001, of whom 9,444 provided in excess of 50 hours unpaid care each week. The Table below details the number and percentage of carers in each district area and the number who support someone for more than 50 hours per week.

Table 1: 2001 Census, People Providing Unpaid Care

DISTRICT	PEOPLE PROVIDING UNPAID CARE		PEOPLE PROVIDING UNPAID CARE – 50 + HOURS	
	No	**%**	**No**	**%**
North Warwickshire	7,070	11.4	1,441	20.3
Nuneaton & Bedworth	13,212	11.0	2,906	22.0
Rugby	9,059	10.3	1,534	16.9
Stratford	11,532	10.3	1,716	14.8
Warwick	12,348	9.8	1,847	14.9
WARWICKSHIRE	**53,221**	**10.2**	**9444**	**17.7**
England & Wales	*5,217,805*	*10.0*	*1,088,336*	*20.1*

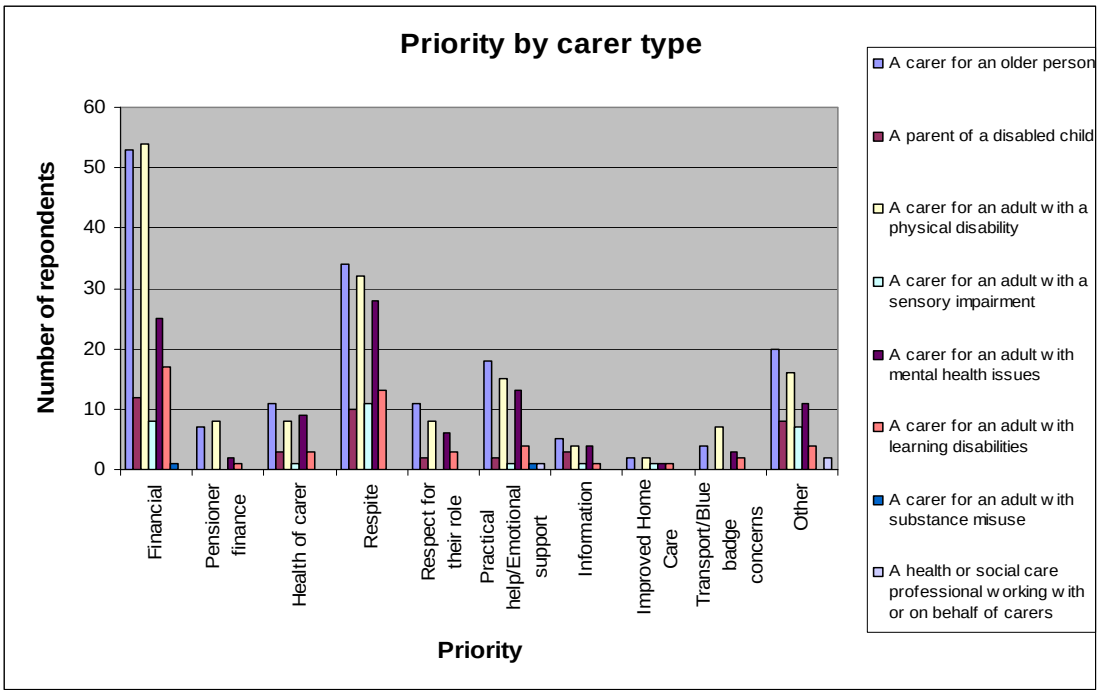
Source: Census 2001

2.4 All districts in Warwickshire with the exception of Warwick were marginally higher than the national average for the proportion of carers in the population. Of those who identified themselves as carers and provided 50 or more hours of care a week, however, only Nuneaton and Bedworth, which also had an increasing number of older people and significant number of people of working age who were sick, had a higher average proportion of carers with Rugby, Stratford and Warwick having lower proportions in this group.

2.5 In terms of carer priorities, the consultation work on the Carers Strategy produced valuable data on what would help sustain carers in their role. The majority of those surveyed expressed their priorities as being financial support and more respite; although emotional and practical support and their own health were also significant factors.

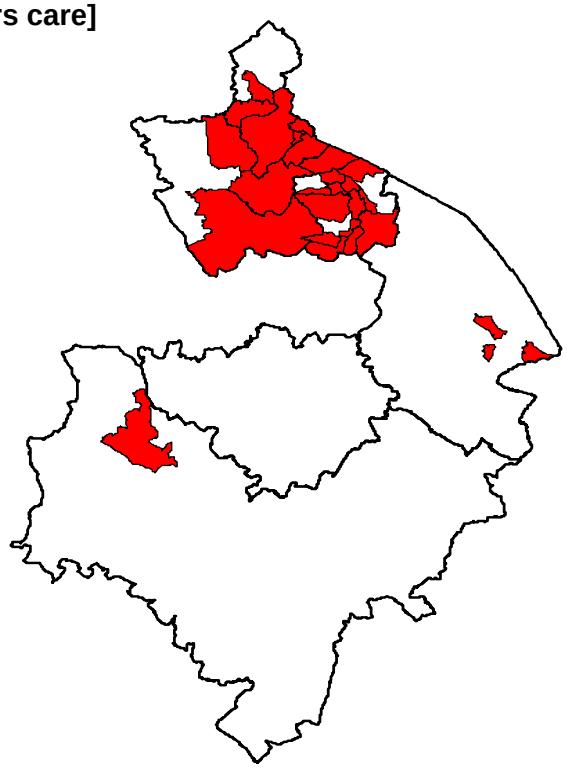
2.6 There are significant numbers of carers from Black and Minority Ethnic (BME) communities providing over 50 hours per week of care in Nuneaton & Bedworth, Warwick and Rugby. There are relatively few BME carers being supported by the current range of services. These findings are generally consistent with evidence at national level. Diagram One below shows carer priorities for all groups.

Diagram 1 – Carers of older people - priorities



2.7 If three dimensions, long term illness, not in good health and providing 50 or more hours care from the 2001 Census are taken together a the potential concentration of need in certain wards emerges. This points to potentially higher risks of future poor health and also to a key group of carers whose support needs may be critical in terms of continuing in their carer role.

Diagram 2: 2001 Census: Wards Exceeding County Averages [Health not good, long term ill and >50 hours care]



2.8 Local information is collected [Performance Indicator C.62] on the number of carers receiving a specific carer's service as a percentage of clients receiving community based service each year. The number carers identified as receiving services within the County has increased on the 2005/06 baseline. To date, however, this information on carer services has not been analysed spatially to see if there is a matching with possible need as outlined above. It may be helpful to do so; although it should be recognised that:

- C.62 will under report the benefits derived for carers from services provided to the user for whom they care; and,
- Census data are subject to certain limitations e.g., self reporting

2.9 There were nearly 1500 carers in receipt of services during 2006/07. Similar activity levels have continued into 2007/08. The expected trend in providing support to carers is toward a more personalised service with a greater emphasis on preventative support. Information on Carer support services is given in **Appendix E 1** as part of the demand side of care.

3. Community Care and Support Services

3.1 The supply side of community care services is not easily mapped. It can be done in two ways. The number of providers and the number of people receiving services. Of existing community care services, domiciliary care providers have to be registered with the Commission for Social Care Inspection. Day care is not subject to registration. Table2 shows current domiciliary care and day care providers.

Table 2: Care Service Supply [not care homes] 2008

District	Registered Domiciliary Care providers	Day Care Providers
North Warwickshire	14	8
Nuneaton & Bedworth	35	13
Rugby	26	14
Stratford upon Avon	27	16
Warwick	37	15
Warwickshire	94	66

Sources: Care First

3.2 These providers will be involved in the provision of community support and personal care services to older people whose services are commissioned by the council as well as for people who fund their own care in whole or in part [self funders]. Table 3 gives information on older people receiving community support in March 2007.

Table 3: Number of people receiving adult social care support, 31st March 2007 [not care homes]

District	60-74	75-84	85+	Total	Rate per 1000 pop'n
North Warwickshire	150	267	241	658	52.4
Nuneaton & Bedworth	421	534	495	1450	61.5
Rugby	193	320	356	869	46.7
Stratford upon Avon	258	456	569	1283	47.7
Warwick	276	472	637	1385	51.8
County	**1298**	**2049**	**2298**	**5645**	**52.1**

Source: Care First, 2006 ONS mid year estimates used.

3.3 The rate at which services are taken up varies. The table below sets out the rates of take up for different age groups. Consistent with operational experience there is a steep increase across all districts after age 75. There are a whole range of factors that will affect service take up such as awareness, availability, cost and so on.

Table 4: Rates per 1000 people receiving adult social care support, 2008 [Note: this table relates to People60 plus]

District	60-74	75-84	85+	Total
North Warwickshire	17.7	85.2	253.4	52.4
Nuneaton & Bedworth	26.7	87.2	289.8	61.5
Rugby	16.3	63.1	208.2	46.7
Stratford upon Avon	14.9	66.0	217.1	47.7
Warwick	16.6	63.0	244.2	51.8
County	18.5	71.3	239.4	52.1

Sources: Care First

3.4 In common with experience elsewhere, service utilisation tends to be higher, earlier, in areas of relative disadvantage and slower and lower in areas of relative advantage. Once the age of 85 is reached the variation between different parts of Warwickshire narrows. This reflects the progressive impact of ageing and is not unexpected. The highest utilisation rate of social care support is found in Nuneaton and Bedworth. The lowest is in Rugby.

3.5 The diversity and level of intensity of service supply is also important. The following table shows the pattern of publicly funded care. It does not include self funded care. Again there are variations between districts in terms of service mix and rate of use.

Table 4: Care Service Supply [not care homes] – publicly funded service use 2008 [Note: This is people 65 and over]

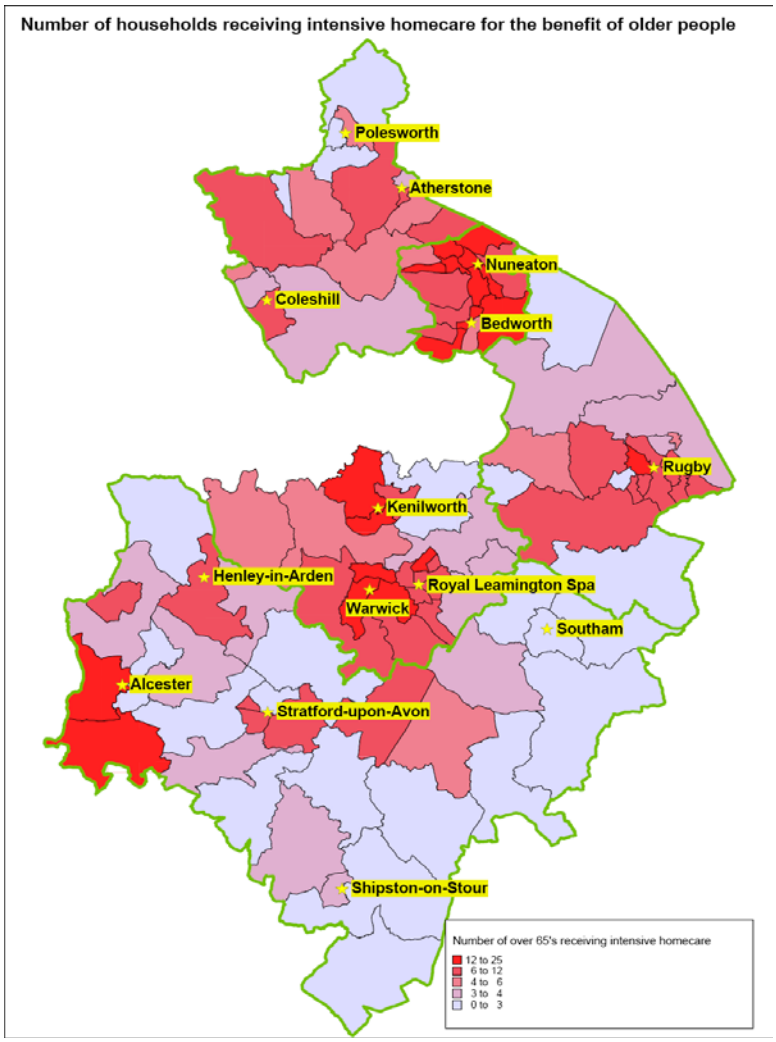
District	People with home care <10 hours pw	People with home care >10 hours pw	People receiving Day Care	People receiving low intensity support [all types]	Total Helped to live at home by WCC	Grant Funded Services Support	Rate per 1000 65+ all services
North Warwickshire	240	75	112	448	625	152	76.9
Nuneaton & Bedworth	462	219	284	828	1332	251	85.1
Rugby	311	111	163	531	818	680	101.2
Stratford upon Avon	517	131	206	900	1229	520	77.7
Warwick	488	182	196	896	1326	420	80.8
County	**2018**	**718**	**961**	**3606**	**5330**	**2023**	**83.9**

Sources: Care First

3.6 The Map overleaf gives information on the number of households receiving intensive home care. The supply of this service is a key component to the delivery of care and choice options for older people. Highest take up is in urban areas. This does not necessarily mean these are the areas of highest need.

3.7 Supply may be more restricted in the more rural areas and may affect take up. Delivery of intensive services may also be affected by distances to be travelled by care workers. These patterns are not unique to Warwickshire.

Map 2: Households with Intensive homecare



Source: Strategic Commissioning

4. Local Sheltered and Extra Care Housing Provision

4.1 Having somewhere to live is a common component of the lives of all of us and not just people who need care and support. The majority of older people live in and will continue to live in their own homes. Enabling them to continue to do so through care, support and adaptations forms an important element of the continuum of care supply. Some initial mapping work with District councils on sheltered and retirement accommodation has begun. This is continuing. It is intended that the proposed consultation with providers to better map independent sector provision will include further discussions with Districts and a strengthening of links with their local housing needs analyses.

4.2 Table 5 overleaf sets out the most recent information on the supply of local sheltered and extra care housing provision. Information on facilities within local authority sheltered housing from a preliminary data collection exercise this year is shown in Table 6. Further mapping work is proposed to ensure a more comprehensive and up to date picture as provision changes and develops.

Table 5: Numbers of units of accommodation in sheltered housing [all types] 2008

District	Local Council	Third Sector	For Profit[1]	Total
North Warwickshire	368	86	0	454
Nuneaton & Bedworth	1150	310	N/a	1460
Rugby[2]	1421	86	263	1849
Stratford upon Avon	All transferred to rsl's*	609	329	938
Warwick	1287	0	479	1766
County	4305	1091	1071	6467

[1] Data taken from www.housingcare.org [2] Data taken from Rugby Borough Council website
*registered social landlords Note: data validation is in process. Totals may not add to those in Table 6.

4.3 What will be important for the future is to have a better understanding of the nature of the accommodation and level of service it offers. Over the years expectations around sheltered housing have changed. For example, bed recess flats forming parts of many initial schemes are increasingly unpopular. Work by other councils has shown an increasing preference for one or two bedroom accommodation where people can afford this. This is also reflected in Department of Health thinking around Extra Care Housing funding streams

4.4 Current information on facilities within local council provision is shown in the table below. It confirms that most accommodation is in one or two bedroom accommodation. This suggests that significant remodelling may not be needed. The possible exception is Nuneaton and Bedworth where, whilst there is a lot of sheltered housing, bed recess flats form an important element of available units. This is an area for further discussion with each district. The aim would be to work in partnership with districts and independent sector providers to develop this information as part of the proposed consultation on the Care and Choice Programme.

4.5 These discussions can also be used to assess the scope for core and cluster floating support schemes as part of a range of solutions appropriate to a County with an urban and rural spatial mix.

Table 6: Local Authority Sheltered Housing Facilities 2008

District	Bed Recess units	One Bed units	Two Bed units	On site warden/ scheme manager	Comm. Alarm	Assisted Bathing Facilities	Telecare & assist tech.*
North Warwickshire	0	274	71	No on-site manager – all floating support	4535	0	0
Nuneaton & Bedworth	231	876	43	1033	1150	Data not available	1150
Rugby[3]	0	1113	308	Data not available	3	Data not available	Data not available
Stratford upon Avon	0	486	60	Data not available	Data not available	Data not available	Data not available
Warwick	0	929	348	186	1101	5	858
County	231	2565	522	1219	6786	5	2008

All data supplied by District/Borough Councils

3 Rugby Borough Council website states that most of the 1500 LA sheltered units are 1 bed flats and all have community alarm service available.

4.6 The increasing diversity of individual circumstances as people age will also lead to an interplay of factors that will affect housing need. This diversity also extends to choices people are able and willing to make about their future needs. Certain factors are key:

- Whether they anticipate changes in their needs and plan accordingly.
- The acceptability of alternative solutions to potential, actual or perceived needs and expectations
- How far their income and access to capital enables or limits choices.

