WARWICKSHIRE PREVENTION DELIVERY PLAN
Update Period: March 2012

Key Service Area	Summary of Development	Aim	Outcome (KPI)	Predicted Spend	Lead Officer WCC	Lead Officer PCT	Update (all Green – on track)
1. Reablement	1. Sustaining the existing service, and 2. Extend the current eligibility and staffing infrastructure so the service is more accessible to health and social care customers. 3. Transfer 3 CCW posts on fixed term contracts into reablement to assist with exit throughput	To offer reablement to all customers that have the potential to be reabled to prevent hospital admission or/and to be provided as a post discharge service	>Emergency readmissions within 28 days of discharge from hospital (low is good) >Proportion of older people (65+) who are still at home after 91 days following discharge from hospital (high is good) > How many referrals made How many referrals responded to. Referral source, (to determine pre admission and post discharge spilt.) Referral quality > Capture who is referred into the service > Response times of service > Capture readmission volumes into	2010/11 £1.4m – reablement service 2011/12: Schedule £3.1m **Forecast £3.6m** reablement service 2012/13 £2.9m – reablement service 2011/12: £60k - additional Community Care Workers	Zoe Bogg/ Joanne Allen	Caron Williams with Jenni McClaren for support	Plans are on track and delivering as expected: Extended eligibility and capacity is rolling out countywide. Last locality to rollout will be N&B, predicted for July 2012 Revised eligibility is embedding, and performance is sustained 3 CCWs recruited into reablement February 2012 to support and facilitate exit throughput within acutues See Q3 KPIs and supporting report for performance details.

			reablement with **timelines and** reasons > and how appropriate was referral				
2. Access Model/ Information, access and advice	Sustaining & developing care management arrangements to ensure a tier 1 and tier 2 response from social care that reflects a single point of access and makes the customers journey seamless	Key information for customers is only collected once and is used generically across social care and health services/intervention	> To provide a seamless journey for the customer in a timely way >To prevent delays to providing support and services to customer by creating an efficient customer focused service >Reduction in staffing and accommodation costs and process costs > Capture who is referred into the service > Response times of service > Capture readmission volumes into reablement with timelines and reasons > Quality of referral and how appropriate was referral > Measure customer outcomes	No specific costs attributed from the grant	David Soley	Caron Williams	Model and principles signed off. Resource Directory launched. Providing information sources for Healths 'Early Intervention Pilot' self assessment pilot. Customer Service Centre 'scripts' being reviewed (improves triage at 'front door) Interim Access model being piloted in N&B (commenced March 2012), evaluation then roll-out of final model. IT development being used to support improved triage at 'front door' (e.g. improved internet-based information and advice). Access model is part of the wider total service redesign of Social Care and Support. Adult Social Care Performance Measures and Corporate Project

			(related to wellbeing and independence)				Plans monitor this (e.g. property rationalisation project. Local Accounts report)
3. Assessment beds within residential care settings	Allocation of assessment beds for health and social care that can be used to discharge to assess.	Assessment beds to be used appropriately to ensure timely discharge for customers. Service within assessment beds can ensure the appropriate signposting to ongoing support	>Timely hospital discharge to discharge to access. >(NI131 exact match) Delayed transfers of care (low is good) > Measure length of stay > Number of referrals that returned home post assessment bed utilisation > Review timescales for customer post stay > Measure customer outcomes (related to wellbeing and independence) > Access into service > Measure readmission to ongoing service	2011/12: £441k 2012/13: £441k	Di King	Alison Horley (Plus Bie Grobert from Health Community Services)	Winter pressures funding being utilised to take this forwards with increased capacity. Up to 20 beds at any one time are available as Moving on Beds for a period of 2 weeks within WCC internal care homes. Complex needs can be accommodated, ie hoisting and plaster care, but not ongoing nursing needs Pathways to/through these beds have been refined; OTs support assessment, provide manual handling support and ensure appropriate equipment is in place. Reablement may be considered to support the customer when they return home, and reablement work with the Moving on OT to support continuum of care.
4. Residential/ respite care at home (in your place)	1. Sustaining and developing residential respite care services in order to prevent carer breakdown.	Reduce carer breakdown & reduce the number of fast response services Support carers to	> Increase/maintain the numbers of carers being supported to maintain their caring role	2011/12: £637k 2012/13 £637k	Di King/Jane Southerd/ Chris Lewington		The 'In Your Place' service has been de-commissioned and replaced by available service within the new Home Care Contracts as of 1st December 2011.

