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Health and Adult Social Care Overview and Scrutiny Committee

Agenda

Date: **Friday, 26th September, 2014**

Time: **1.00 pm**

Venue: **Executive Meeting Room 1 - Town Hall, Macclesfield SK10 1EA**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Minutes of Previous meeting** (Pages 1 - 4)

   To approve the minutes of the meeting held on 11 September 2014

3. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

4. **Declaration of Party Whip**

   To provide an opportunity for Members to declare the existence of a party whip in relation to any item on the Agenda

5. **Public Speaking Time/Open Session**

For requests for further information
Contact: James Morley
Tel: 01270 686468
E-Mail: james.morley@cheshireeast.gov.uk with any apologies

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

Note: in order for officers to undertake and background research, it would be helpful if members of the public notified the Scrutiny Officer listed at the foot of the Agenda at least one working day before the meeting with brief details of the matter to be covered.

6. **Adult Social Care Commissioning Strategy** (Pages 5 - 212)

(1) To examine the amended draft Adult Social Care Commissioning Strategy as appended.

(2) To agree any comments and recommendations it may have for Cabinet.

Agenda Item 2

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Overview and Scrutiny Committee**
held on Thursday, 11th September, 2014 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor M J Simon (Chairman)
Councillor J Saunders (Vice-Chairman)

Councillors R Domleo, L Jeuda, S Jones and G Merry

Apologies

Councillors C Andrew and A Moran

ALSO PRESENT

Councillor Ken Edwards – Visiting Councillor
Councillor Janet Clowes – Cabinet Member for Care and Health in the Community
Brenda Smith – Director of Adult Social Care and Independent Living
Dr Heather Grimbaldeston – Director of Public Health
Jacki Wilkes – Eastern Cheshire Clinical Commissioning Group
Sue Milne – South Cheshire Clinical Commissioning Group

27 MINUTES OF PREVIOUS MEETING

RESOLVED – That the minutes of the meeting held on 7 August 2014 be approved as a correct record and signed by the Chairman.

28 DECLARATIONS OF INTEREST

There were no declarations of interest

29 DECLARATION OF PARTY WHIP

There were no declarations of party whip

30 PUBLIC SPEAKING TIME/OPEN SESSION

There were no members of the public present who wished to speak

31 ADULT SOCIAL CARE COMMISSIONING STRATEGY

Brenda Smith, Director of Adult Social Care and Independent Living, presented the draft Adult Social Care Commissioning Strategy to enable the Committee to submit comments and recommendations to Cabinet and Officers.

During the presentation the following points were made:

- The purpose of the strategy was to map the current situation regarding the needs in the Borough, the support available and where the gaps in support were, as well as to identify priority areas of joint commissioning with health services, public health, children's services and housing.
- The strategy was guided by national policy and legislation but was also developed using a wide range of intelligence gathered from customers through surveys and engagement events.
- Two of the key strategic outcomes were to enable people to live at home as independently as possible and to enable carers of people to live well and be supported to fulfil their caring role.
- The strategy outlined the specific commissioning intentions for 2014/15 for all adults, for frail older people, for older people living with dementia, for people with learning disabilities, mental health issues, physical or sensory disabilities and for carers.

The Committee asked questions and the following points arose:

- Members were keen to see the delivery plan for the strategy; which was expected to be finalised once the strategy was approved.
- Concern was expressed that work had not taken place yet, almost mid way through the municipal year because the strategy was still to be approved. Assurance was given that activity had always been taking place but an overarching strategy, which would catalogue what the Council was doing, had not yet been put in place.
- The strategy covered a three year period and would be continually refreshed and the action plan for delivery was always being updated. An up to date plan could be made available for members to see.
- The integration agenda brought about by national changes to health services and the imminent changes expected resulting from the Care Bill meant that strategies had to be rethought.
- Community groups needed to be empowered to contribute to providing services and support. Many groups were lacking young people as members which meant older members were not being replaced creating an unsustainable situation.
- Future services needed to be flexible to peoples need and provide personalised care. Greater support would also be needed for carers as more people were encouraged to stay in their own homes the burden and reliance on carers would increase.
- Members were concerned that some groups, such as young carers, were not mentioned in the strategy. It was explained that there were separate strategies for a variety of groups, such as young carers, rather than linking them into one strategy because delivery of outcomes for each groups required different approaches.
- It was suggested that the strategy document did not contain enough detail about what would be done and that the document should be written in plain English to help people understand it. It was explained that the strategy focused on high level outcomes and

intentions and that the detail of what would be done to achieve the desired outcomes would be provided by delivery plans.