4.7 A possible need for some remodelling and reprovision of existing sheltered accommodation has to be allowed for. This may apply across all sectors. Some remodelling, as part of wider development of Extra Care Housing may be possible. At the same time the availability of better sheltered and extra care accommodation may result in units in some schemes becoming harder to let. The information in **Appendix D** suggests that older people have clear ideas and expectations around accommodation and care that needs to be built into thinking now.

4.8 Information on future planned provision is limited. Recent contacts with independent providers indicates that a range of schemes and potential applications are being contemplated. Some appear to be in terms of more traditional retirement apartments and housing. Others are more specifically for "extra care". It is also apparent that some proposals for care home provision are in development in the majority of Districts.

5. Supporting People Programme

5.1 The Supporting People Programme is a central government grant programme that commenced in 2003 and operates as a Partnership between the County Council, the five District and Borough Councils, Warwickshire Probation Service and the Warwickshire Primary Care Trust. The Programme funds housing related support services to enable vulnerable people to live independently in the community and enhance their quality of life.

5.2 In Warwickshire Supporting People receives an annual grant of £10,146,789 and spends almost £2.5 million annually, almost a quarter of its programme grant, on services for Older People, delivering services to almost 5,500 older people.

5.3 In 2005/2006 Warwickshire Supporting People completed in depth service reviews of all sheltered housing and community alarm services funded by Supporting People to review and improve, amongst other things, the quality, performance and value for money of these services.

5.4 The review of sheltered housing provision in North Warwickshire led to the service being re-modelled from an accommodation based service, where support can only be provided within sheltered accommodation, to a floating support service, to enable the service to reach not only people living in sheltered housing but also to older people living in their own homes or other rented accommodation. This has enabled the service to meet the needs of older people in the wider community including the rural areas of the Borough.

5.5 The vision for the Warwickshire Supporting People Programme is to deliver needs led housing support focused around positive outcomes for individuals. The current provision is very much reflective of the service inherited when the Programme commenced in 2003. A programme of Strategic Reviews is planned over 3 years for all Supporting People user groups. This will enable Supporting People to make informed commissioning decisions.

5.6 The Strategic Review for Supporting People Older People services is expected to establish the level of need related to current provision and identify opportunities to ensure services are provided that meet identified need across the County. In doing this the Strategic Review is also expected to identify opportunities for aligning Supporting People funding with that of other relevant public bodies and programmes to optimise the use of resources.

6. Care Home Provision

6.1 Care homes cater for a range of older people and their different needs. There are two principal types of care home:

- Homes providing accommodation and 24 hour personal or general care but not registered to provide nursing care
- Homes providing accommodation, personal care and with permanent nursing care and medical care for people not requiring hospitalisation.

6.2 Both types of home then divide into sub-categories based around main client groupings such as dependent elderly, mentally infirm elderly and so across all client groups. Homes have to register for both the type of care they provide and the people they provide the care for. Some homes are dually registered in that there are designated residential and nursing beds within it. The tables that follow set out the distribution of homes for 2000 and 2008.

Table 7: Number of care home places for older people by category in Warwickshire, 2000

District	Nursing	Residential	EMI care	Total
North Warwickshire	183	134	26	343
Nuneaton & Bedworth	286	267	79	632
Rugby	379	362	31	772
Stratford upon Avon	313	441	24	778
Warwick	369	614	54	1037
County	1530	1818	214	3562

Source: Registration & Inspection Unit, Warwickshire County Council

Table 8: Numbers of care home places for older people by category in Warwickshire, 2008

District	Nursing	Residential	EMI care	Total
North Warwickshire	156	191	199	340
Nuneaton & Bedworth	235	285	312	801
Rugby	256	257	240	754
Stratford upon Avon	446	463	291	793
Warwick	257	501	142	1055
County	1350	1697	1184	3743

Source: CSCI

6.3 What this regulatory information indicates is:

- A reduction in places for dependent elderly in care and nursing homes
- A shift towards more specialist provision for people who are mentally infirm.

6.4 These trends in supply are to be expected. They match the process of increasing age and dependency on admission seen by many councils. The further development of intensive home care linked to telecare and the commissioning of extra care accommodation will reinforce these trends.

6.5 Vacancy information from the WPIC web site suggests that there is a vacancy factor of around 7% for single rooms across the county. The vacancy factor in respect of double rooms appears to be running at twice that level at 14%. Further market mapping is to be undertaken to look at the spatial distribution of vacancies and to compare this with feedback from local commissioning teams on the ability to secure care at the council's prices.

6.6 Consistency and quality of care are key considerations. The Commission for Social Care Inspection is developing information available around the quality of care services. The Local Area Market Analyser (LAMA) is a tool the Commission for Social Care Inspection (CSCI) shares with Councils, which shows them the Key National Minimum Standards (NMS) data for all the regulated provision in their area.

6.7 The CSCI LAMA data offers Warwickshire, and other Authorities, the opportunity to:

- Assess the extent to which national minimum standards are being met by local providers.
- Improve understanding of local markets and quality of care; and

Inform and improve local authority commissioning of care and market management.

- Contribute to the assessment of Council performance in terms of the effectiveness of commissioning across all sectors, the quality of their own direct provision and contract monitoring of commissioned services.
- Make decisions about possible remedial action to improve performance when used alongside other intelligence about performance

6.8 In identifying the benefits of the LAMA it also has its limitations which include;

- The data are drawn from CSCI registration and inspection activity and is a relatively new information stream.
- Some providers from all sectors of the service, have highlighted some issues of consistency by inspectors in their approach to standards.
- The extent to which national standards are met is derived from cumulative data over the year.
- There is a time lag on some of the information provided in the LAMA

6.9 Because of the limitations outlined, the information in the LAMA needs to be approached with a measure of caution. Even so, the information provides sufficient detail to point to possible areas that suggest a need for improvement.

6.10 In addition to the LAMA, CSCI have started to gather information that will populate a new document, Capturing Regulatory Information at Local Level (CRILL). This document will use information from local regulatory inspections and will be used in performance assessment to promote a more robust scrutiny of a Council's commissioning behaviour in terms of service user experience and outcomes.

6.11 The Commission for Social Care Inspection is scheduled to be replaced by the new Care Quality Commission from April 2008. It is also intended to review existing regulatory frameworks and standards to ensure they are risk based and proportionate. This change dimension has been allowed for in the programme risk register.

6.12 The tables below give information on registered care homes and available places for adults and older people in Warwickshire for 2006 and 2007. This suggests a relatively stable market provision with only minor changes in capacity.

Table 9 [a] - Registered Provision 2006

	Nursing		Personal care	
Sector	**Establishments**	**Places**	**Establishments**	**Places**
LA	0	0	10	349
Private	29	1361	56	1166
Voluntary	7	254	81	1021
NHS	0	0	5	25
Other	0	0	0	0
Total	36	1615	150	2551

Table 9 [b] Registered Provision 2007

	Nursing		Personal care	
Sector	**Establishments**	**Places**	**Establishments**	**Places**
LA	0	0	10	349
Private	30	1420	60	1195
Voluntary	7	250	80	1022
NHS	0	0	5	25
Other	0	0	0	0
Total	37	1670	155	2591

6.13 Warwickshire has, however, a lower number of places per 1000 population than its comparator group. This is important when considering market management. At present we have 33.55 older people places per 1000 people and only 10.32 for people over 65 with dementia. This indicates a potential level of under supply for people needing 24 hour care with dementia and is consistent with the feedback coming from local commissioning teams. At the same time the need for options such as extra care housing is also recognised and these issues are picked up within **Appendix E.3**

6.14 The following tables give information on publicly funded placements in care homes for different age groups

Table 10 a - Service Users Aged 60-74 in Care Homes [31 March 2007]

	Nursing	Residential	EMI	Total
North Warwickshire	6	10	2	18
Nuneaton and Bedworth	9	24	10	43
Rugby	12	17	3	32
Stratford	10	18	5	33
Warwick	25	26	1	52
Out of County	7	16	4	27
Total	69	111	25	205

Table 10 b:- Service Users Aged 75 - 84 in Care Homes [31 March 2007]

	Nursing	Residential	EMI	Total
North Warwickshire	32	24	16	72
Nuneaton and Bedworth	34	43	30	107
Rugby	34	27	15	76
Stratford	25	58	11	94
Warwick	37	56	17	110
Out of County	19	18	30	67
Total	181	226	119	526

Table 10c: Service Users Aged 85 and over in Care Homes [31 March 2007]

	Nursing	Residential	EMI	Total
North Warwickshire	43	46	17	106
Nuneaton and Bedworth	42	106	34	182
Rugby	50	64	27	141
Stratford	55	132	24	211
Warwick	47	131	22	200
Out of County	32	51	30	113
Total	269	530	154	953

Source: care first

6.15 The majority of residents of all the main types of care home are aged over 85 with residential care homes having the highest percentage in this age group. There appear to be fewer people in this age group, in specialist care homes, which might be looked at further.

6.16 At the same time these figures need to be treated with some caution and a whole systems view kept in mind. Whilst Warwickshire appears to place fewer people in care homes than comparator authorities its intensive home care figures are increasing. This will be explored further.

6.17 In terms of quality of care and meeting national minimum standards [NMS] the number of council care homes meeting 0–50% of NMS has reduced to zero. It was previously 10%. Care homes for older people provided by the voluntary sector have increased the number of NMS being met in every category apart from 26–50% which has decreased and there remain no homes in the 0-25% band. These results are a positive achievement. Generally speaking achievement of NMS was lower in the private sector.

6.18 Local commissioning teams report difficulty in obtaining care home places for older people with mental confusion and in securing single rooms in parts of the county. It is not clear whether this is a product of price or supply or a mix of both. The latter seems the most likely.

7 Market Mapping – Quality of Care Home Accommodation.

7.1 Market mapping work is currently underway to have more detailed information on the quality of accommodation within care homes. The intention is to complete this work shortly. Information from the WCIS web site suggests that around 10% of current provision is in shared rooms: nearly 400 beds. As time passes and dependency increases this living arrangement will be increasingly inappropriate in relation to expectations of commissioners, users and carers. Some market adjustment can be expected. This needs to be factored in to thinking around the future balance of care

7.2 Further market mapping work has produced more detailed information but at the time of preparing this paper this exercise was still in process. The tables that follow show the information collected in 2008 on single rooms and shared rooms. The location of the home does not, of course, mean that it serves the area in which it is situated. The total places in each table is derived from regulatory information. It is intended that this market mapping process, which has been commenced, will be completed and validated as part of the overall approach for consultation with stakeholders over the summer of 2008. This work would be linked to ongoing data collection to ensure accuracy. The tables below should be read in this context.

Table 11a: Places for Dependent elderly, standard of facilities [Care Homes – not nursing] 2008

District	Single rooms with En-suite rooms	Single rooms Without en suite facilities	Shared Rooms	Total Places*	Places per 1000 75 +
North Warwickshire	179	14	11	191	46.7
Nuneaton & Bedworth	124	33	4	285	36.4
Rugby	284	122	18	257	37.9
Stratford upon Avon	205	89	10	463	48.6
Warwick	291	94	9	501	49.6
County	-	-	-	1697	44.3

Sources: * Care First. Note data collection is still in collection – no county totals.

Table11b Places for Older People, standard of facilities [Care Homes – with nursing]

District	Single rooms with En-suite rooms	Single rooms Without en suite facilities	Shared Rooms	Total Places	Places per 1000 75+
North Warwickshire	34	44	3	156	38.2
Nuneaton & Bedworth	127	0	2	235	30.0
Rugby	141	0	18	256	37.8
Stratford upon Avon	247	40	16	446	46.8
Warwick	164	61	1	257	25.4
County	-	-	-	1350	35.2

Sources: strategic commissioning & care first. Data still in process of collection – no county totals

Table 11c: Places, Elderly Mentally Infirm, standard of facilities [Care Homes both types]

District	Single rooms with En-suite rooms	Single rooms Without en suite facilities	Shared Rooms	Total Places	Places per 1000 75+
North Warwickshire	126	1	6	199	48.7
Nuneaton & Bedworth	43	35	17	312	39.9
Rugby	158	17	5	240	35.4
Stratford upon Avon	121	13	5	291	30.5
Warwick	65	31	7	142	14.1
County	-	-	-	1184	30.9

Sources: Commissioning and Care First. Data collection still in process – no county totals.

7.4 Table 11c relates to both care and nursing homes. The intention in future is to distinguish between homes with nursing care and those without nursing care in analyses. County totals, apart from registered places have not been calculated pending data validation work as part of consultation on a future balance of care.

7.5 Mapping is more complete on residential care homes than for nursing homes where most rooms at most homes offer en-suite single room accommodation.

7.6 Information from independent sector providers indicates an intention to further develop nursing and residential care home provision within the County. Further mapping of the care home economy is planned as part of the consultation on the analysis flowing from this report. This information can then be used to "fine tune" commissioning intentions.

8. Training and Staff Development – Competence in Caring

8.1 Staff training and supervision are important. The quality of care experience is related to the quality of staff and the leadership within care homes. The National Minimum Standards make provision for achievement of certain levels of training and supervision. Workforce mapping across all sectors is also a requirement placed on councils and progress assessed by the Commission for social care inspection.

8.2 Generally speaking progress against meeting National Minimum Standards in Warwickshire is lower than for England as a whole. In terms of training standards all local authority homes and the majority of voluntary care homes meet them. In the case of private provision the level of achievement is lower and suggests a need for more investment by providers.

8.3 Older people entering care settings generally expect those who care for them to be trained. Having confident, competent and caring staff is invariably the key to quality care. Basic training around safe lifting and handling is essential. The National Minimum standards for care include requirements around the number of staff with NVQs. For its part the council has started to make premium payments through the Warwickshire Care Partnership to incentivise and recognise progress with front line staff training.

8.4 Recent workforce mapping activity has collected information on this area. Whilst still in progress it indicates progress towards achievement of standards. As part of the stakeholder consultation these data will be discussed further with the Warwickshire Care Partnership, training bodies and with providers.

Table 12: Number of places for people [all categories] according to % trained staff [All Homes]

District	Places Care Homes Residential < 50% staff NVQ 2	Places Care Homes Residential >50% staff NVQ2	Places Care Homes Nursing < 50% staff NVQ2	Places Care Homes Nursing >50% staff NVQ 2	Places Care Homes EMI < 50% staff NVQ2	Places Care Homes EMI >50% staff NVQ
North Warwickshire	0	209	47	37	0	139
Nuneaton & Bedworth	0	165	0	131	30	82
Rugby	0	442	56	88	144	41
Stratford on Avon	0	314	0	309	0	144
Warwick	59	344	0	227	24	86
County	59	1474	103	792	198	492

Sources: commissioning

APPENDIX E [3]

THE BALANCE OF CARE

1. Introduction

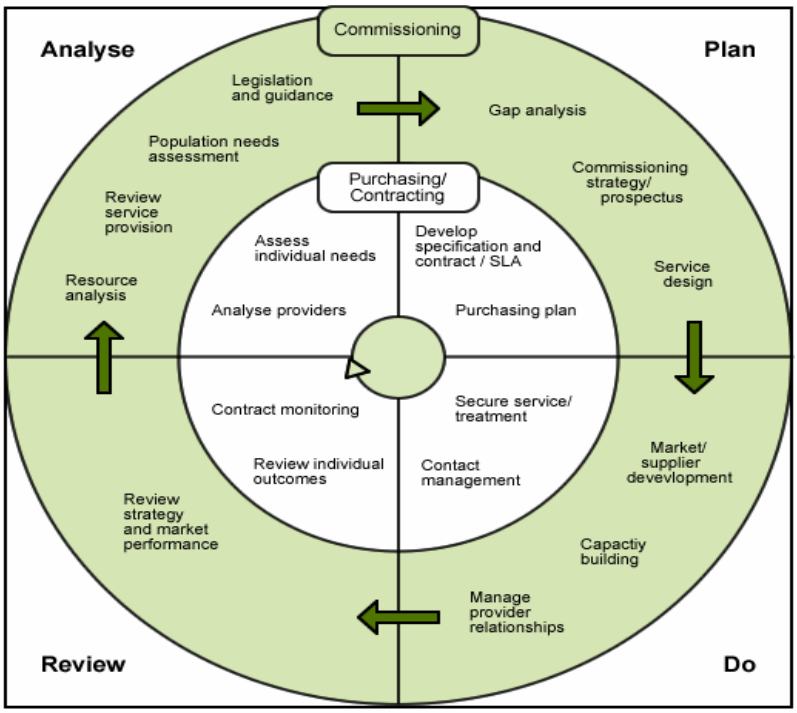
1.1 Commissioning is the process used to identify need, map supply and match them in ways that secure best care value for users, carers, patients and the public and achieve the following goals:

- Improved care, health, well being and independence;
- Reduced inequalities and social exclusion
- Access to a comprehensive range of fit for purpose services
- Increased choice and control by those using services
- Delivers a better care experience that is responsive to individual needs and preferences
- Ensures cultural sensitivity.