		maintain their caring role &	>Reduces carer **breakdown** > Measure outcome related to individual maintaining life at home with carer support Referral rate/ > Access into the service > Measure customer outcomes				This decision has been taken as it will enable greater choice and flexibility and increase the responsiveness of service to carers with unique situations Additionally, a new respite service is being scoped and will be completed by May 2012
5. Telecare and telehealth	1. Sustaining the existing service, and 2. Developing a countywide telecare model/pathway that will help individuals maintain independence, increase safety and confidence and support carers alongside traditional healthcare, social care and housing initiatives. To provide the three elements of a telecare service across the county; equipment and installation, monitoring and telephone response and a physical response service for those customers without key holders. 3. Telehealth	This service will be available to customers through reablement and for FAC's eligible customers where the provision of telecare will meet outcomes in a more cost effective way than traditional care	>Emergency readmissions within 28 days of discharge from hospital (low is good) >Proportion of older people (65+) who are still at home after 91 days following discharge from hospital (high is good) >Acute hospital admissions as a result of falls or injuries for over 65s (low is good) >Admissions to residential care homes per 1,000 population (low is good) >The proportion of people suffering fragility	2010/11 £109k – telecare development 2011/12: Schedule £157k **Forecast £206k** general telecare expenditure 2012/13: £157k –general telecare expenditure	Andy Sharpe	Caron Williams	Assistive Technology and Telecare Board established. Representatives from health and social care driving forward prevention agenda. Clear referral /protocols now in place, plus improved information for practitioners on equipment. Current focus on skilling up reablement practitioners. An interim service reflecting the new preferred model for telecare is in place in N&B. Referrals and equipment provision are increasing. Evaluation is due in the new year. Telehealth lead left – awaiting information on

	provision in Warwickshire is in its infancy, with only small scale trials conducted by community matrons to date. A strategic commissioner has been applied WTE to this area to develop plans and a serve an economy wide steering committee. The first plan that has been developed is a programme of work combining Simple Telehealth (mobile phone based technology) with Virtual Wards and Community nursing in the North of Warwickshire to provide support to patients who have long term conditions and need support to build confidence in self management of their conditions. (start of self directed LTC healthcare)		fractures who recover to their previous levels of mobility at 120 days (high is good) >(NI124 derivative) Proportion of people with long term conditions feeling supported to be independent and manage their condition (high is good) >Proportion of Council spend on residential care (low is good) > Capture who is referred into the service > Response times of service > Capture admission /readmission volumes > Quality of referral and how appropriate was referral				progress from Health A significant series of awareness raising and information giving events are in progress for staff with very positive feedback and increased awareness and take up of telecare equipment.
6. ICES	1. To cover the costs of the ICES service, and 2. To develop a hybrid retail model.	Early interventions of equipment whilst controlling the volumes of equipment spend.	>Reduction in the number of emergency admissions >Admissions to	2010/11 £20 k - retail model development	Andy Clayton	Caron Williams	Hybrid retail model developed which supports customers identifying and accessing equipment quickly and at

	Support customers to access equipment quickly, when they need it		residential care homes per 1,000 population (low is good) >(NI136 derivative) The proportion of those using social care who have control over their daily life (high is good) >Emergency readmissions within 28 days of discharge from hospital (low is good) >Proportion of older people (65+) who are still at home after 91 days following discharge from hospital (high is good) >Acute hospital admissions as a result of falls or injuries for over 65s (low is good) > Referral source Referral quality How many referrals made How many referrals auctioned. > Capture who is referred into the service	2011/12: **Schedule:** £1.1m **Forecast:** **£1.6m** –general equipment expenditure 2012/13: £1.1m –general equipment expenditure			point of need Assessor appointed at NRS assessment centre to support / offer advice / guidance Contract arrangements continue (targets in place, e.g., for 'recycle' rate for equipment). OT blue badge assessors were recruited January 2012 and will be located at NRS, which further supports retail model and public awareness.

			> Response times of service > Capture readmission volumes with timelines and reasons > Access to service				
7. Domiciliary Care Commissioning	1. To shape future commissioning of home care to ensure the principles of prevention and personalisation are met, and 2. Includes the introduction of individual service funds (ISF's) & breaks for carers.	Commissioning contracts to reflect customer outcomes and this will be measured through contract monitoring and performance	>Positive results from customer satisfaction questionnaire > Cost efficiency to be generated by the introduction of EVR within all contracts >Contracts to reflect flexibility and make provision for cost and volume within a changing market >Contracts to reflect specialism's so to ensure that those most at risk and vulnerable receive a tailored home care service. > referral source referral quality > Capture who is referred into the service > Response	No specific costs attributed from the grant .	Rob Wilkes		New Home Care Contracts for Domiciliary Care providers implemented from 16.1.12 which includes emphasis on personalisation and how care can be delivered in an outcome focussed and customer centred way This new contract incorporates Fast Response service Contract has also introduced other beneficial clauses, such as shortened notice period before payment stops when packages are on hold (e.g. hospital admission) New Home Framework is being monitored by Contract Monitoring for compliance and sustained performance

			times of service >how appropriate was referral > Access to service > Measure customer outcomes (related to wellbeing and independence)				
8. Rapid Response Services	To cover the costs of a rapid response domiciliary care service available countywide and accessible to health and social care customers	To prevent hospital admission and to minimise carer breakdown To reduce hospital admissions in the patient group. To facilitate early supported discharge support carers and avoid breakdown of care plans	>Reduction in the number of emergency admissions >Enhancing quality of life for carers >Admissions to residential care homes per 1,000 population (low is good) > Increased carer satisfaction in response to questionnaire > Reduction in DTOC's > Measure outcome related to individual maintaining life at home with carer support > Response times of service > Access to service > Quality of referral	2011/12: £59k 2012/13: £59k	Rob Wilkes	Caron Williams with support from Wayne Bartlett	From 1.12.11 this is being provided by external providers via the new home care framework, and is available countywide . This will be monitored for effectiveness.