RESOLVED:

(a) That the report be noted.

(b) That the Director of Adult Social Care and Independent Living be requested to provide the Committee with a copy of the delivery plan for the Adult Social Care Commissioning Strategy.

32 **WINTER WELLBEING**

The Committee received three reports, one from each of the Council, the Eastern Cheshire Clinical Commissioning Group and the South Cheshire Clinical Commissioning Group on winter planning and the multi agency approach to winter wellbeing.

Dr Heather Grimbaldeston, Director of Public Health, presented the Council's report on Winter Wellbeing and Winter Planning.

Jacki Wilkes, Head of Clinical Developments and Health Outcomes, presented Eastern Cheshire Clinical Commissioning Group's report on Operational Resilience: planning process and assurance 2014-2015.

Sue Milne presented South Cheshire Clinical Commissioning Group's report on Preparing for Winter in the Health Service.

During the discussion the following points were made:

- The winter planning activity was an excellent example of partnership working between the three organisations.
- Cheshire East had people in fuel poverty right across the Borough in affluent as well as deprived areas. The age of housing stock and social isolation were factors that contributed to excess winter deaths.
- The take up of the free flu vaccination needed to be increased, particularly for elderly people. Information about issues that occurred over cold winter months and the support that was available over winter needed to be shared with residents. One initiative taking place was that ANSA, the Council's waste collection company, was putting leaflets on bins.
- The Fire Service had access to useful information on vulnerable people through its work on checking homes for fire safety. It could have been possible for the three partners to tap into this information and target vulnerable people.
- Appendix Two of the Council's report listed all the services that were provided by the Council to support winter wellbeing. It was suggested that all Councillors should receive an information pack about all the services that the Council provided so that they could inform residents about what was available.

RESOLVED – That the reports be noted.

33 **WORK PROGRAMME**

The Committee considered the work programme. The following items were discussed:

- Integrated Care briefing – to be received in October 2014
- Health and Wellbeing Board Performance Review – to be considered in November 2014
- Health Impact Assessments – date to be confirmed
- Impact of Social Landlords on Health and Wellbeing – to be considered in November

RESOLVED – That the Work Programme be updated as discussed.

The meeting commenced at 10.00 am and concluded at 12.35 pm

Councillor M J Simon (Chairman)

Agenda Item 6

CHESHIRE EAST COUNCIL

REPORT TO: Health and Adult Social Care Overview and Scrutiny Committee

Date of Meeting:	26 September 2014
Report of:	Director of Adult Social Care and Independent Living, Brenda Smith
Subject/Title:	Draft Adult Social Care Commissioning Strategy
Portfolio Holder:	Cllr Janet Clowes

1.0 Report Summary

1.1 The Council is putting residents first and intends to ensure that social care needs are a top priority in Cheshire East Council. This is a strong response to plan actions now that will make a real difference going forward. The commitment to residents first has resulted in a full consideration of the key changes that will make a difference to the outcomes of all people who may need social care support in future. This draft strategy outlines the key actions for 2014/15 that will improve outcomes. It recognises the challenge of an increasing older population and complex needs and will ensure that Council outcomes can be delivered into the future.

1.2 The Council intends to have a planned programme of further development of support to adults who may require social care, building on the current best practice locally. We will be seeking innovations and creativity to ensure that independence and choice and control for individuals continue to increase.

1.3 This report seeks input from the Committee to enhance the draft Adult Social Care Commissioning Strategy at Appendix 1.

1.4 The Adult Social Care Commissioning Strategy will be a working document that is revised regularly to reflect the progress of plans and identify further stages of these plans. This strategy will be the tool that the Council uses to ensure continuous improvements in support that will result in better outcomes.

2.0 Recommendation

2.1 That the Committee examine the amended draft Adult Social Care Commissioning Strategy as appended.

2.2 That the Committee agree any comments and recommendations it may have for Cabinet.

3.0 Reasons for Recommendations

3.1 As part of the policy development process the Committee is being provided with the opportunity to submit comments and raise any issues it feels need to be taken into consideration by Cabinet when it receives the draft Adult Social Care Commissioning Strategy.

3.2 The principal aims and benefits that the Commissioning Strategy will realise are to:

- Map the current picture of needs, available support and gaps in support
- Consider customer insights and feedback and ensure they are driving improvement in support
- Enable the identification of priority areas of joint commissioning with health, public health, children's services, housing and others
- Use this analysis to clarify and prioritise the adult social care commissioning annual delivery plan to improve support and address gaps.