1.2 Effective commissioning, therefore, is about care that adds maximum value within a whole systems approach that promotes inclusion, fairness, and respect across all sections of the community. By designing care around people we can more reliably secure the right care, in the right place at the right time and ensure its provision in the right way by the right people***: better care, better value, better outcomes.***

1.3 We can both improve quality, match interventions better to need, improve user and carer satisfaction, make best use of available human resources in ways that confer a sense of value to staff and build on their potential and make better use of total resources in ways that can deliver better outcomes at lower cost. By bringing the system together in this way it should be possible to increase system capacity and capability to meet needs, offer choice and enhance control. The model underpinning the approach adopted is reproduced below, again, for ease of reference:

Diagram 1 – Strategic and Operational Commissioning Model



Source: IPC joint commissioning model for public care

1.4 **Appendices E 1 & 2** looked at population needs, supply side, service take up and issues. This was done in the context of social care reform and the policy agenda for future care and support provision. It also makes clear that this work is linked to the development of a Joint Strategic Needs Assessment with the Primary Care Trust.

1.5 The balance of care considered in this Appendix is about planning, doing and demonstrating an understanding of current and future care needs. This will be used to commission services and interventions that will achieve better health and well being outcome and contribute to the reduction of inequalities identified in the needs assessment.

1.6 It is also about tipping the balance of the care economy more in favour of the needs and preferences of older people. It is about identifying gaps, the need for change and outlining in broad terms how what we have needs to adapt to what we need for the future. It is about ensuring sufficient capacity with in the care economy to offer choice and collaborative competition. It is about delivery of the wider goals outlined above and achievement of the following specific objectives:

- To **respond creatively to the impact of demographic change** between now and 2021 by better use of existing care capacity and better matching of service take up with needs identified through care assessment and advice.
- To **enable more older people to stay at home** and to live independently, with or without support or re-ablement inputs for as long as it is reasonable, practicable and safe to do so.
- To **stimulate the local care economy to better meet care needs** and promote care solutions without recourse to significant public capital or health and social care revenue funding.
- To **enhance overall care value to purchasers of care** [includes people who self fund care] by generating care solutions through care markets that better meet needs and expectations, meet national minimum standards, assure quality care through quality people and deliver improved care outcomes.
- To **secure maximum affordable choice and fair care access by** older people that offers the best match to their needs, maximises their resources and improves the care value that they receive.
- To **reshape care accommodation provision** to better meet current and future specialist needs and preferences of older people and their supporters without significantly increasing total capacity within care homes.
- To **increase user, carer and community satisfaction with care services** and promote informed care choices that offer real control to people seeking care and support and treats people who self fund care on an equal basis.

1.7 The changes we want to see through joint commissioning and change within the local care economy to achieve these high level aims are:

- Secure more low intensity and information and advice services for older people and with special reference to those who intend to self-fund care.
- Use care pathways with special reference to better managing tipping points into to and better manage requirements for intensive care
- Shift the balance of care away from residential and nursing care settings and so better meet preferences.
- Develop floating support services through the supporting people initiative
- Deliver more care options around high intensity home care, adaptations and telecare together with housing with care support as alternatives to care homes.

1.8 The outcomes of care and support also need to be articulated and understood as part of this process. The Wanless Review Report [2006] identifies four:

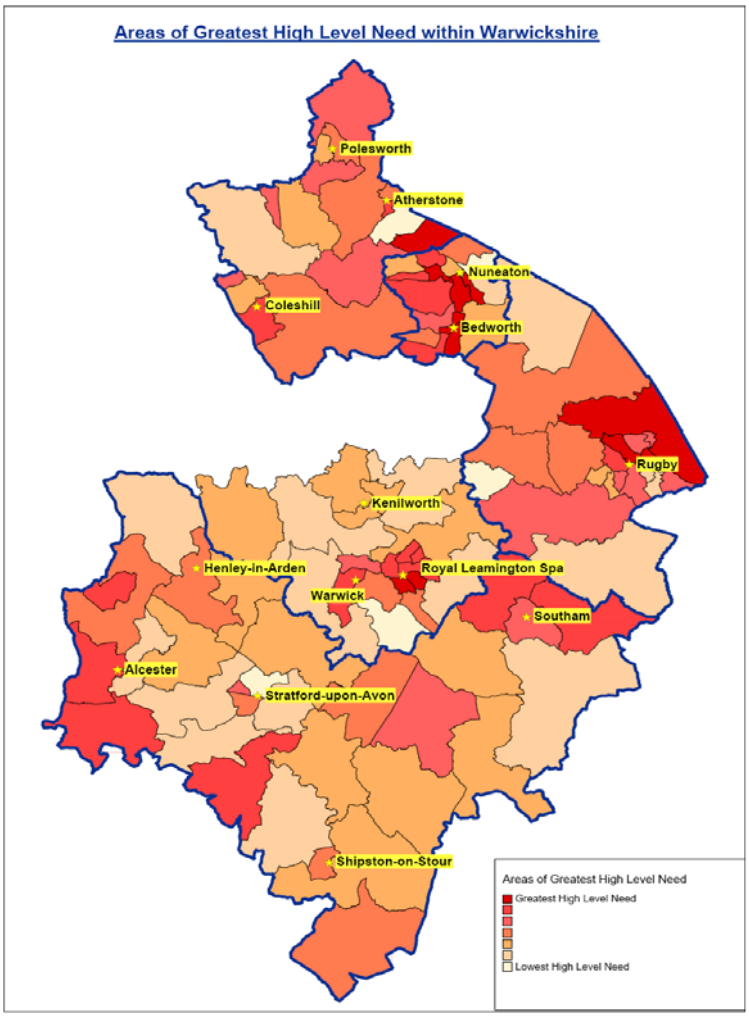
- First, core outcomes: being clean, comfortable, having sufficient food and achieving the basic standards of personal care.
- Second, being safe, and protected from unreasonable risks, including potentially self induced risks and those that stem from own circumstances.
- Third, enjoying fulfilling lives, including social participation and social inclusion, self esteem and a sense of well being; and,
- Fourth, for carers, to lead, where possible, normal lives and be free of undue stress.

1.9 This focus is very much about dignity and respect, freedom from discrimination, choice and control and achievement of the seven key outcomes for social care. It is about tackling inequalities.

2. Predicting Future Need

2.1 The West Midlands Resource Allocation Model was produced by Tribal Consultancy for the West Midlands performance network. The model looks at a number of factors contributing to social care need to identify the wards where high level social care need is likely to be greatest in the next 10 years.

Map 1: Predicted areas of future high level need for older people in Warwickshire



Source: West Midlands Resource Allocation Model

2.2 What the map above shows is the wards identified by the West Midlands Resource Allocation model, as likely to have the greatest requirement for high level social care. It suggests the major concentrations are likely to be in Nuneaton and Bedworth as well as some in Rugby and Leamington Spa. At the same time, there is a funnel of uncertainty that widens as we look further forward. At the same time it needs to be recognised that there appears to be a Care gap across the county and all Districts will experience an increase in the number of older people and more especially those aged 75 and over.

2.3 Department of Health Circular LAC [2008] 1 confirms Joint Strategic Needs Assessments [JSNA] are linked to the reform agenda. Not only does adult social care have to meet changing needs and expectations but is also expected to do so in new ways. It cannot be about more of the same. JSNAs are also expected to provide the foundations for much future service planning around the balance of care.

3. Shaping the Local Care Economy – Managing Uncertainty

3.1 In 2006, the Wanless Social Care Review Report ***"Securing Good Care for Older People – Taking a long term view"*** identified three key drivers:

- Health and disability related impairment [both physical and cognitive]
- Housing and accommodation circumstances
- Family and informal carer circumstances.

3.2 **Appendix E 1** has profiled needs of older people, the impact of demography, identified some risk factors and linked these to some data on disadvantage. Difficulties with activities for daily living formed the basis of the Wanless approach to estimating need. This also forms the basis of the approach in this report which will seek to relate fair access criteria and Wanless need criteria to prevalence data and supply

3.3 Social care does not exist in isolation. The present balance of care arises from a number of interdependent factors. A significant change in one area can impact on the others. We can be fairly confident there will be more older people, to some extent about levels of morbidity and likely preferences but there are still lots of variables that will come into play to shape future care arrangements. These include "What if" factors such as:

- Care costs rise above expected rates of inflation
- Social change reduces availability of informal care
- Morbidity improves [or deteriorates] and people remain independent longer
- Care expectations and preferences change and continue to increase
- Public funding for care reduces or does not keep pace with need
- Supply side confidence: care service providers leave the market/don't enter the market
- Impact of new models or influences on care [e.g. telecare and telehealth]
- Impact of low intensity support, information and advice services
- Changes in housing provision and design [e.g. lifetime housing, extra care]
- Impact of national service frameworks and existing or new strategies [e.g., Older people, Strokes, Falls, Dementia, Carers, Coronary Heart Disease [CHD]
- Pacing and impact of Social Care reform and the personalisation agenda
- General movements in interest rates, housing capital values and overall housing market confidence.
- Availability of capital within financial markets
- Attractiveness or otherwise of care sector as source of employment
- Changes to care regulation impact on requirements for operation

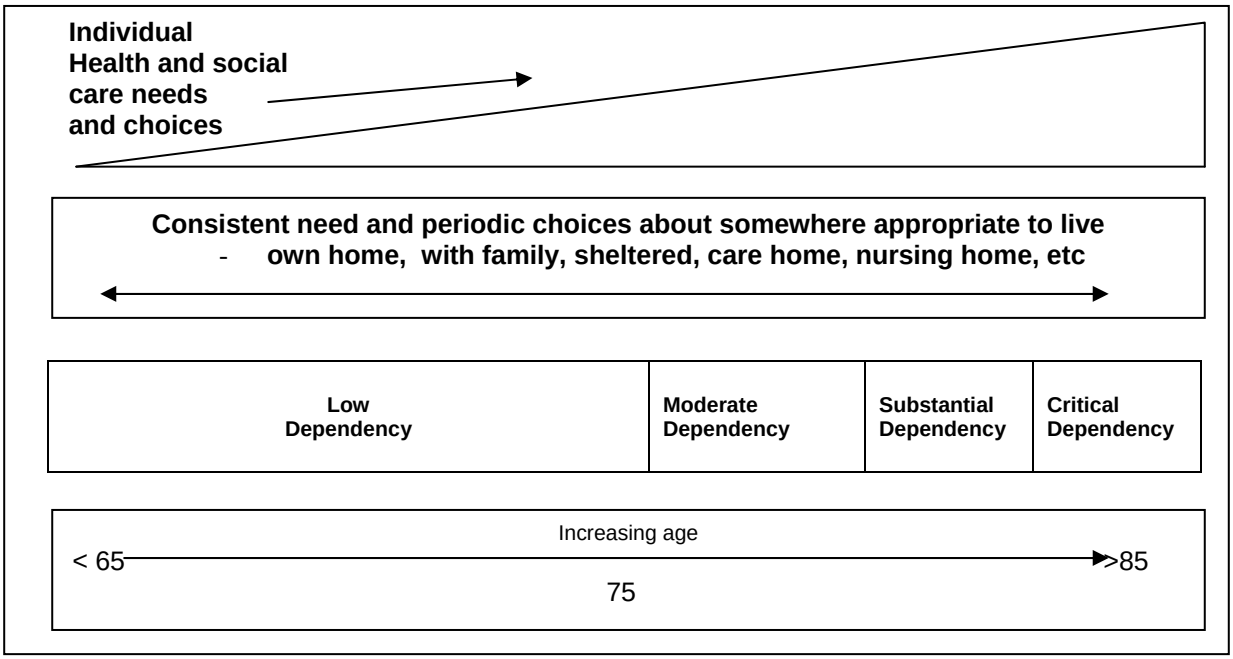
4. Shaping the Care Economy: A continuum of care

4.1 The central proposition within the balance of care model being used is that people have care and accommodation needs throughout their lives. Health, social care and security needs also exist throughout life but tend to increase as the impact of ageing increases on individuals. Both these dimensions exist along a continuum although they may consist of some distinct elements at certain stages. In most circumstances there will be an appropriate balance between health, social care and accommodation. It is when these factors are not in balance and difficulties with activities for daily living or security arise that people may begin to contemplate change.

4.2 Thus, for example, adaptations to property may be pursued so people get a better fit with their preferred lifestyle and needs: e.g. chair lifts to overcome difficulties in mobility. Some will come into contact with adult social care but others may not. Most will prefer to stay where they are. Some people will choose to move into Extra Care Housing. Few will choose care homes.

4.3 This concept of a continuum of care and accommodation is set out in the Diagram 2 below:

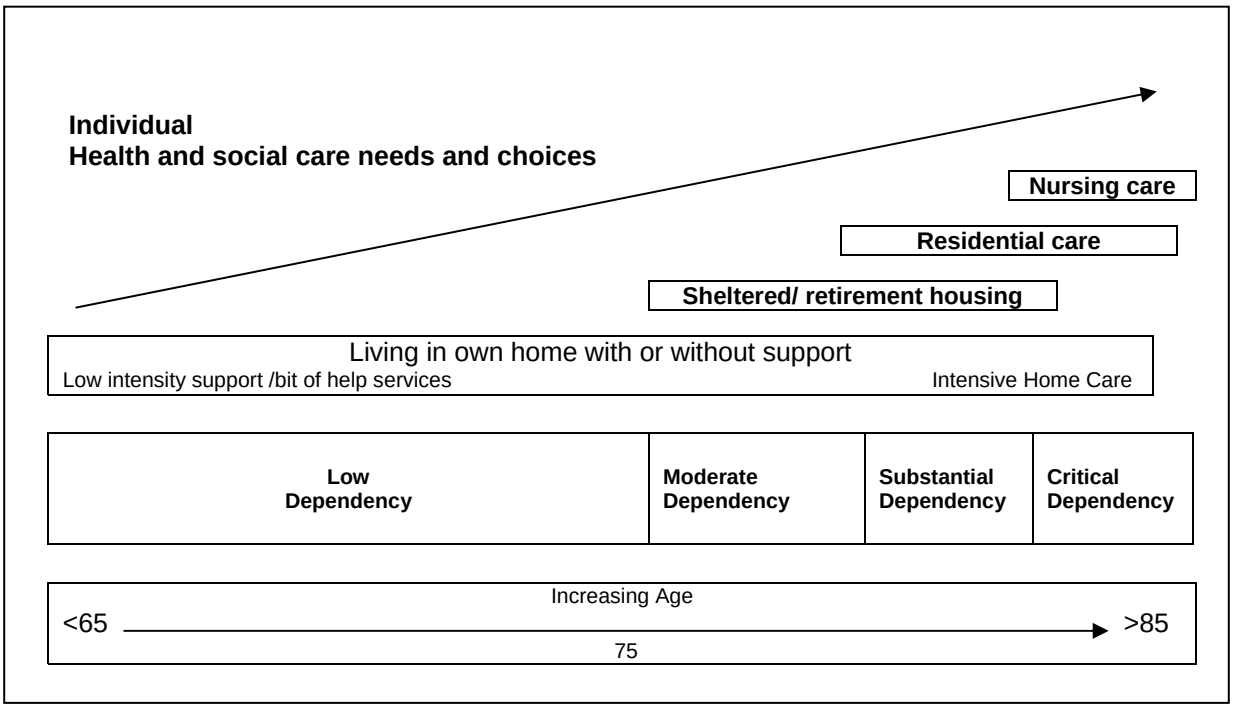
Diagram 2: The continuum of care model



4.4 **Appendix D** outlines some of the factors that older people consider when making choices about where and how to live in later life. These choices will at any one time shape the local balance of care. All too often, however, older people may be faced with fitting into what is available rather than services developing around what they need. This is gradually changing and the social care reform agenda is set to accelerate that pace of change.

4.5 The information in **Appendices E1** and **E2** offers substantial information about need and supply availability. The diagram overleaf incorporates the main themes of that information at county level to show a current balance of care for Warwickshire. As part of the proposed arrangements for consultation there will be further analysis of this material at district level. Market mapping work will also continue and be developed.