			Referral source How appropriate was referral				
9. Dementia	1. To reflect the principles of the Dementia Strategy to robust referral pathways into health to assist with early diagnosis, and 2. To deliver the dementia home care service	To support nursing homes, IC and reablement to deliver dementia friendly services. To reduce hospital admissions for primary diagnosis of dementia or confusion	> Reduce acute admissions for people with a primary diagnosis coding of dementia or confusion >Referral source Measure the quality of referral > Capture who is referred into the service > Response times of service > how appropriate was referral > Measure outcome related to individual maintaining life at home with carer support	2011/12 Schedule: £454k **Forecast: £1m** 2012/13 £454k	Chris Lewington	Sally Eason	1) Joint pathway agreed. Some improvements to pathway are currently being negotiated with CCG and CWPT at point of referral and pre/post diagnosis to improve patient experience 2) Action plan has been developed and agreed jointly post diagnosis to improve information and support to people with dementia and their carers 3) Significant work progressing re the use of anti psychotics 4) Rugby Ward closed – currently awaiting evaluation report on impact from PCT. Awaiting consultation regarding further closures and joint approach to social care impact. 5) EMI care home long term placements continue. 6) More detailed joint work being developed to understand impact on social care of CAIT model 7) Community support redesign workshop planned for end of March 2012 to shape CSS redesign

10. Extra Care housing	Costs of **sustaining and expanding extra** care housing as an alternative to residential care. Possible development of reablement flats for assessment within extra care accommodation	To offer alternative **living environments** to customers. To maintain independence and dignity within a supported environment within a community setting To reduce the costs on residential care placements	>Admissions to **residential care** homes per 1,000 population (low is good) >(NI136 derivative) The proportion of those using social care who have control over their daily life (high is good) > Proportion of Council spend on residential care (low is good) **> Measure** outcome related to individual independence and wellbeing > Access to provision	2011/12: £41K **2012/13 £41k**	David Friday		OPEN: Briar Croft providing 64 units (shared ownership and social housing) opened 11.6.10 Farmers Court providing 45 units (all social rented) from 20.6.11 In-year identification, development and opening of Kingston House – 10 units for people with Learning Disabilities, resulting in increased independence and wellbeing. IN DEVELOPMENT: Supported housing for adults with learning disabilities – 30 units at Warwick and Bidford plans to provide 42 units, construction to commence late 2011 (Avon Court) Partnership Framework – development of up to 600 ECH units, of which half will be for AH&CS customers on the following sites : Mancetter First School playing field, St Margarets Griff School, Mayfield Care Home site, Abbotsbury Care Home site.

							Marie Corelli School playing field; St Nicholas School Alcester Great Alne – this development will be made up of 179 units in total. It is expected these will become available towards the end of 2013 Possibility being explored of converting a number of sheltered housing schemes into Extra Care Schemes in Leamington, Nuneaton and Bedworth
12. Funding the cost of changing demand	Applying an uplift to the general budget to reflect demand & demographic pressures.	Ensuring the ability to meet the needs of an ageing & more complex customer base	>Sustaining performance despite demand & demographic pressures.	No specific costs attributed from the grant, but spend elsewhere in this plan by its nature contributes towards meeting this cost	N/A	N/A	Direction and project plans continue to focus on improving early intervention and prevention services and support, to reduce long term care costs, where possible. NB (The demand pressure is estimated at £3m in 2011/12 rising to £5.7m in 2012/13)

Summarised Winter Pressures Funding

	£'000
Maximising use of bed spaces in Internal Care Homes	50
Spot purchasing of Nursing Home beds	84
Night sitting at home	30
Additional social workers to provide capacity planning in hospitals (SWFT only at present)	24
Additional nursing support (SWFT only at present)	26
Age UK Information & Advice Pilot	50
Additional home care hours to help with discharge for people with dementia	225
Increased carer support to families to help with discharge of people with dementia	50
Employment of specialist nurses for delirium care in hospitals	83
Improve web information on care homes	30
Appointment of specialist infection control nurse + support	53
Physiotherapist support for reablement services	24
Additional ICES equipment	136
Interactive resources relating to common childhood illnesses	102
TOTAL COMMITTED TO DATE	**967**
AVAILABLE	**433**
TOTAL FUNDING	**1,400**