4.0 Wards Affected

4,1 All Wards

5.0 Local Ward Members

5.1 All Ward members

6.0 Policy Implications

6.1 This Adult Social Care Commissioning Strategy supports The Strategic Direction of Travel for Adult Social Care Services – Promoting Open Choice as agreed at Cabinet of 4 February 2014 and the Strategic Direction of Travel – Informal Support as agreed at Cabinet of 4 February 2014. It will contribute to the delivery of the Cheshire East Council Three Year Plan outcomes:

Outcome 1: Our Local Communities are Strong and Supportive

Outcome 2: Cheshire East has a Growing and Resilient Economy

Outcome 5: Local People Live Well and for Longer

7.0 Financial Implications

7.1 None. Any key decisions will be taken through further Cabinet reports as necessary.

8.0 Legal Implications

8.1 None. Any key decisions will be taken through further Cabinet reports as necessary.

9.0 Risk Management

9.1 No identified risks in this overall strategy.

10.0 Access to Information

Name: Ann Riley
Designation: Corporate Commissioning Manager
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Appendix 1 – Draft Adult Social Care Commissioning Strategy 2014- 2017

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Adult Social Care Commissioning Strategy

Commissioning to meet social care needs

2014 - 2017

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Executive Summary

Introduction

This is Cheshire East Council's Adult Social Care Commissioning Strategy. It is a working document that will be updated annually to reflect progress and provide for continuous improvement of all our support to adults. Adults in the context of this strategy mean adults in need of social care support. The priorities identified are based on our current understanding of customer needs and gaps but this understanding is work in progress; hence annual updates will refine this. This document was submitted to Health and Adult Social Care Scrutiny Committee on 11th September 2014 and their comments have been taken on board as part of the update to this strategy.

Its principal aims are to:

- Map the current picture of needs, available support and gaps in support
- Consider customer insights and feedback and ensure they are driving improvement in support
- Enable the identification of priority areas of joint commissioning with health, public health, children's services, housing and others
- Use this analysis to clarify and prioritise the adult social care commissioning annual delivery plan to improve support and address gaps

The objectives to be achieved in 2014/15 are outlined in a delivery plan that will be updated annually.

Scope

Adult social care services are the primary focus of this commissioning strategy. These services are targeted services that provide support to adults with social care needs who meet the eligibility criteria of the Council i.e. substantial and critical needs. In addition the service also seeks to provide advice and information and early help to those who are at risk of becoming more dependent so that they can maintain their independence for longer. Where there are key links or joint commissioning with health, public health, children's services or others these have been identified.

The strategy has many aspirations that relate to all adults but some particular groups require additional specialist focus, those groups include the following:

- Frail Older People

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- Older People with Dementia
- Adults with Learning Disabilities
- People with Mental Health Problems
- People with Physical and Sensory Disabilities
- Carers of people with health and social care needs including Young Carers

This strategy is for all people with eligible social care needs, this includes those who fully fund their own care as well as those the Council support financially. The strategy recognises the new requirements of the Care Act 2014, which includes a new duty to provide personalised support to carers as well as carer assessments.

Key Strategic Outcomes

- Enable people to live well and for longer – (Council Outcome 5)
- *Enable people to live at home and as independently as possible – this is what people say they want*
- *Enable people to fully contribute to and be supported in strong and supportive communities – (Council Outcome 1)*
- *Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their well-being*
- *Enable carers of people to live well and be supported to fulfil their caring roles*

Specific Commissioning Intentions

Whilst all current support seeks to achieve the strategic outcomes above the analysis in this strategy indicates where commissioning plans are needed to improve on achieving these. Those areas are in summary:

For all adults:

- Provide support that informs, advises and encourages self-help and self-management to maintain healthy independence.

  For example: information and advice. Having a range of information easily available helps people to stay independent, customers tell us this needs to improve. (Think Local Act Personal (TLAP) report)

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- Stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes.

  For example: Community group support to provide stimulating recreational activities and low level counselling for older people, using volunteers.

- Greatly increase the choices of support available for social care need so that it can be tailored to particular needs and individual's preferences – personalising support.

  For example: By developing a wide and diverse range of choices in support across geographical locations individuals can choose their preferences. This is particularly important for the rural communities in Cheshire East to ensure that people can continue to live well where they prefer.

- Adults should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this. Social isolation and loneliness blights lives and must be addressed urgently.

  For example: a wide range of community activities that people can enjoy as individuals, for daytime and social activity. This improves outcomes by helping people to choose how they prefer to meet their needs, not fit to a service that may exclude them from the community. This area requires joint working with the Council's communities, housing and leisure functions and with the voluntary, community and business sectors. Customers tell us that some day activities offered now are not appropriate for them and that more opportunities in the community need to be available. (TLAP)

- Further develop support that helps people to gain or regain the capacity to live well independently.