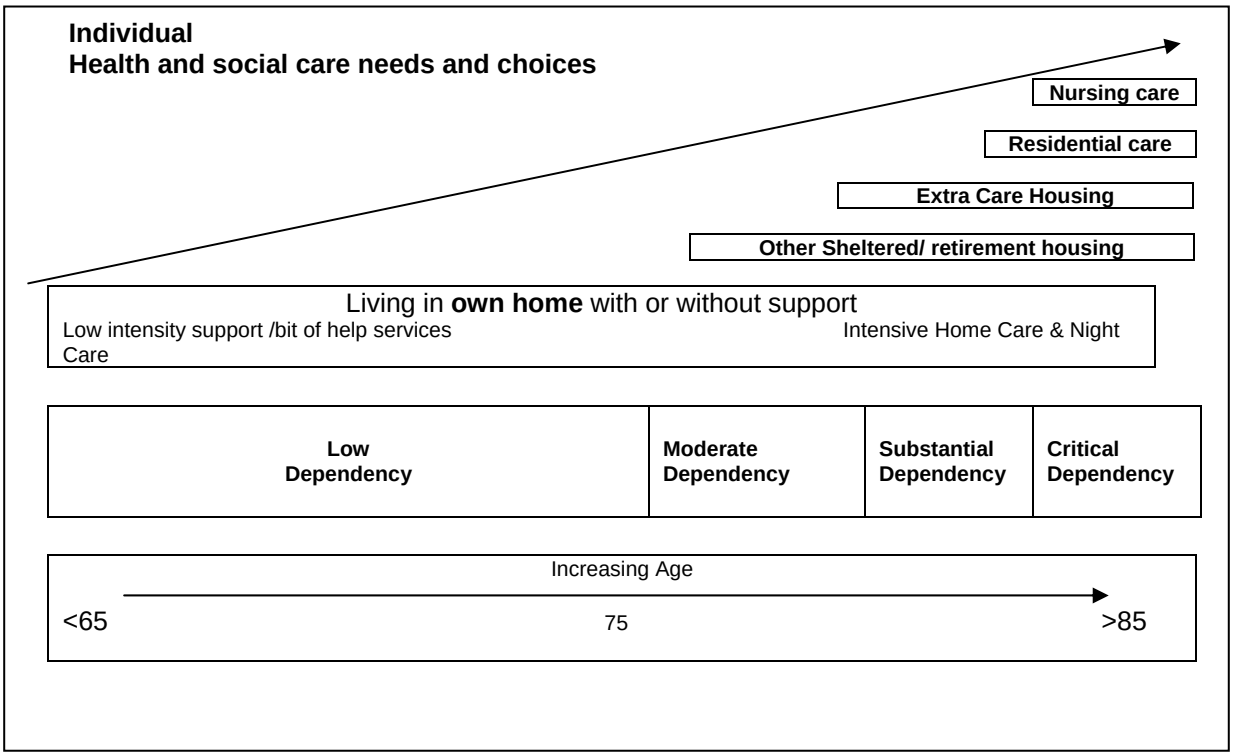
Diagram 3: The current local "Balance of Care" [2008]



5. A New Local Balance of Care

5.1 The key change in the local balance of care would be the development of extra care housing and the support of more people in their own homes. The aim would be that, overall, current provision of care and nursing homes should be at the around same level as now. It would be more focussed, however, on people with "critical" needs that cannot be met reasonably or practically in any other care and accommodation setting. This proposed new balance of care is set out in Diagram 4 below

Diagram 4: A New Balance of Care for Warwickshire



6. Reframing the Local Balance of Care

6.1 The County tables overleaf make use of information on the current need, demand and supply side estimates in **Appendices E [1]** and **E [2].** Each then identifies the variance between the two. The figures include people who self fund their care. The populations are then increased for demography whilst current use remains constant.

6.2 This approach allows the impact of demography to emerge and offers a basis for deciding how best to meet future need and demand. This can be done without being over constrained by existing supply and enables a strategic view to be formed having regard to the outcomes we are seeking.

6.3 The aim is to meet part of the expected impact of demographic change by the development of extra care housing for people with substantial needs. This would be accompanied by action to develop overall capacity within the care economy. The generation of additional capacity can then be used as a lever to promote market change. In this way it should be possible to better match care and nursing home provision to the needs of the most dependent; with special reference to older people with dementias.

6.4 Properly co-ordinated and with appropriate use of influence within the care economy, these shifts could become powerful drivers of better care outcomes at lower costs. This process of reframing and developing the local care economy would be undertaken within agreed and available resource parameters. It would involve continuing dialogue with care providers. The care and choice programme would be underpinned and reinforced by a continuing and developing close partnership working with health, housing, care providers, users and carers designed to secure:

- Provision of improved advice and support to better match care needs and settings with reduced use of care and nursing homes.
- Promotion of low intensity support, self directed care, direct payments together with improved support to carers and a focus on re-ablement as a means of generating care options and enhanced capacity for independent living.
- Commissioning of creative and personalised solutions for improved intensive care at home services making full use of direct payments, individual budgets, telecare, adaptations, carer support and night sitting services and contracting mechanisms to stimulate diversity and development within domiciliary care.
- Reframing of current direct care home provision to meet higher dependency needs and to help effect market shifts so that the vast majority of care and nursing home provision is within single rooms of 12m2, with en-suite facilities and consistent with preferences.
- Using contracting mechanisms as a direct incentive to the phasing out of shared bedrooms for older people who are not related to one another and to stimulate market change to reframe total provision to modern standards and future expectations.
- Facilitating the development of care settings better able to meet the care requirements of people with special needs for dementia and nursing care and to deliver the right care in the right setting.

6.5 **The key message is that it is not possible to shift the balance of care at the higher end of the care spectrum without allied changes at other levels and capacity to do so.** This needs to include provision for a new approach to people who self fund their care and responds to the concerns in the State of Social Care in England Report for 2006-2007 published by the Commission for Social Care Inspection in January 2008 and the wider agenda for Social Care Reform.

Table 1:The Balance of Care 2007 [Warwickshire] – 2007

	Warwickshire - 2007											
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	192	161	344	1134	1831	390	407	1018	986	423 - 438	4	10.3
9	460	563	705	1436	3164	897	937	740	718	1509 - 1527	4/3	36.4
8	536	523	705	1310	3074	1841	1922	93	90	1062 - 1140	3	26.4
7	575	764	705	1764	3808	2950	3080	0	0	728 - 858	3/2	19.0
6	613	925	672	1739	3949	1154	1204	0	0	2745 - 2795	2	
5	958	1327	968	1915	5168	1154	1204	0	0	3964 - 4014	2	
4	1149	1206	968	1562	4885	0	0	0	0		1	
3	1455	1447	984	1613	5499	0	0	0	0		1	
2	1992	1648	1197	1663	6500	0	0	0	0		1	
1	2911	2050	1492	1764	8217	0	0	0	0		1	

Table 2: The Balance of Care, 2011 [Warwickshire]

	Warwickshire - 2011					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	219	184	389	1193	1985	390	407	1018	986	577 - 592	4	13.0
9	526	643	796	1511	3476	897	937	740	718	1821 - 1839	4/3	40.7
8	613	597	796	1378	3384	1841	1922	93	90	1372 - 1450	3	31.4
7	657	872	796	1855	4180	2950	3080	0	0	1100 - 1230	3/2	25.9
6	701	1056	759	1829	4345	1154	1204	0	0	3141 - 3191	2	
5	1095	1515	1092	2014	5716	1154	1204	0	0	4512 - 4562	2	
4	1314	1377	1092	1643	5426	0	0	0	0		1	
3	1664	1652	1110	1696	6122	0	0	0	0		1	
2	2278	1882	1351	1749	7260	0	0	0	0		1	
1	3329	2341	1684	1855	9209	0	0	0	0		1	

Table 3: The Balance of Care, 2021 [Warwickshire]

	Warwickshire - 2021					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	240	198	550	1530	2518	390	407	1018	986	1110 - 1125	4	18.6
9	576	692	1127	1938	4333	897	937	740	718	2678 - 2696	4/3	44.6
8	672	642	1127	1768	4209	1841	1922	93	90	2197 - 2275	3	37.1
7	720	939	1127	2380	5166	2950	3080	0	0	2086 - 2216	3/2	35.7
6	768	1136	1074	2346	5324	1154	1204	0	0	4120 - 4170	2	
5	1200	1630	1546	2584	6960	1154	1204	0	0	5756 - 5806	2	
4	1440	1482	1546	2108	6576	0	0	0	0		1	
3	1824	1778	1572	2176	7350	0	0	0	0		1	
2	2496	2025	1913	2244	8678	0	0	0	0		1	
1	3648	2519	2384	2380	10931	0	0	0	0		1	

Source: all tables use 1989 OPCS data and 2006 ONS mid year estimates with local Strategic Commissioning data.

Notes:

Fair Access Levels 4 = Critical; 3 = Substantial; 2 = Moderate; 1 = Low. Where two numbers are shown severity category is considered to contain a mix of both levels of need.

The severity categories are the same as those used by OPCS [see **Appendix E 1**]. Category 10 has the highest level of disability and Category 1 the lowest.

The information on people who self fund care has been drawn from different sources. The estimated percentages of self funding vary. To recognise this both have been estimated and are shown in columns 1 and 2 of provision within the two main sectors: community services and care home services. This in effect provides a range.

The variance is the difference between the estimated number of people with disabilities using the OPCS prevalence data and the estimated number of people supported through the local care economy. Inevitably there is a potential margin for error here. For the purposes of this report the variance is described as a potential care gap. This raw care gap is then adjusted as shown later in this paper.

6.6 This analysis is repeated at district council level and the relevant tables appear as **Appendix E. 3 Balance 2.** In striking this balance of care a number of assumptions have had to be made about current need, the distribution of existing community services and migration. They are;

- Morbidity in the population will stay much the same or improve slightly on current levels in all areas [Note: progress in tackling health inequalities can make a major contribution towards reducing future care needs]
- The number of Warwickshire residents who move to care and accommodation schemes in other areas is the same as the number of people from other areas who move to Warwickshire.
- The current proportion of people who self fund their care is similar to that identified nationally.
- A measure of under-utilisation of supply is inevitable and is necessary to permit choice.
- A proportion of people will continue to make their own arrangements for care and will not come into the care or benefits system and need to be deducted from the variance shown in lower severity categories.
- Some people will be within NHS or continuing healthcare arrangements and need to be deducted.
- The prevalence data includes adults with learning disabilities who need to be deducted from the variance shown.
- Numbers do not include those people within sheltered housing schemes who may not be in receipt of care services and rely on informal support

6.7 Robust population needs assessment is an essential component of strategic commissioning. To underpin Joint Strategic Needs Assessments a number of tools have been developed to help strategic commissioners to clarify needs and help assess likely future needs. One of the more recent tools is Plannign4care which is designed to help commissioners explore the implications of changing needs by linking needs projections to service options and costs using the basic five level model from the Wanless Report.

6.8 Initial internal discussion suggests, however, that the outputs have a “reality” feel about them and appear consistent with other information available. The analysis arising from this paper should not be treated as an event but rather more as part of an ongoing process of measuring and matching, need, demand and supply over time.

6.9 The analysis made is not overly complex. As market mapping develops and more data become available the analysis can be reviewed and updated. Future work would be assisted by use of analytical tools that are becoming available. Such tools have a potentially valuable role to play in enabling the further development of a shared understanding around variables, their likely impact under different circumstances and assumptions surrounding ageing arising, for example, from gender, culture, beliefs, economic situation, use of and access to care pathways and so on.

6.10 Access to such a tool with an ability to generate timely and intelligent information for discussion at strategic commissioning and decision-making levels is likely to be a valuable component of continuing work in this area. These data can be used to inform dialogue with existing and future providers of care services of all types about what might be needed, when and for whom in the future. It would also contribute to the year three review proposed in this report that will consider progress and the future direction of travel in the longer term.

7. Assessing the Warwickshire Care Gap

7.1 Having considered the various factors surrounding the information available the material generated points to an existing and widening variance or "potential care gap" as follows:

Table 4: Estimated variance between supply and demand for care, 2007, 2011, 2021

	OPCS Severity Category/ FACs Group				
OPCS Severity	**5-6**	**7**	**8**	**9**	**10**
Approximate FACs group	**3/2**	**3**	**3**	**4/3**	**4**
Year					
2007/2008	7,000*	500	800	1,100	200
2011	8,000*	900	1,100	1,400	400
2021	10,000*	1,800	1,900	2,200	800

Note: Fair Access to Care [FACS] Levels 4 = Critical; 3 = Substantial; 2 = Moderate; 1 = Low. Where two numbers are shown severity category is considered to contain a mix of both levels of need.

Note: all numbers rounded and are likely to vary according to developments in need and market supply. A potential care gap exists against all severity categories. The widening gap shows the impact of demography.

7.2 It is intended that the potential care gap around OPCS Severity Categories 5 -6 [FACS 3/2] should be considered as part of the development of low intensity support services and not as part of this programme. This work together with other work being undertaken on care pathways will, however, be relevant to the way in which the estimated care gap is responded to. Many people in these groups may make own arrangements for care and support. There is also some evidence that proportions of people doing so may vary across the county. This aspect will be allowed for in the more detailed district analyses it is intended to make.

7.3 It is essential to remember that these are estimates. The figures given are not inevitable. With the passage of time, new circumstances and changing expectations there is an increasing funnel of doubt as we move further into the future.

7.4 The general picture that has emerged for 2007/08, however, has a consistency with recent local commissioning experience in relation to need at the critical and substantial level. It also matches up with understandings around the need for development of low intensity support services. Whilst the data have limitations it seems reasonable to conclude for strategic planning purposes that;

- Existing supply and need are not in balance and there may be a shortfall in care and support availability for those with critical and substantial needs that may inhibit choice and responsive delivery.
- The evidence of potential demand in excess of supply suggests there may be specific areas where it is difficult to obtain care where intensive help is needed for people who are older and frailer than previously.
- Low intensity support services appear to be under developed.
- There appear to be gaps around intensive care for older people with mental health needs in need of 24 hour care and the need for more intensive options for this group which is confirmed by local commissioning experience around access to care and accommodation for older people with moderate and more severe levels of dementia.
- The ability to review and remodel existing care and accommodation services is likely to be linked to the ability to stimulate the care economy and as a commissioner to try to increase capacity so as to create scope for choice and change.
- Action on service change needs to expand care system capacity at the same time as or preferably in advance of any re-modelling or re-balancing of care options within the care economy in order to minimise risk of disruption to service users and carers.
- Supply availability in relation to need varies within Warwickshire and access to local and convenient care services may need to develop more in some Districts than in others to ensure equality of access across the County.
- Demographic change will lead to a widening gap between existing supply and demand which creates an opportunity to remodel the balance of care towards more care at home and extra care housing services and away from care homes offering personal care only.
- Sheltered housing is making a contribution which, if linked to the development of extra care accommodation with appropriate facilities and an appropriate mix of tenure types matching local circumstances, could make a greater contribution, together with Supporting People, to care and choice options for older people.
- The development of extra care housing may need to be accompanied by remodelling of existing sheltered provision and further mapping activity is needed in this area.
- As both a provider and a commissioner of care the Council needs to consider how it can maximise its contribution to securing the best balance of care possible and determine how best its own directly provided care services can contribute.

7.5 Applying the balance of care is about using our understanding of ageing and how people respond. It is about framing responses in terms of everyday lives that enable people to optimise residual abilities, stay in a familiar environment and provide support to enable them to remain independent with a real say about how their life is to organised. It is not just about buildings and accommodation important as they are.

7.6 The tables also indicate a widening care gap as we move down the severity categories. This indicates a need to consider further the availability of intensive support at home. It is at home that the majority of older people are to be found and it is at home, generally speaking, where they wish to remain. It does not follow that all these people will seek or need publicly funded support. Some will continue to make their own arrangements.

7.7 A lot will depend on general social and emotional sense of well being, age-friendly housing and neighbourhoods, friends and networks, beliefs and ability to carry on. In thinking about how best to respond it is important to identify better those factors leading to service take up from different sources and the circumstances whereby they arise.

7.8 In planning how we might meet the future balance of care needs, the identification of "tipping points" along care and support pathways that lead to higher intensity health and social care support is essential. We should aim to see what might be done to anticipate them or generate meaningful alternatives that offer better outcomes but at lower cost. Being better informed and feeling able to exercise choice and control are essential components of this process of user and carer choice and control.

7.9 Finally, attention needs to be given, also, to the supply of human resources. This includes ensuring robust linkages to the development of a more skilled and highly competent workforce across all sectors able to deliver care and support consistent with the principles of social care reform outlined in the earlier sections of this report. This of itself is a potentially huge challenge which needs to be met if the sort of care services and choices we are pointed towards are to become an everyday reality in the future.

8. District Variations in the Care Gap – Initial Findings

8.1 Supplementary tables to this Appendix set out the initial assessment of the care gap at District level. Further work on District analyses is intended as part of the proposed arrangements for consultation and in the development of the local Joint Strategic Needs Assessment in partnership with health and Districts.

8.2 In general most issues applying at county level would also apply at local level. The District data add to the county picture in the following ways:

- District variations in the supply of care at home and care home services need to be allowed for when assessing current and future needs.
- The accommodation available across the county in terms of bedroom facilities varies and may present further local challenges on suitability and availability [e.g. nursing homes in Stratford upon Avon District, as dependency rises.
- In terms of "critical "needs North Warwickshire appears proportionately to have a slightly better balance than the county average.
- The effects of demography and the balance of older populations impacts differently in districts but all have a widening care gap in severity categories 9/10.
- The widest care gaps in groups 8 –7 appear to be in Stratford and Warwick with the narrowest care gaps being found in Rugby, Nuneaton and Bedworth which may reflect relative advantage and disadvantage which should be allowed for.

9. Responding to a New Balance of Care

9.1 If a better balance of care, more appropriate to individual needs, consistent with the principles of social care reform, is to be delivered the Council needs to influence overall provision and activity. The material in **Appendices D & E1 – E3** would form the basis of consultation with stakeholder to gain their views on the approach and direction of travel being suggested.

9.2 In providing this information for strategic commissioning purposes, the Council also needs to consider how it may wish to contribute to a new balance of care. The Council is a key player both as a commissioner and as a provider of care homes. Reflecting on and possibly reframing the role of direct provision would be part of this.

Predicting the Future Balance of Care [County & District Tables]

1. Estimated Care Gap [all types] - Warwickshire - 2007

Warwickshire - 2007												
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	192	161	344	1134	1831	390	407	1018	986	423 - 438	4	10.3
9	460	563	705	1436	3164	897	937	740	718	1509 - 1527	4/3	36.4
8	536	523	705	1310	3074	1841	1922	93	90	1062 - 1140	3	26.4
7	575	764	705	1764	3808	2950	3080	0	0	728 - 858	3/2	19.0
6	613	925	672	1739	3949	1154	1204	0	0	2745 - 2795	2	
5	958	1327	968	1915	5168	1154	1204	0	0	3964 - 4014	2	
4	1149	1206	968	1562	4885	0	0	0	0		1	
3	1455	1447	984	1613	5499	0	0	0	0		1	
2	1992	1648	1197	1663	6500	0	0	0	0		1	
1	2911	2050	1492	1764	8217	0	0	0	0		1	

2. Estimated Care Gap [all types] – Warwickshire - 2011

Warwickshire - 2011						Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	219	184	389	1193	1985	390	407	1018	986	577 - 592	4	13.0
9	526	643	796	1511	3476	897	937	740	718	1821 - 1839	4/3	40.7
8	613	597	796	1378	3384	1841	1922	93	90	1372 - 1450	3	31.4
7	657	872	796	1855	4180	2950	3080	0	0	1100 - 1230	3/2	25.9
6	701	1056	759	1829	4345	1154	1204	0	0	3141 - 3191	2	
5	1095	1515	1092	2014	5716	1154	1204	0	0	4512 - 4562	2	
4	1314	1377	1092	1643	5426	0	0	0	0		1	
3	1664	1652	1110	1696	6122	0	0	0	0		1	
2	2278	1882	1351	1749	7260	0	0	0	0		1	
1	3329	2341	1684	1855	9209	0	0	0	0		1	

3. Estimated Care Gap [all types] – Warwickshire - 2021

Warwickshire - 2021						Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	240	198	550	1530	2518	390	407	1018	986	1110 - 1125	4	18.6
9	576	692	1127	1938	4333	897	937	740	718	2678 - 2696	4/3	44.6
8	672	642	1127	1768	4209	1841	1922	93	90	2197 - 2275	3	37.1
7	720	939	1127	2380	5166	2950	3080	0	0	2086 - 2216	3/2	35.7
6	768	1136	1074	2346	5324	1154	1204	0	0	4120 - 4170	2	
5	1200	1630	1546	2584	6960	1154	1204	0	0	5756 - 5806	2	
4	1440	1482	1546	2108	6576	0	0	0	0		1	
3	1824	1778	1572	2176	7350	0	0	0	0		1	
2	2496	2025	1913	2244	8678	0	0	0	0		1	
1	3648	2519	2384	2380	10931	0	0	0	0		1	

4. Estimated Care Gap [all types] – North Warwickshire – 2007

North Warwickshire - 2007												
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	24	19	38	108	189	42	44	124	120	23 - 25	4	5.2
9	58	67	77	137	339	99	104	90	88	147 - 150	4/3	32.3
8	67	62	77	125	331	219	228	11	11	92 - 101	3	21.0
7	72	91	77	168	408	352	368	0	0	40 - 56	3/2	10.4
6	77	110	74	166	427	87	90	0	0	337 - 340	2	
5	120	158	106	182	566	87	90	0	0	476 - 479	2	
4	144	144	106	149	543	0	0	0	0		1	
3	182	173	108	154	617	0	0	0	0		1	
2	250	197	131	158	736	0	0	0	0		1	
1	365	245	164	168	942	0	0	0	0		1	

5. Estimated Care Gap [all types] – North Warwickshire - 2011

	North Warwickshire 2011					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	28	22	42	135	227	42	44	124	120	61 - 63	4	12.4
9	66	78	86	171	401	99	104	90	88	209 - 212	4/3	42.1
8	77	73	86	156	392	219	228	11	11	153 - 162	3	31.5
7	83	106	86	210	485	352	368	0	0	117 - 133	3/2	25
6	88	129	82	207	506	87	90	0	0	416 - 419	2	
5	138	185	118	228	669	87	90	0	0	579 - 582	2	
4	165	168	118	186	637	0	0	0	0		1	
3	209	202	120	192	723	0	0	0	0		1	
2	286	230	146	198	860	0	0	0	0		1	
1	418	286	182	210	1096	0	0	0	0		1	

6. Estimated Care Gap [all types] – North Warwickshire - 2021

	North Warwickshire 2021					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	30	24	63	167	284	42	44	124	120	118 - 120	4	17.8
9	72	85	129	211	497	99	104	90	88	305 - 308	4/3	45.7
8	84	79	129	192	484	219	228	11	11	245 - 254	3	37.2
7	90	116	129	259	594	352	368	0	0	226 - 242	3/2	34.9
6	96	140	123	255	614	87	90	0	0	524 - 527	2	
5	150	201	177	281	809	87	90	0	0	719 - 722	2	
4	180	183	177	229	769	0	0	0	0		1	
3	228	220	180	237	865	0	0	0	0		1	
2	312	250	219	244	1025	0	0	0	0		1	
1	456	311	273	259	1299	0	0	0	0		1	

7. Estimated Care Gap [all types] – Nuneaton and Bedworth 2007

Nuneaton and Bedworth - 2007												
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	42	36	69	230	377	92	96	235	228	50 - 53	4	6.1
9	100	126	142	291	659	210	219	171	165	275 - 278	4/3	32.9
8	116	117	142	265	640	481	502	11	11	127 - 148	3	16.4
7	125	171	142	357	795	736	769	0	0	26 - 59	3/2	5.1
6	133	207	135	352	827	144	150	0	0	677 - 683	2	
5	208	297	195	388	1088	144	150	0	0	938 - 944	2	
4	249	270	195	316	1030	0	0	0	0		1	
3	315	324	198	326	1163	0	0	0	0		1	
2	432	369	241	337	1379	0	0	0	0		1	
1	631	459	300	357	1747	0	0	0	0		1	

8. Estimated Care Gap [all types] – Nuneaton and Bedworth - 2011

	Nuneaton and Bedworth 2011					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	48	41	80	243	412	92	96	235	228	85 - 88	4	9.4
9	115	143	163	308	729	210	219	171	165	345 - 348	4/3	37.7
8	134	133	163	281	711	481	502	11	11	198 - 219	3	22.7
7	144	194	163	378	879	736	769	0	0	110 - 143	3/2	13.8
6	154	235	156	373	918	144	150	0	0	768 - 774	2	
5	240	337	224	410	1211	144	150	0	0	1061 - 1067	2	
4	288	306	224	335	1153	0	0	0	0		1	
3	365	367	228	346	1306	0	0	0	0		1	
2	499	418	277	356	1550	0	0	0	0		1	
1	730	520	346	378	1974	0	0	0	0		1	

9. Estimated Care Gap [all types] – Nuneaton and Bedworth - 2021

	Nuneaton and Bedworth 2021					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	53	44	109	320	526	92	96	235	228	199 - 202	4	16.3
9	127	154	224	405	910	210	219	171	165	526 - 529	4/3	42.9
8	148	143	224	369	884	481	502	11	11	371 - 392	3	31.0
7	159	209	224	497	1089	736	769	0	0	320 - 353	3/2	27.4
6	170	253	213	490	1126	144	150	0	0	976 - 982	2	
5	265	363	307	540	1475	144	150	0	0	1325 - 1331	2	
4	318	330	307	440	1395	0	0	0	0		1	
3	403	396	312	454	1565	0	0	0	0		1	
2	551	451	380	469	1851	0	0	0	0		1	
1	806	561	473	497	2337	0	0	0	0		1	

10. Estimated Care Gap [all types] – Rugby - 2007

Rugby - 2007												
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	33	27	61	194	315	75	79	195	190	45 - 46	4	6.4
9	79	94	125	245	543	131	137	142	138	268 - 270	4/3	37.9
8	92	87	125	224	528	283	295	11	11	222 - 234	3	32.1
7	99	127	125	301	652	445	464	0	0	188 - 207	3/2	27.8
6	106	154	119	297	676	388	405	0	0	271 - 288	2	
5	165	221	171	327	884	388	405	0	0	479 - 496	2	
4	198	201	171	267	837	0	0	0	0		1	
3	251	241	174	275	941	0	0	0	0		1	
2	343	275	212	284	1114	0	0	0	0		1	
1	502	342	264	301	1409	0	0	0	0		1	

11. Estimated Care Gap [all types] – Rugby - 2011

	Rugby 2011					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	37	30	67	203	337	75	79	195	190	67 - 68	4	8.8
9	89	105	138	257	589	131	137	142	138	314 - 316	4/3	40.9
8	104	98	138	234	574	283	295	11	11	268 - 280	3	35.6
7	111	143	138	315	707	445	464	0	0	243 - 262	3/2	32.8
6	118	173	131	311	733	388	405	0	0	328 - 345	2	
5	185	248	189	342	964	388	405	0	0	559 - 576	2	
4	222	225	189	279	915	0	0	0	0		1	
3	281	270	192	288	1031	0	0	0	0		1	
2	385	308	234	297	1224	0	0	0	0		1	
1	562	383	291	315	1551	0	0	0	0		1	

12. Estimated Care Gap [all types] – Rugby - 2021

	Rugby 2021					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	40	32	97	261	430	75	79	195	190	160 - 161	4	15.4
9	95	112	198	331	736	131	137	142	138	461 - 463	4/3	44.4
8	111	104	198	302	715	283	295	11	11	409 - 421	3	39.9
7	119	152	198	406	875	445	464	0	0	411 - 430	3/2	40.4
6	126	184	189	400	899	388	405	0	0	494 - 511	2	
5	198	264	271	441	1174	388	405	0	0	769 - 786	2	
4	237	240	271	360	1108	0	0	0	0		1	
3	300	288	276	371	1235	0	0	0	0		1	
2	411	328	336	383	1458	0	0	0	0		1	
1	600	408	419	406	1833	0	0	0	0		1	

13. Estimated Care Gap [all types] – Stratford - 2007

Stratford - 2007												
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	50	41	84	297	472	83	87	242	235	147 - 150	4	13.9
9	119	144	172	376	811	220	230	176	170	411 - 415	4/3	38.6
8	139	134	172	343	788	369	386	11	11	391 - 408	3	37.3
7	149	196	172	462	979	730	762	0	0	217 - 249	3/2	21.8
6	158	237	164	455	1014	296	309	0	0	705 - 718	2	
5	248	340	236	502	1326	296	309	0	0	1017 - 1030	2	
4	297	309	236	409	1251	0	0	0	0		1	
3	376	371	240	422	1409	0	0	0	0		1	
2	515	422	292	436	1665	0	0	0	0		1	
1	752	525	364	462	2103	0	0	0	0		1	

14. Estimated Care Gap [all types] – Stratford - 2011

	Stratford 2011					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	57	49	101	311	518	83	87	242	235	193 - 196	4	16.6
9	136	171	206	393	906	220	230	176	170	506 - 510	4/3	43.4
8	158	159	206	359	882	369	386	11	11	485 - 502	3	42.2
7	170	232	206	483	1091	730	762	0	0	329 - 361	3/2	29.5
6	181	281	197	476	1135	296	309	0	0	826 - 839	2	
5	283	403	283	524	1493	296	309	0	0	1184 - 1197	2	
4	339	366	283	428	1416	0	0	0	0		1	
3	429	439	288	442	1598	0	0	0	0		1	
2	588	500	350	455	1893	0	0	0	0		1	
1	859	622	437	483	2401	0	0	0	0		1	

15. Estimated Care Gap [all types] – Stratford - 2021

	Stratford 2021					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	63	53	151	423	690	83	87	242	235	365 - 368	4	22.1
9	151	186	310	536	1183	220	230	176	170	783 - 787	4/3	47.3
8	176	173	310	489	1148	369	386	11	11	751 - 768	3	45.8
7	189	253	310	658	1410	730	762	0	0	648 - 680	3/2	40
6	202	306	295	649	1452	296	309	0	0	1143 - 1156	2	
5	315	439	425	714	1893	296	309	0	0	1584 - 1597	2	
4	378	399	425	583	1785	0	0	0	0		1	
3	479	479	432	602	1992	0	0	0	0		1	
2	655	545	526	620	2346	0	0	0	0		1	
1	958	678	655	658	2949	0	0	0	0		1	

16. Estimated Care Gap [all types] – Warwick - 2007

Warwick - 2007												
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	44	37	90	297	468	97	101	221	215	150 - 152	4	14.0
9	104	130	185	376	795	238	249	161	156	390 - 396	4/3	36.4
8	122	121	185	343	771	382	399	11	11	361 - 378	3	34.2
7	131	177	185	462	955	687	718	0	0	237 - 268	3/2	23.4
6	139	214	176	455	984	239	250	0	0	734 - 745	2	
5	218	307	254	502	1281	239	250	0	0	1031 - 1042	2	
4	261	279	254	409	1203	0	0	0	0		1	
3	331	335	258	422	1346	0	0	0	0		1	
2	452	381	314	436	1583	0	0	0	0		1	
1	661	474	391	462	1988	0	0	0	0		1	

17. Estimated Care Gap [all types] – Warwick - 2011

	Warwick 2011					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	51	41	99	302	493	97	101	221	215	175 - 177	4	15.4
9	121	144	202	382	849	238	249	161	156	444 - 450	4/3	39.2
8	141	134	202	348	825	382	399	11	11	415 - 432	3	37.1
7	152	196	202	469	1019	687	718	0	0	301 - 332	3/2	27.8
6	162	237	193	462	1054	239	250	0	0	804 - 815	2	
5	253	340	277	509	1379	239	250	0	0	1129 - 1140	2	
4	303	309	277	415	1304	0	0	0	0		1	
3	384	371	282	429	1466	0	0	0	0		1	
2	525	422	343	442	1732	0	0	0	0		1	
1	768	525	428	469	2190	0	0	0	0		1	

18. Estimated Care Gap [all types] – Warwick - 2021

	Warwick 2021					Provision 2007						
Severity Category	60-74		75+		Total (a)	Community Care Support (b)		Care Homes (c)		Variance (a-(b+c))	Fair Access Category	Variance per 1000 75+
	Men	Women	Men	Women		1	2	1	2			
10	55	44	132	365	596	97	101	221	215	278 - 280	4	19.4
9	132	155	271	462	1020	238	249	161	156	615 - 621	4/3	42.9
8	154	144	271	421	990	382	399	11	11	580 - 597	3	40.9
7	165	211	271	567	1214	687	718	0	0	496 - 527	3/2	35.5
6	176	255	258	559	1248	239	250	0	0	998 - 1009	2	
5	275	366	372	616	1629	239	250	0	0	1379 - 1390	2	
4	330	333	372	502	1537	0	0	0	0		1	
3	418	400	378	518	1714	0	0	0	0		1	
2	572	455	460	535	2022	0	0	0	0		1	
1	836	566	573	567	2542	0	0	0	0		1	

Source: all tables use 1989 OPCS data and 2006 ONS mid year estimates with local Strategic Commissioning data.