  For example: specialist reablement support for older people and older people living with dementia. People who have had a fall and need help to recover their confidence and physical strength and avoid future falls.

- Enable access to support which affords adults protection from harm and safeguards them appropriately

- Redesign assessment and care management processes and systems to ensure customers receive a timely, effective, outcome- focused service.

  For example: the Care Bill requires and it is established good practice for assessment of young people with learning disabilities to commence from age 14 in order to ensure plans to prepare for adulthood begin as early as possible. Assessment and care management resources need to be designed to achieve this.

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Frail Older People

- Develop rapid response 7 day support in the community to avoid health deterioration and the risk of an emergency admission to hospital.

  For example: domiciliary care support that can be put in place very quickly the same day, any day of the week. This needs to be joint work with health as urgent health care in the community is a critical gap currently. (Better Care Plan). Too often frail older people have to be taken to A&E as an urgent response when a community health response is not available quickly enough. Frail older people can deteriorate very rapidly and become seriously ill if treatment is delayed. Social care support to complement rapid health treatment in the community can allow the person to stay at home and recover from the illness. Hospital in-patient stays for this group can result in permanent loss of independence and capacity.

- Develop further the range and scale of community based wrap-around support to keep people living well at home and avoid the risk of needing long-term residential or nursing home care.

  For example: Community based services of social care and health need to be jointly commissioned to ensure that a suitable range of skilled support is co-ordinated around a frail older person. This could include for example: GP, district nurse, podiatry, mental health, occupational therapy, physiotherapy, domiciliary care (home care), reablement, intermediate health services (intermediate care), community equipment, assistive technology, housing adaptations.

- Ensure support is flexible and skilled to respond to people with complex and multiple needs.

Older People Living with Dementia

- Develop the range and focus of the health, social care and community support for people with dementia and their carers.

  For example: Better information for carers about what to expect at diagnosis so that both the carer and the person living with Dementia can accept their diagnosis and plan for their future (Event November 2013). When good information is not provided early this leads to greater anxiety and opportunities to mitigate the consequences for both the person and carer are lost.

- Support the need for early diagnosis and specialist interventions/treatment.

  For example: Dementia reablement and the use of assistive technology.

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Learning Disabilities

- Develop a more effective joint health and social care approach to support adults with complex needs, including challenging behaviour. The complexity of needs is growing in the group of young adults who from children's services to adult social care and health support (often referred to as transition).

  For example: specialist health input tailored to an individual in the community. At present some people with challenging behaviour are in residential provision rather than in community settings or their community accommodation is not stable. The aim would be to develop pro-active specialist community support that enables them to live sustainably in the community. This will require joint commissioning with health.

- Community inclusion to be developed further to ensure that day time and social opportunities encourage and enable access for adults with learning disabilities, including voluntary work and employment.

  For example: befriending schemes that help people with learning disability to find friends with similar interests. The particular needs of people with learning disability require a renewed focus. Encouraging more informal support from friends and communities needs to be a priority in commissioning strategy, it is key to community inclusion and often what individuals say they want.

  Clarify and plan for a suitable range of housing options for the future, under the Council's vulnerable people housing strategy. Including the needs of older people with learning disabilities.

Mental Health

- Develop the preventative support to people at risk of and experiencing poor mental health by working with Public Health and Health partners.

  For example: Lower level counselling support. Social care specialist support has to be targeted at those with serious mental illnesses yet there are opportunities to avoid the increase in this group by preventative commissioning by Public health and Health. Informal social support can be joined with those resources using stronger and supportive communities to mitigate against poor mental health; improving mental health and well-being is a priority in the Health and Well-being Strategy H&WB strategy.

- Ensure that informal support is developed and encouraged to provide better community and social inclusion for those recovering from serious mental illness. Including, where appropriate, remote services (such as support via webcams) in rural and more isolated areas.

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For example: befriending from the wider community can offer a key support to help someone on the path back to a successful and independent life. Often users of specialist mental health services are isolated from the community and their social contacts are those with similar difficulties.

- Focus on prevention by influencing in areas linked to wider determinants of health.

  For example: homelessness as a contributor to increased risk of poor mental health.

Physical and Sensory Disabilities

- Improve the outcomes of the rehabilitation/reablement of those affected by specific conditions to ensure individuals live well for longer.

  For example: a new specialist stroke rehabilitation approach in the community. Some people who experience a stroke have not been achieving the maximum rehabilitation possible. Some individuals may be remaining physically and emotionally disabled when they could regain a much greater level of capacity and independence. The approach combines a different health response with community based social care support.