Note: Fair Access Levels 4 = Critical; 3 = Substantial; 2 = Moderate; 1 = Low . Where two numbers are shown severity category is considered to contain a mix of both levels of need.

APPENDIX F

Adult, Health & Community Services

Strategic Commissioning Division

Warwickshire County Council

SERVICE MODEL

Extra care housing, support and care

This service model sets out what we understand to be meant by the term Extra Care Housing, support and care. It provides the framework for the development of service specifications for individual schemes and is part of the overall procurement process of the Council.

Dated:	**3rd**	**Day Of**	**April**	**2008**

APPENDIX F

1.1. Overview of service:	1. Extra Care housing is purpose built accommodation in which varying amounts of care and support can be offered and where some services and facilities are shared. 2. Extra Care Housing may have a number of different formats and designs however, it does have a number of defining features including: • It is first and foremost a type of housing. • It is a person's individual home. • It is **not** a care home or hospital and this is reflected in the nature of its occupancy through ownership, lease or tenancy. • It is accommodation that has been specially designed, built or adapted to facilitate the care and support needs that its owners/tenants may have. 3. Extra care housing should aim to provide people with the maximum possible opportunities to maintain their privacy and independence and to have choice and control over their lifestyle and their care and support arrangements. 4. Extra Care Housing is seen as an alternative for people who might otherwise have entered residential care homes. It will provide accommodation and support for people as they age and for as long as they would wish or until their needs can no longer be met in this environment and are assessed to be best met in another setting 5. Extra Care Housing will normally provide: • Safe and secure self-contained accommodation for people who require varying levels of support to enable them to live independently in a home environment. • The service will include the provision of care based on individual assessment. • Access to flexible care and support which 'work with' rather than 'doing for residents' and aim to maximising the opportunity to preserve or rebuild independent living skills. • Emergency assistance and support is available 24 hours per day either on site or by call. • Access to domestic and housing support services is available through the scheme. • The service has options for a range of social activities and amenities, which serve the needs of both service users within the extra care facility and facilitates access to local community networks and support. • Access to one or more meals every day, which can help to ensure that residents receive their minimal nutritional value per day. These may be provided by on site catering facilities or by existing providers of such services of the resident's choice.

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	• Makes use of appropriate Assistive and Information Technology approaches designed to promote independence, control and choice and ease of communication with social networks or when in need of assistance. 6. It is anticipated that the scheme may include a range of facilities and activities demonstrating flexibility within the scheme such as: • Communal facilities for socialising/activities • Restaurant/bistro/cafe/bar facilities • Shop/s/Kiosk services • Range of social activities including lunch club • Access to other Day opportunities (7 day) for residents and this may include facilities for older people from the local community • Guest room/s • Hairdressing/dental/ GP/chiropody/active learning/exercise/mobile library/arts • Intermediate care services to prevent hospital admissions/facilitate timely hospital discharge. • Assistive Technology will be provided as required and where appropriate, be hard wired throughout the facility to productively assist the individual's greater independence and aid staff to ensure the safety and well being of services user • Internet and telephone access 7. All services provided within an Extra Care Housing setting must be flexible, consistent and reliable and in line with the needs of each Customer, and take into account the following five strategic commissioning priorities: **a). Choice and Control** Putting people in control of their own services, giving them more choice and a stronger voice **b). Services that are Joined Up** Ensuring people experience seamless services from health and social care **c). More Community Based Services** Commissioning services that ensure that the independence of people can be maintained and increased and that will support carers **d). Promoting Independence** Commissioning more community-based services for older people **e). Prevention and Well-Being** Commissioning more services that promote well-being and prevent older people from needing more intensive health and social care services.

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1.2 Service Outcomes	Extra care housing needs to be so organised that it will deliver the following key outcomes that enable older people to: • Live Independently • Stay Healthy • Exercise maximum control over their own lives • Sustain family units and age appropriate caring roles • Participate as active and equal citizens • Maintain Quality of Life • Maintain maximum dignity and respect Above all, extra care housing must meet the needs and expectations of those who use it and be able to demonstrate high levels of service user/resident satisfaction.
1.3 Need for the service:	We have identified that locally the range of accommodation and care options available to local people could be wider. In particular we see extra care housing as offering additional options for more choice and control. Extra care housing is seen as a real alternative for people who either find that their housing situation is no longer convenient or consistent with their care needs or whose care needs would otherwise suggest a need for 24 hour care and support. The needs this type of service has to meet are: • Personal care and support needs(to include day and night services). • Sense of independence, choice and control needs • Support with household maintenance. • Practical help needs • Assistance with shopping and in managing finances where needed [but not lasting powers of attorney]. • Support needs of service users to self direct their own support and care packages. • Motivational needs and to encourage and enable people to arrange their support using either a Direct Payment or an Individual Budget, together with family or community support as appropriate.

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1.4. Service principles:	1. Extra Care Housing is based on 3 main principles: • **To promote independence** – the provision of self contained accommodation with access to on-site care and support enables individuals to live independently in the community, promotes their well-being and helps to alleviate social isolation. • **To be empowering** – primary health, care and support services should come to the individual, as and when needed, rather than the individual being required to change their accommodation in order to receive services that can and should be available in the community. • **To be accessible** – where individuals live should be designed, or be capable of being adapted, to facilitate the delivery of personal social and health care services. 2. The service will support the development of the government and County Council's Health and Well-Being agenda, with a focus on the following: • Choice and Control • Community Based Services • Services that are joined up • Prevention and Well-Being • Promoting Independence • Outcome based person-centred service 3. The domiciliary services will meet the minimum standards specified by the Commission for Social Care Inspection (CSCI) and other relevant standards. 4. Links will be established and maintained with Health professionals, voluntary sector provision, local housing departments and carers. The service will consistently promote and support the social inclusion of all tenants both within the facility and with the surrounding community. 5. Service Users and carers will have a right to privacy, independence, dignity, consultation, choice and fulfillment. 6. Services will respect diversity in age, disability, gender, culture, religion, sexual orientation, and the individual, physical, psychological, social and spiritual needs of all individuals. 7. Accommodation to be appropriate to individual needs. The aim of the service is to provide a home for life through assured tenancies, although this may not always be possible, for example where the person may be a significant risk to themselves or others.

APPENDIX F

1.5. Who is the Service for?	The service will provide for a broad range of need and offer a range of tenant options. Services may therefore be provided to: • Principally, older people aged 60+ who meet the Council's Fair Access to Care Services (FACS) criteria (currently critical and substantial needs] for intensive social care. A care needs assessment will be undertaken by Council care managers and will be available to people irrespective of whether or not they intend to self fund care. • Also for, Older people aged 60+ who have chosen to purchase care services using their own resources but who do not wish to have a social care assessment and for whom the service is judged to be appropriate by the provider. • In addition, older people aged 60+ who meet FACS criteria for low intensity social care services (i.e. with moderate or low needs) for whom the service is judged to be appropriate. Take up of accommodation and use of care services will be managed in accordance with arrangements agreed between the County Council/Supporting People, the housing provider, the care provider and the individual seeking accommodation and care.
1.6 Access to the service:	Extra care housing and support services are expected to operate on a 24-hours per day, 365 days per annum basis, including all public holidays.
1.7 Relevant documentation:	1. Our Health, Our Care, Our Say – White Paper, 2005. 2. The National Service Framework for Older People 3. NHS & Community Care Act, 1990 4. The Warwickshire Strategy for Older People. 5. The Warwickshire Preventative Strategy. 6. The Regulation of Extra Care Housing – The Commission for Social Care Inspection 7. Extra Care Housing for Older People – Department of Health. 8. Mental Health Act 2007 9. Mental Capacity Act 2005 10. Carers [Recognition & Services]Act 1995 and subsequent legislation 11. Everybody's Business. Integrated Services for Older Adults Service Development Guide 12. Warwickshire Mental Health Older People's Strategy. 13. WCC Supporting People Strategy 14. WCC Joint Commissioning Strategies 15. Individual Budgets information 16. FACS criteria [Warwickshire County Council 17. Housing LIN extra care information 18. Putting People First - Concordat 19. Extra Care Housing Toolkit- CSIP 20. Lifetime Homes, Lifetime Neighbourhoods

APPENDIX G

MANAGING CHANGE – THE CARE GUARANTEE

"A programme about people and their lives – not buildings"

CARE GUARANTEE

1. What is happening and why?

We aim to provide the highest quality of care. To do this we have to be sure that what we are doing, or encouraging others to do, meets the needs and expectations of older people we are here to help. There will also be more older people than now.

The big message about people's needs and expectations is that they want care at home or close to home. If they need to move home in later life they do not want to move more than they need to. People want care services to fit in with how they wish to live and not the other way around. People have said that if they have to move in later life then the preference is for "housing with care".

We don't have enough of this type of service. We intend, over the next few years, to develop housing with care services within the County. We want people to have real choice and be able to have more control over their lives. We want better care and better care outcomes for local people. This means changing what we do and where we do it.

If people need to live in a care home [this includes nursing homes] they have expectations around what is on offer. Many of the care homes for older people that we have were designed for older people who were younger, less dependant and able to move around without much assistance. These homes are not best suited to what people need now. We need to make changes so that care homes are designed to help deliver personalised care and promote dignity and respect.

2. What is the care guarantee about?

Our long term care charter ***"Better Care Higher Standards"*** [2006] sets out what people might expect from us and our partners when it comes to care provision. We recognise that change can be unsettling. This guarantee is part of that care commitment to you. It sets out what you can expect from us if the home where you live now is affected by changes we wish to make to improve the care, choice and control people have available to them.

3. Who does the care guarantee apply to?

The care guarantee applies to all people in Council and Warwickshire Care Services care homes. It is available whether people pay for their own care [self funders] or receive financial help from the Council.

4. When does the care guarantee apply?

The care guarantee goes "live" if the care home where you live now is likely to be affected by major change. These include:

- Building new services that may involve some disruption to amenity [e.g. building noise, dust, traffic etc] but does not require you to move home; or
- Making major changes to your care home but not involving a move; or
- Replacing your care home with a new service and means a move to a new home on either a permanent or temporary basis.

5. The Care Guarantee

If where you live now is affected by change we offer the following three guarantees:

- **I**f you have a place in a care home now you will have a place in the future: no one will be without a place to live.

- If you have to move home permanently, you will not be asked to move more than once; but,

- If your current home is to be replaced, you have a right to return to it following a temporary move, if that is what they want to do, provided the new setting can still meet your assessed care needs.

6. What else does the care guarantee cover?

The aim of the guarantee is to remove some of the natural worries people and their relatives may have about the prospect of change. Where the care guarantee applies it also means that:

- You and your relatives will be consulted about change, how it might affect you and what it means for where you live now.

- We will keep you and your relatives informed and involved: you will always know what is happening and if things have changed.

- We will minimise any disruption or inconvenience caused by any building work and ensure your care, health and safety remains the priority.

- We will take account of your views and work out with you a way forward that will meet your assessed care and support needs.

- Your care needs will be assessed and a care plan discussed with you to ensure your current and future needs continue to be met.

- You will have your own social worker to turn to for advice and support throughout the change and if you have to move during the first three months after your move.

- If you feel the changes are more than you can cope with and want to move then we will help arrange a new place in a home of your choice:

    - Provided that the home you have chosen can meet your care needs as assessed by us; and,
    - Is willing to accept you, and
    - Its terms and conditions meet our standards for care services in homes.

- The amount you pay for care following a move under the Care Guarantee will not be greater than what you would have paid for the same facilities and type of care where you are now. [Excludes inflation increases].

- Third Party “top ups” under the Care Guarantee will not be greater than they are where you live now for the same facilities and type of care where you are now. [Excludes inflation increases]

- If you move care homes under this Guarantee, we will see if we can help with any increased travel costs of relatives that are a result of the move.

- You and your relatives have the right to see a new care setting before you move there.

- If you move and other residents are moving as well then, when arranging things with you, we will do our best to take account of friendships.

- We will ensure there is health oversight throughout and be sure you are medically fit to move homes when the time comes.

- At the end of the changes we will ask you how you feel we have done and what we might have done better.

7. Want to know more?

If you are worried about anything or want to know more or to discuss your needs or any aspect of the Care Guarantee then please tell us. We will be pleased to listen and to talk things through with you and your relatives.

If you want independent advice, please let us know. We can then put you in touch with people who will be pleased to advise.

8. Who is my Care Guarantee Contact?

Your Care Guarantee contacts are:

Jane Southeard, Care & Choice Service Manager, Adult Health and Community Services, Telephone: 01926 – 731154

Chris Lewington, Customer Engagement Service, Manager, Adult, Health and Community Service. Telephone: 01926 - 743259

The home manager of the home where you are living.

APPENDIX H

CONSULTATION & COMMUNICATIONS

1. WHAT WE HAVE DONE SO FAR

1.1 The Care & Choice (Accommodation) Review was launched in July 2007 and information widely distributed. A communications strategy was agreed which identified a list of target audiences (since extended). All have been addressed:

- Residents and service users
- Families of the above
- Staff
- Unions
- MPs
- Councillors
- Media
- Pressure groups
- Potential partner organisations
- WCC Colleagues

1.2 Since launch we have:

- Produced two editions of 'Caring Choices' newsletter - widely distributed to interested parties and made available to the public in all local libraries and online.
- Set up a special websection: ***www.warwickshire.gov.uk/caringchoices***
- Produced a 4.5-minute movie/DVD showing what extra care accommodation looks and feels like.
- Featured review information in two WCC magazines: 'Working for Warwickshire' and 'Warwickshire View'.
- Toured the 10 WCC-run and 11 WCS-run homes to explain about the review and and answer questions from staff, residents, service-users and relatives.
- Offered a tour visit to Avon Court, run by Prime Life. Date to be arranged.
- Presented the review to other interested parties including older people's forums, district, borough and housing association colleagues, and MENCAP.
- Met with local pressure group DAWN (Dementia Action Warwickshire Network).

2. WHAT PEOPLE WANT TO KNOW

2.1 The Top 10 questions from our first round of tour visits to residential care homes were:

1 Are you going to close homes?
2 Is this home safe – will it remain as it is?
3 Is my job safe?
4 Will we still be under the WCC umbrella?
5 What is 'extra care' - a bit more than sheltered housing?
6 What sort of people would go into extra care housing?
7 Would there be support staff on site 24 hours a day?
8 Where will the money come from to pay for modernisation/extra care?

9 Will traditional residential care homes still be needed?
10 What is the modernisation timescale?

2.3 Answers appeared in the first edition of 'Caring Choices' newsletter and can be viewed at: *warwickshire.gov.uk/caringchoices*

2.4 Other issues that keep coming up, on our tour visits, include the low wages paid to care workers and the higher-level care needs of people entering residential care homes in recent years.

3. LOOKING AHEAD

3.1 Forward plans include:

- Further tours of both WCC-run and contracted-out homes.
- Further editions of 'Caring Choices' newsletter.
- Developing the Caring Choices websection, both for information sharing and as a potential consultation tool.
- Working with the new Service Manager for Customer Engagement to set up 'user groups' to inform the review process.
- Working with the new Service Manager for Customer Engagement on both general and specific **consultation** (see below).
- Pursuing the idea of creating/using cartoon characters for a more visual presentation of key information to interested parties/consultees.
- Proactive media campaigns to publicise specific modernisation/development proposals as they emerge.
- Publicising the work of the Learning Disability Partnership Board in the run up to Learning Disability Week in June.
- Working jointly with Prime Life to publicise the official opening of a new home for older people in Kineton.

3.2 We have already done a fair amount of work to raise awareness of the issues and to communicate with target audiences. To date, this has been about the 'bigger picture' and the shape of services countywide rather than specifics. This work will continue. In addition, once proposals for specific sites are published, we will need to formally consult those potentially affected, in compliance with legal requirements:

- Anyone who would be affected by the proposals must be fully consulted.
- 'Fully' means making sure the implications of the proposed changes (and any options) are clearly explained, with user-friendly ways to comment made available.
- The formal consultation period must last a minimum of eight weeks.
- Timescales must allow for responses to feed into the decision-making process and potentially make a real difference.
- At the same time, residents and service-users who would be affected by the proposals would have their current needs assessed.

3.3 There are different audiences with different concerns and needs:

- Care home staff [See also: covering report]
- Residents
- Other service users (day and respite care)
- Relatives and carers
- Stakeholder organizations [e.g. user groups]

3.4 We face several communication challenges. Many of the residents and service users of Care Homes for Older People are hard of hearing, sight-impaired or may experience cognitive impairment or memory loss. Many of their relatives are getting on, too. Arrangements for information and consultation will allow for these and the understandable impacts of anxiety and uncertainty on the ability to remember or take in what is being communicated..

4. MOVING FORWARD

4.1 We intend to continue to follow a robust, reliable and user-friendly formal consultation process. The appointment of a customer engagement specialist in April will add to capacity.

4.2 Effective consultation and engagement are not only essential but are an indispensable part of the way the Council seeks to work and to improving quality of life. The Local Government and Public Involvement in Health Act, 2007, confers new duties to inform, consult and involve people. Consultation has to be an ongoing process with residents.

4.3 Consultation is an indispensable bridge across which information and ideas can be exchanged, discussed and acted upon. It is a two way process. Key aspects are:

- Continued general consultation on the overall direction we have been exploring following the Cabinet of June 2007.
- Continued and specific consultation at the formative stage with residents and relatives of homes that have been identified for consideration for change prior to any decision about change by Cabinet.
- Ensure arrangements embrace not only what is being proposed [this is what we are thinking of doing] but also the reasoning behind proposals [this is why we are doing it].
- Ensure that prior to making decisions Cabinet has available to it information on the individual assessed needs of all residents and having taken these into account be satisfied that the proposals would be consistent with those needs in the future.
- Facilitate a range of opportunities to find out about and to comment upon changes and that information is available in appropriate formats and through suitable mechanisms.
- Ensure sufficient time is available to collate the results of consultation.
- Be clear that decisions on consultation feedback will be accompanied by reasons.
- Keep people informed of any changes in proposals or timeframes.
- Treat all residents equally and irrespective of whether they are publicly funded or not.

PROGRAMME STRATEGIC RISK REGISTER [INTERIM]

[Note: this risk register uses an earlier Council framework. It has been adopted for interim used whilst it is being updated both in terms of format and content. The intention is to ensure consistency with a revised corporate approach flowing from the Risk Management Strategy. Cabinet approved this at the end of 2007. The revised register will include a new matrix scoring framework and information on risk opportunities, owners and action leads. It is being developed in consultation with Corporate Strategic Risk Manager. The updated risk register will be considered by an early meeting of the Programme Board.

APPENDIX I

Programme:	**CARE & CHOICE PROGRAMME**	**Project:**	**-**		
Author:	**Michael Hake [subject to project consultation]**	**Document Ref & Version No:**	PRE - DRAFT	**Date:**	**02 April 2008.**

Risk Assessment Matrix

High	A	R	R
Medium	G	A	R
Low	G	G	A
Impact			
Probability	**Low**	**Mod**	**High**

(To be undertaken and updated for all projects)

[Probability of event and impact on project achievement]

Identified Risks [Inherent Risks]	Gross Probab-ility of Risk	Gross Impact on Project	Steps Taken to Mitigate Risk [include controls in place]	Net Probab-ility of Risk	Net Impact on Project	Net residual Risk Rating
	High, Moderate, Low	High, Medium, Low		High, Moderate, Low	High, Medium, Low	See Grid
1. Care cost inflation rises at a faster rate than Council allows for with the result that projects cost more than expected and affects programme viability. [Market Risk]	M	H	Improve understanding of unit costs and the costs of care. Conclude market-mapping work. Review arrangements for inflation provision and scope for better outcomes at lower cost. Shorten project completion timescales. Ensure project briefs costed fully.	M	L	
2. Expected/reasonable project consents take longer to achieve or are declined and results in programme delay. [Organisational Risk]	M	M	Develop standard project and procurement tool to ensure all projects are time bounded and resourced. Reschedule projects to allow for time needed. Identify through project team potential difficulties and seek to manage them down/out. Use criteria. Cover environmental and sustainability dimensions.	M	L	
3. Supply side [human resource dimension] limitations inhibit the recruitment of staff for care schemes with the result that services cannot operate as specified. [Market risk]	M	M	Continue with workforce mapping and development work. Identify need for staff and commence recruitment processes early.	L	M	

Identified Risks [Inherent Risks]	Gross Probab-ility of Risk	Gross Impact on Project	Steps Taken to Mitigate Risk [include controls in place]	Net Probab-ility of Risk	Net Impact on Project	Net residual Risk Rating
	High, Moderate, Low	High, Medium, Low		High, Moderate, Low	High, Medium, Low	See Grid
4. Housing and care market turbulence and uncertainty lead to a reduction in the ability of care providers to enter into/remain in the local care economy with the result that care demand exceeds care supply which may also reduce. [Commercial Risk]	L	M	Consult on needs analysis and balance of care. Complete market mapping. Ensure regular engagement and sharing of intelligent information with providers. Monitor market intelligence on regular basis – keep in touch with all sectors.	L	L	
5. Housing and care markets seek to enhance provision in an unplanned way with the result that provision develops in the wrong places or in excess of demand affecting viability of local markets. [Commercial risk]	M	M	Share information on needs analysis and seek to engage with providers to co-ordinate changes and development in ways that maximise value all round. Maintain regular contact with providers. Build into programme manager brief.	L	M	
6. Supply side [land and property] proves inflexible with the result that sites to permit programme of change to meet needs do not emerge. [Market risk]	M	H	Pursue corporate and strategic approach to land use and disposals so that potential need for social care sites to shape the market and deliver change are identified. Work with independent sector and districts to identify sites that will lead to better balance of care. Ensure ongoing site monitoring by board.	L	M	
7. Support at political management level is not secured /sustained with the consequence that the programme stalls or is not sustained. [Political risk]	M	H	Ensure effective involvement and engagement at Cabinet and Scrutiny levels so that programme is understood. Engage with Councillors Ward/Divisions], Area Committees and District Councils & Councillors. Have effective dialogue and communication with stakeholders and partners. Organise member briefings and seminars.	L	M	
8. Technological change moves at a much faster pace than expected with the result that different care options and choices emerge. [Technical risk]	L	M	Link to work on county roll out of telecare as part of overall approach to shaping local care economy. Link with PCT on development of telehealth. Maintain liaison with market.	L	L	
9. Morbidity within the population changes with the result that need is significantly higher or lower than expected. [Social/environmental risk]	L	L	Link to work on joint strategic needs assessment and work to promote improved health and social inclusion. Monitor data.	L	L	

Identified Risks [Inherent Risks]	Gross Probab-ility of Risk	Gross Impact on Project	Steps Taken to Mitigate Risk [include controls in place]	Net Probab-ility of Risk	Net Impact on Project	Net residual Risk Rating
	High, Moderate, Low	High, Medium, Low		High, Moderate, Low	High, Medium, Low	See Grid
10. Social and economic change reduces the availability of carer and social network support with the result that demand for care exceeds assumed resource levels used for programme planning. [Social/environmental risk]	L	M	Ensure effective monitoring of social trends as part of an annual process of needs analysis and market modelling.	L	L	
11. Consumer preferences change with the result that expectations are different from those used for strategic planning purposes. [Social risk]	L	M	Develop systematic data collection and ensure effective use of national and regional data.	L	L	
12. New care regulator/regulations changes standards for providers with the result that care economy struggles and costs to commissioners rise. [Regulatory risk]	M	M	Track progress of current legislation and consultations on new regulatory frameworks. Maintain close links with current regulator and use relevant data.	M	L	
13. Negative perceptions and adverse media coverage results in a lack of confidence to proceed and reputational damage to organisation [Political/reputational risk]	M	H	Progress consultation and engagement strategy on programme. Monitor feedback and respond. Develop links and understanding of all stakeholders and media. Ensure effective staff consultation.	M	M	
14. Bidders/providers do not respond to need for strategic change and/or find invitation to bid unattractive with result that new schemes do not proceed [Commercial risk]	M	H	Link to work on consultation on needs analysis and ongoing dialogue with potential providers as part of ongoing procurement process. Develop market forum to developed shared and mutual understanding of needs. Deliver bidders event and consider seminars with other councils.	L	M	

Identified Risks [Inherent Risks]	Gross Probab-ility of Risk	Gross Impact on Project	Steps Taken to Mitigate Risk [include controls in place]	Net Probab-ility of Risk	Net Impact on Project	Net residual Risk Rating
	High, Moderate, Low	High, Medium, Low		High, Moderate, Low	High, Medium, Low	See Grid
15. Bidders/providers do respond but prices quoted in response to specifications are significantly higher than expected with the consequence that the scheme or programme cannot be funded. [Commercial risk]	M	H	Link to work on consultation on needs analysis and ongoing dialogue with potential providers. Ensure ongoing procurement arrangements on price are consistent with market reality and intended direction of change. Be clear on maximum/minimum acceptable cost frameworks. Identify potential walk away points.	M	M	
16. Expected funding streams such as Supporting People, Extra Care Grant and Housing Corporation do not materialise with the result that social housing dimension does not develop as expected. [financial/market risk]	M	M	Develop extra care funding bid. Develop links with housing providers and districts. Develop partnership agreements. Review supporting people strategy and ensure inclusion. Cover at criteria consideration stage and document.	M	M	

Notes: The task of the register is to Identify risks to achievement of programme objectives and outcomes between 2008 and 2015. The register seeks to identify risks, assess risks, manage risks and provide a framework for reviewing and reporting risks. The aim is to generate an optimum response to risks that supports the delivery of the business objectives being pursued. Responses to risks or internal control involve judgments about whether to take, treat, transfer or terminate risks. All programmes involve risks and some are inherent

Risk of Event happening during strategic timeframe:

High Probability: Almost certain to happen or has happened previously in similar circumstances on one or more occasions
Moderate Probability: Would probably happen [more likely to happen than not] and experience on other programmes suggest it might,
Low Probability: Could happen given the right combination of circumstances but experience of other programmes indicates it seldom does.

Level of Impact during strategic time frame:

High Impact: Has the potential to bring the programme to a halt or prevent progression as envisaged.
Moderate Impact: Has the potential to delay progress in key areas, increase costs or damage reputation in ways that erode support
Low Impact: Has the potential for some delay or increased costs but would not necessarily erode support or ability to progress.

Document Information

Revision History

Date of this revision:
Date of Next revision:

Revision date	Summary of Changes	Changes marked
30.04.08	Note and status as Interim Register ,	See headings -yes

Approvals

This document requires the following approvals.
Signed approval forms are filed in the Management section of the project file.

Name	Signature	Title	Date of Issue	Version
Programme Bd.				

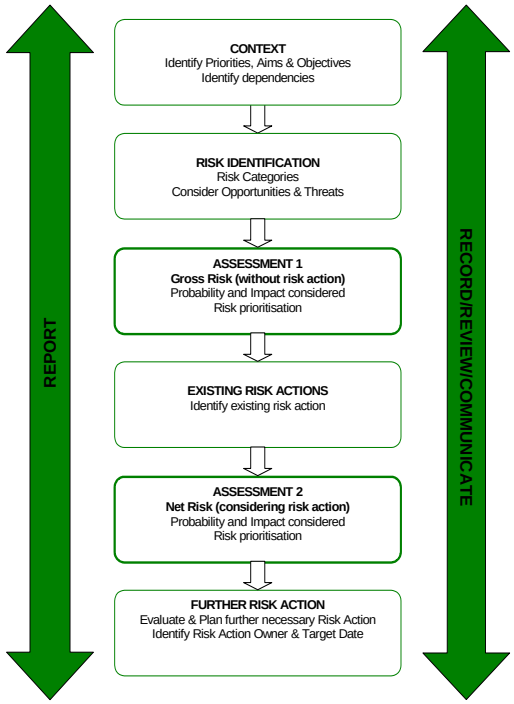
Distribution

This document has been distributed to

Name	Title	Date of Issue	Version
			1

A Short Guide to Risk Management

Risk Assessment Process



Risk Identification

Risk: is defined as the combination of the probability of an event and its consequences. Risk can have an upside (opportunity) and a downside (threat).

Context: risks should be identified against the achievement of the objectives for the matter subject to risk assessment.

Risk Categories: provide a starting point for risk identification:

Political
Economic
Regulatory
Financial
Organisational Behaviour
Resource Management
Management Systems
Alliances
New Partnerships & Projects
Customers & Citizens
Environment

Risk Assessment

Risk Matrix: see over the page for further guidance. This is used to ensure consistency when risks are rated. It also enables risks to be prioritised so that the management and reporting of risk can be focussed on the key risks.

Corporate Risk Profile: risk doesn't exist at any one level and needs to be considered in the context of the Corporate Business Plan, Directorate and Service Plans, Projects and Partnerships.

Risk Owner: each individual risk will have a Risk Owner assigned who will be responsible for reviewing and monitoring the risk within the risk register.

Review Date: a date which the Risk Owner feels is an appropriate time to review the information contained in the risk register, make sure it is up to date and that any risk action is being progressed by Risk Action Owners.

Risk Action Planning

The strategies outlined below should be used for planning risk action to manage opportunities and threats once risks have been identified and rated. A **Risk Action Owner** will be assigned to each risk action who will be responsible for ensuring the action is completed.

Threats			Risk Action Strategies			Opportunities
	Avoid	Quick, decisive action, fundamental change eg revise strategy, revisit objectives or stop the activity		Quick, decisive action, fundamental change eg revise strategy, or revisit objectives to make the opportunity happen	**Exploit**	
	Transfer	Insure against the risk or transfer to a third party eg a contractor or partner who is better able to manage the risk		Seek a third party best able to manage the opportunity	**Share**	
	Reduce	Plan actions that target the cause of the risk and/or reduce the potential impact		Plan actions that increase the probability and/or consequence of the opportunity to maximise the benefit	**Enhance**	
	Accept	Where costs of action outweigh potential benefits or nothing further can be done to reduce the level of the threat.		Where costs of action outweigh potential benefits.	**Ignore**	

Recording, Reviewing & Reporting Risk

Risk Register: the output from the risk assessment process is a document called the risk register. This records specific information about individual risks, their importance and an action plan for managing them.

Magique: this is the risk management software used by WCC to hold all risk registers in electronic format within one database. The software facilitates the management, review and reporting of risk information.

Risk Reporting: key risks should be reported by the Directorate Risk Champion to the local management team on a quarterly basis. Projects and Partnerships will have additional localised reporting requirements.

For further guidance refer to the risk management policy and strategy held on the Corporate Document Library under Risk

Warwickshire County Council

A Short Guide to Risk Management

Understanding Business Risk Assessment

Step1: Score Probability

Gross/Net Risk: risks are assessed twice. Once without considering any existing risk action in place (Gross Risk) and again considering the effect of risk actions in place (Net Risk).

PROBABILITY (Over next 12 months)						
Almost Certain >90%	5	5	10	15	20	25
Likely 50%-90%	4	4	8	12	16	20
Moderate 30%-50%	3	3	6	9	12	15
Unlikely 10%-30%	2	2	4	6	8	10
Rare < 10%	1	1	2	3	4	5
		1 Insignificant	2 Minor	3 Moderate	4 Significant	5 Major
		IMPACT				

Select a score for the probability of the risk materialising over a 12 month period on a scale of 1-5. Use the descriptions above for guidance.

Step 2: Score Impact

	OPPORTUNITY IMPACT DESCRIPTIONS (Upside Risk)				
	1 Insignificant	2 Minor	3 Moderate	4 Significant	5 Major
Service, Partnership & Project Delivery	No improvement in systems and processes within normal daily routine.	Slight improvement in systems and processes within normal daily routine.	Improvement on internal business only.	Noticeable improvement to customer service.	Noticeable and measurable improvement in customer service.
Financial	<1% or up to £100k positive variance against annual revenue budget or capital budget.	2% > £500k positive variance against annual revenue budget or capital budget.	3% > £2m positive variance against annual revenue budget or capital budget.	4% > £10m positive variance against annual revenue budget or capital budget.	5% or greater than £10m positive variance against annual revenue budget or capital budget.
Reputation	Event or decision not in the public domain that has little impact outside of WCC.	Event or decision in the public domain that receives small positive coverage by local media.	Event or decision in the public domain that receives significant positive coverage by local media and/or pressure groups.	Event or decision in the public domain that receives significant positive coverage by national media and/or pressure groups.	Event or decision in the public domain that receives extensive positive coverage by national media and/or pressure groups.

	THREAT IMPACT DESCRIPTIONS (Downside Risk)				
	1 Insignificant	2 Minor	3 Moderate	4 Significant	5 Major
Service, Partnership & Project Delivery	Minor errors in systems and processes that occur within normal daily routine.	Short-term disruption - action required. Managed by intervention from Head of Service/ Block Leader or Project Manager.	Noticeable disruption affecting customers. Intervention and management by local management team.	Disruption of core activities. Key targets missed, some services compromised. Intervention by SDLT or Project Board or Block Leaders Group and/or WACE required.	Loss of core activities. Strategic aims compromised. Intervention by Cabinet/Public Service Board.
Financial	<1% or up to £100k negative variance against annual revenue budget or capital budget.	2% > £500k negative variance against annual revenue budget or capital budget.	3% > £2m negative variance against annual revenue budget or capital budget.	4% > £10m negative variance against annual revenue budget or capital budget.	5% or greater than £10m negative variance against annual revenue budget or capital budget.
Reputation	Event or decision not in the public domain and has little impact outside of WCC.	Event or decision in the public domain that receives minimal negative coverage by local media	Event or decision in the public domain that receives significant negative coverage by local media and/or pressure groups.	Event or decision in the public domain that receives significant negative coverage by national media and/or pressure groups.	Event or decision in the public domain that receives extensive negative coverage by national media and/or pressure groups

Select a score for the impact of the risk if it materialised on a scale of 1-5. Use the appropriate table above for guidance, considering the effect on delivery, finance and reputation. Select whichever scores the highest.

Step 3: Calculate Risk Rating

Calculate the risk rating by multiplying the score for probability by the score for impact.

Probability x Impact = Risk Rating

Step 4: Further Risk Action

Use the key below to identify whether it is necessary to plan further risk action to reduce the level of a threat or to maximise the level of an opportunity. The level of the risk will also determine the review and reporting requirements.

Key

Consider immediate risk action, review regularly and report upwards to senior management

High

Consider risk action and review regularly

Tolerable

Consider risk action and review periodically

Acceptable

No action required. Review annually to ensure risk level does not change.

Warwickshire County Council

APPENDIX K

MANAGING CHANGE-PROJECT PROGRESSION
DRAFT AGREED CRITERIA POLICY

1. We will be taking forward the Care and Choice Programme and each Project forming part of its delivery within an overall pattern of need and care economy that form a sliding scale of care opportunities. This ranges from people being totally independent in terms of self-care up to full dependency. What we will deliver is a new balance of care that delivers defined outcomes within agreed timescales and resource parameters. The Programme is about market and place shaping. It is not just about what the Council commissions or provides. The Council is a key player, however, within the care economy and the intention is to remain one as a means of ensuring adequate supply of places to meet needs for publicly funded care.

2. The development of consistent criteria for project progression is an essential element of a local need and delivery framework. The criteria policy would apply to action to stimulate the local care economy as well as to action to reframe current direct care provision. Some criteria are likely to have more weight than others. In some cases an inability to meet a specific criterion might well be a “showstopper” or “deal breaker”.

3. Different stakeholders were also seen as likely to place varying amounts of emphasis on particular criteria. We need to allow for these dimensions in setting the criteria for project progression. Affordable, for example, means affordable to the Council, the commissioner, the provider and the service user.

4. In setting the governance framework for the programme the officer Programme Management Board has a “gateway role”. This requires the Board to test all projects against an agreed set of criteria and determine whether and how best they might be taken forward.

5. No projects would proceed or be reported to Cabinet unless gateway clearance by the Board has been given.

6. Four general criteria have been chosen and would apply to all schemes. They are:

- Affordable
- Accessible
- Achievable
- Acceptable

7. Each criterion would be assessed in terms of whether it is:

- Fully met
- Partially met
- Not met

8. It is possible, however, that some proposals may not fully meet all criteria. Where criteria are “not met” or “partially met” the significance of this will be considered along with the scope for remediation where this is appropriate. There may be discrete aspects of individual projects that require specific consideration. These need to be considered on their merits at the time the project comes forward for decision.

9. Bringing greater security to the process through the development of an agreed criteria policy does not restrict Member discretion in any way. Evidence to support judgments on criteria will be required and tested. As indicated above, not every criterion is of equal weight but all are interlinked. The proposed factors for use in making judgments are set out overleaf.

CARE & CHOICE PROGRAMME

PROJECT/SCHEME ASSESSMENT CRITERIA POLICY [DRAFT]

CRITERION	DESCRIPTORS or MEASURES
PROJECT IS AFFORDABLE 	❑ A capital funding stream has been identified/secured ❑ Transitional revenue costs can be covered ❑ Housing support costs can be funded ❑ Care costs can be funded ❑ Within agreed budgetary framework of AHCS overall ❑ Meets procurement guidelines ❑ Secures best care value for council/community ❑ Customers can afford [equity or rent] ❑ Considered commercially prudent and offering best value
PROJECT IS ACCESSIBLE 	❑ Meets agreed service specification ❑ Meets agreed design specification ❑ Includes community safety dimensions [Secured by Design] ❑ Convenient to local facilities and accessible ❑ Positive Equalities Impact Assessment ❑ Tested with potential users & carers for convenience/access ❑ Project progression meets health and safety requirements ❑ Environmental and sustainability dimensions confirmed ❑ Organisational and training requirements for staff identified ❑ Evidence from local commissioning does not conflict/supports
PROJECT IS ACHIEVABLE 	❑ Planning consent in place or advice received is that scheme is within planning policy guidelines and is likely to be granted? ❑ Design Brief agreed with work packaged or being progressed ❑ Project/ Programme Plan in place [time bounded] ❑ Risk register completed and risk management plan in place. ❑ Premises or site are or will be under Council control ❑ Does not conflict with known intentions of other sectors ❑ Consistent with assessed needs of users ❑ Potential provider/ bidder interest identified ❑ Partnership requirements are met ❑ CSCI/CQC input has been obtained and is supportive.
PROJECT IS ACCEPTABLE 	❑ The care guarantee will be/has been met ❑ Consultation has been completed with users and carers and can be shown to have been considered in a meaningful manner ❑ Proposed design allows for user and carer comments/expectations ❑ Staff consultation and regulatory requirements are met. ❑ Consistent with needs analysis – strategic fit ❑ Contributes to expected Balance of care ❑ Project has been tested for alternatives ❑ Partner support available: health, housing, independent sector ❑ Has fit with LAA and is not inconsistent with it ❑ Member support tested [Division-Ward-Area-Lead] ❑ Tested with District Councils

Note: Evidence for each criterion to be completed and available for inspection by Programme Board having been tested and signed off by the Care and Choice Project Team.

APPENDIX L **PROGRAMME EQUALITY IMPACT ASSESSMENT [2008]**

INITIAL SCREENING FOR STRATEGY/POLICIES/SERVICES/FUNCTIONS FOR EQUALITIES RELEVANCE TO ELIMINATE DISCRIMINATION AND PROMOTE EQUALITY

An equality impact assessment (EIA) is a systematic and thorough way of finding out whether a policy, function or service affects different groups of people in different ways. All public authorities have a statutory duty to conduct and publish the outcomes of race, disability and gender EIAs for all its functions, policies and services. Good practice indicates that we review all equality dimensions (race, gender, disability, religion/belief, age, sexual orientation) at the same time.

By carrying out an EIA before a new service or policy is introduced should enable us to identify and reduce the potential for institutional discrimination. An assessment is normally carried out across a number of dimensions.

This Appendix sets out the initial equality impact assessment for this programme.

High relevance/priority Medium relevance/priority Low or no relevance/ priority

Note:

1. Tick coloured boxes appropriately, depending on degree of relevance to each of the equality strands
2. Any strategies/policies/services or functions in relation to race, gender or disability which are highlighted as high relevance (i.e. “red”) are a high priority and must proceed to impact assessment
3. Medium (amber) and longer term (green) priorities to be assessed after high priority assessments are complete
4. Summaries of the legislation/guidance should be used to assist this screening process

DEPARTMENT:	Relevance/Risk to Equalities																				
State the Strategy/Policy/Service/Function being assessed:	Gender			Race			Disability			Sexual Orientation			Religion/Belief			Age			Priority status For EIA		
	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Taking forward a vision for future care and choice that links change to local action to transform social care and use a whole market analysis to ensure responsiveness to need, reflect realities of supply and to better understand user and carer preferences to identify priorities for care, accommodation and support.	✓			✓			✓			✓			✓			✓			✓		

Appendix H Initial Screening(Please note you will need data/evidence to assist you in completing this assessment)

Name of the strategy/ policy/ service or function being screened	Care and Choice Programme	**Is this a new or existing strategy/policy/ service or function?**	New approach to commissioning and provision
When was this last impact assessed?	N/A	**Date of this assessment**	April 2008
Questions to help you complete the Screening:-		**Explain**	
1. What is the aim/purpose of the strategy/policy/service or function?		The overarching purpose of this strategy is to improve individual outcomes for older people in Warwickshire, with effective commissioning being a central tool to deliver these better outcomes.	
2. How does the strategy/policy/service/function fit in with the Council's wider objectives?		It will maximise the quality of life for older people by working in partnership to reduce inequalities, improve well being, promote individual independence and enrich people's lives through learning and culture.	
3. What are the expected outcomes of the strategy/policy/service/function?		The aim in essence is to make Warwickshire a place where people want to grow old. It is a programme about people and their lives not just buildings; although a reframing of current accommodation services is a key element of the policy and the evolving programme. The principal focus is on older people.	
4. Does this strategy/policy/service/function have the potential to directly or indirectly discriminate?		No	
5. From the groups you have already identified as having high relevance which groups should benefit from this strategy/policy/service/function?		Older people including elders from black and minority ethnic groups.	
6. Are there any groups who might be expected to benefit from the intended outcomes but who do not?		No	
7. Are there any obvious barriers to accessing the service? E.g. language, physical access; opening hours		Current variations in standard of care home provision across the county, communication and accessibility.	

8. How does this strategy/policy/service/function contribute to the promotion of equality?	Fully, The aim of the programme is to increase choice around care options and to improve access to services by improving the balance of care for older people across the county. There should be no adverse impact in these areas. Some existing residents will be affected by changes and arrangements have been put in place to ensure effective consultation and engagement, The majority of service users will have impairments resulting in a measure of physical, cognitive and sensory disabilities. A needs analysis has been undertaken and dependency information gathered consistent with the programme aim of securing better care provision more responsive to needs and capable of delivering improved care outcomes. The programme does not apply to adults with disabilities under the age of 65. Neither does it apply to adults with a learning disability for which a separate programme is to be developed. The majority of staff providing long term care services and the majority of service users are women. Issues of gender balance within the workforce fall to be considered within overall approaches to cross sector workforce mapping and development. Women tend to predominate as residents of care homes. This tends to reflect differences in life expectancy and circumstances. One of the outcomes of the programme will be to ensure women have more information and can access wider care options in future with special reference to the ability to continue to live independently in line with their needs and having regard to their preferences. The needs analysis takes account of the distribution of black elders and in the future. The intention is that all services should be culturally sensitive. The development of specialist services is to be explored.

9. Are there any concerns that the strategy policy/service/function <u>could</u> have a differential impact between: **a) Any racial group (please refer to census 2001 categories)** **b) Disabled and non disabled users** **c) Male and female users**	No
10. If yes, which groups, and can this be justified?	N/A
11. Describe the type and range of evidence or information that you have utilised to help you make a judgement about all of the above? E.g. recent service user feedback (consultation), national/local statistics.	Local consultation, Comprehensive analysis at County and District level of needs and supply. Use of national and local evidence on preferences around care. Putting People First, Ministers, local government, NHS, social care, professional and regulatory organisations (2007),
✓ **No need for full EIA – Following actions identified:** ☐ **Must Proceed to a Full EIA**	**Keep under review. Update EIA by Programme Board March 2010.** **Date by which EIA should be completed:**

Signed: **KIM HARLOCK** **Signed: GRAEME BETTS**

Head of Strategic Commissioning and Performance **Strategic Director**

Care and Choice Programme Resource Issues

1. Types of Cost

There are a number of costs involved in the development of new extra care or residential provision. In the case of extra care there are also a number of different funding streams. This appendix aims to illustrate the costs, funding streams, and high level finance issues in general terms. Table 1 below sets out the types of cost.

Table 1 – Types of Cost [Illustrative]

Type of Cost	Explanation
Project Costs	Costs of getting the point of having a contract with a provider. • Cost of project team • Scoping and evaluating • Tendering
Land and Building Costs	Capital costs of land and buildings, for example: • Land acquisition • Designing • Building
Transitional Costs	Temporary costs incurred during the transition from old provision to new provision or during the setting up and bedding in of new provision. For example: • Double running of beds • Retraining staff • Cost of unwinding existing contracts early • Costs of care guarantee • Consultation and information costs
Running costs	Cost of operating the services. For example: Extra Care • Accommodation • Housing support • Personal expenses • Personal care Residential Care • Full cost of running a residential care unit (employee costs, premises costs, supplies and services, etc)

In addition there will be costs associated with ongoing data analysis in relation to needs, supply side mapping and user and carer preferences. These are seen as part of ongoing operational procurement (See: **Diagram 1 Appendix E.1**] and will be met within existing directorate resource allocations).

2. Sources of Funding

Table 2 sets out the potential sources of funding for the costs. Not all will apply in every case. The intention is to show the range of sources from which funding might be found.

Table 2 – Sources of Funding

Type of Cost	Potential Sources of Funding
Project Costs	• One off calls on the revenue budget
Land and Building Costs	• Capital programme • Capital receipts • Use of land we already own • Prudential borrowing • Department of Health Extra Care Housing Fund • Direct contributions from revenue budget (note 1) • Earmarked revenue reserves • Developer funding (which developers may in turn get from financial markets, grants, etc) • Telecare funding • Partner funding
Transitional Costs	• Earmarked revenue reserves • Revenue budget (note 1)
Running Costs	Extra Care • Local authority revenue budget (note 1) • Client contributions • Self funders (people who meet the whole cost of their care themselves) • Attendance allowance • Personal income • Other benefits and allowances • Supporting People Funding • Other grants and charitable sources Residential Care • Local authority revenue budget (note 1) • Client contributions under National Assistance Act 1948. • Self funders • Attendance allowance

(Note 1 – revenue budget could mean demographic budget allocation, efficiency savings, existing budgets, etc)

The total weekly cost of all the services in an Extra Care setting may add up the same as or more than the total weekly cost of residential care. This is because an extra care resident may have a one or two bedroom flat with a kitchen, lounge, and bathroom whereas a residential care client may have a single room with an en-suite.

However, in extra care, because a number of other funding streams can be accessed the financial cost to the local authority can be lower than residential care where the local authority bears the full cost of the service (net of client contributions). Table 3 sets out the various potential sources of funding for the full costs of running an Extra Care development.

Table 3 – Sources of Funding for Extra Care Running Costs

Type of Running Cost	Potential Source of Funding
Accommodation (e.g. rent and housing management)	• Housing benefit • Personal income (pension, pension credits, savings, etc)
Housing support	• Supporting people grant
Personal expenses (e.g. utility bills)	• Personal income • Benefits and allowances
Personal and Telecare	• Local authority funding/individual budgets & direct payments • Client contributions • Self funded care • Attendance allowance

Nursing care and continuing health care funding from the PCT could be available where appropriate in the same way as they are now for residential clients. There is also potential for PCT support of “Telehealth” services linked to new extra care provision.

3. Cost Savings from Extra Care

The key aim is to secure better outcomes. The potential financial benefits to the local authority of Extra Care come from the following main drivers:

- Cheaper cost of care compared to residential care due to maintenance of lower levels of dependency (residential care accelerates dependency).
- Cheaper cost of domiciliary care by having on-site domiciliary care provision which avoids travel time costs.
- Reduced client contact time through modern communication and support technology.
- Tapping into other funding sources to fund non-care costs.

4. Cost Savings from Residential Care

The potential financial benefits to the local authority of developing modern residential units is that the unit cost of care would be lower due to:

- Economies of scale arising from raised unit capacity [e.g. more beds]
- Efficiency savings by matching capacity to optimum staffing levels.
- Cheaper running costs and care costs of a modern residential care building.

5. High Level Financial Risks

- High inflation on construction costs and social care costs.
- The Olympics in 2012 and its effect on construction costs.
- Demographic pressures outstrip demographic provision in the budget.
- The medium term financial plan, which commits to funding demographics only extends to 2010/11, this programme will go well beyond that time.
- The cost of land being higher in the south of Warwickshire than the north.
- Potentially reducing capital value of client property reducing affordability to clients.
- Capacity of partners to deliver building developments.
- Failure to secure other funding streams.

See also Appendix **B** for the governance framework, Appendix **I** for the strategic risk register for the programme. **Appendix L** sets out the Equalities Impact Assessment.

APPENDIX

CARE & CHOICE REPORT

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