- Expand awareness of and access to assistive technology to ensure those with disabilities can maximise their personal independence.

  For example: the advent of the 'Apps' world is starting to provide innovative solutions that can enable independence. There is an app on the market that turns an android phone into a speech board to 'speak' for a person who has speech difficulties (e.g. motor neurone disease or stroke). Another provides fall detection via an android phone, there any many others developing. Many other solutions are available or being developed.

- Work with Housing through the Vulnerable People Housing Strategy to ensure housing supply and use enables those with physical disabilities to live as independently as possible.

  For example: the housing strategy seeks to promote general accessibility standards through planning processes, to ensure that as many new build homes as possible are suitable for people with physical disabilities.

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Carers

- Increase the range of respite care choices available to ensure that carers can have periodic respite from their caring roles that meets their particular needs and preferences. Explore the options of respite models for young carers.

  For example: choices for respite for carers that are non-residential. The pre-dominant type of respite currently is residential and is focused on a small number of locations. A much wider choice can be provided by developing this market so that carers can select their preference. Other choices are needed to include non-residential options so that the cared for person does not need to be moved from their home environment.

- Increase the range of early advice, information and support to people new to the caring role.

  For example: carers knowing what help is available to them and the person they care for.

- Enable carers to develop skills and expertise to assist them in their caring role.

  For example: ensure health and social care services provide training and education for carers in relation to disease and condition specific interventions to help them care with confidence and know when to call in specialist help.

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Commissioning Strategy

Introduction

Background and Aims

This is Cheshire East Council's Adult Social Care commissioning strategy. It is a working document that will be updated annually to reflect progress and provide for continuous improvement of all our support to adults. The priorities identified are based on our current understanding of customer needs and gaps but this understanding is work in progress, annual updates will refine this.

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This strategy is for all people with eligible social care needs, this includes those who fully fund their own care as well as those the Council support financially.

Principles of Commissioning Approach

Listening to customers

Co-production/Co-design

Empowering people

Equity

Quality

Value for money

Longer-term cost-benefit

Targeting need/locality focus

Prioritisation

Affordability

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Direction of Travel – How Social Care Support Needs to Be Different in Future

Cheshire East Council has set a new clear direction of travel to change how social care needs are supported; this underpins and directs this commissioning strategy. To be sustainable and meet the challenge of demographic change and complexity of need and still achieve good outcomes for the citizens of Cheshire East the way we support people needs to change. Hence this first iteration of a commissioning strategy that will achieve planned change, through effective commissioning, over the next 3-5 years.

The number of people aged 65 and older in Cheshire East Growth is forecast to increase by 49% in the next 16 years. The demographic growth will not be matched by public funding. To respond to these challenges the council recognises that we need to change the way we commission services and work with specialist social care providers. There are changes needed in the social care market to respond to the changing demographic and economic environment.

The direction of travel demonstrates how by 'doing things differently' we will:

- *do more for less* to meet the forecast growth in demand. We will encourage innovation and find new ways of delivering services so that people receive quality services which meet their care needs and deliver outcomes for individuals and for the council.
- *enable individuals to control their own care and support* and make open choices about how and when they are supported to live their lives.
- *increase opportunities for local businesses* to compete in the market and ensure that people have a varied care and support market to purchase from.

To complement our work with specialist regulated social care we need to shift the focus in commissioning to maximise the opportunities for self-reliance, independence and healthy lives. This will be done in conjunction with our commissioning colleagues, health, public health and communities.

The vision for the future is for the Council and partners to enable adults to be self-reliant and healthy for as much of their lives as possible. The goal is to make Cheshire East a place where strong empowered communities, including businesses, create that self-reliance.

In this context the informal support for adults and their carers needs to change to maximise the opportunities for self-reliance, independence, and healthy lives. The strategic direction of travel for informal support is to increase prevention and early intervention for people with social care eligible needs.

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Quality informal support is needed that meets the objectives of:

- encouraging the prevention of ill-health or dependency
- accessing early help and advice to maintain or regain health and independence
- promoting self-reliance and community inclusion to increase well-being
- personalisation and promoting open choice

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How the Social Care and Health Economy Needs to Change – Working with Partners

Over time the resources in the local health and social care economy, including public health, need to be realigned to increase investment in prevention and early intervention. The current pattern of resource use is a high proportion invested at the bottom of the triangle below on the substantial and complex needs. This investment needs to decrease to allow more to be invested in the middle of the triangle where prevention can be maximised. The key and major shift required is in health investment, which social care can then support; without the health changes the goal of early help and prevention will be unachievable.

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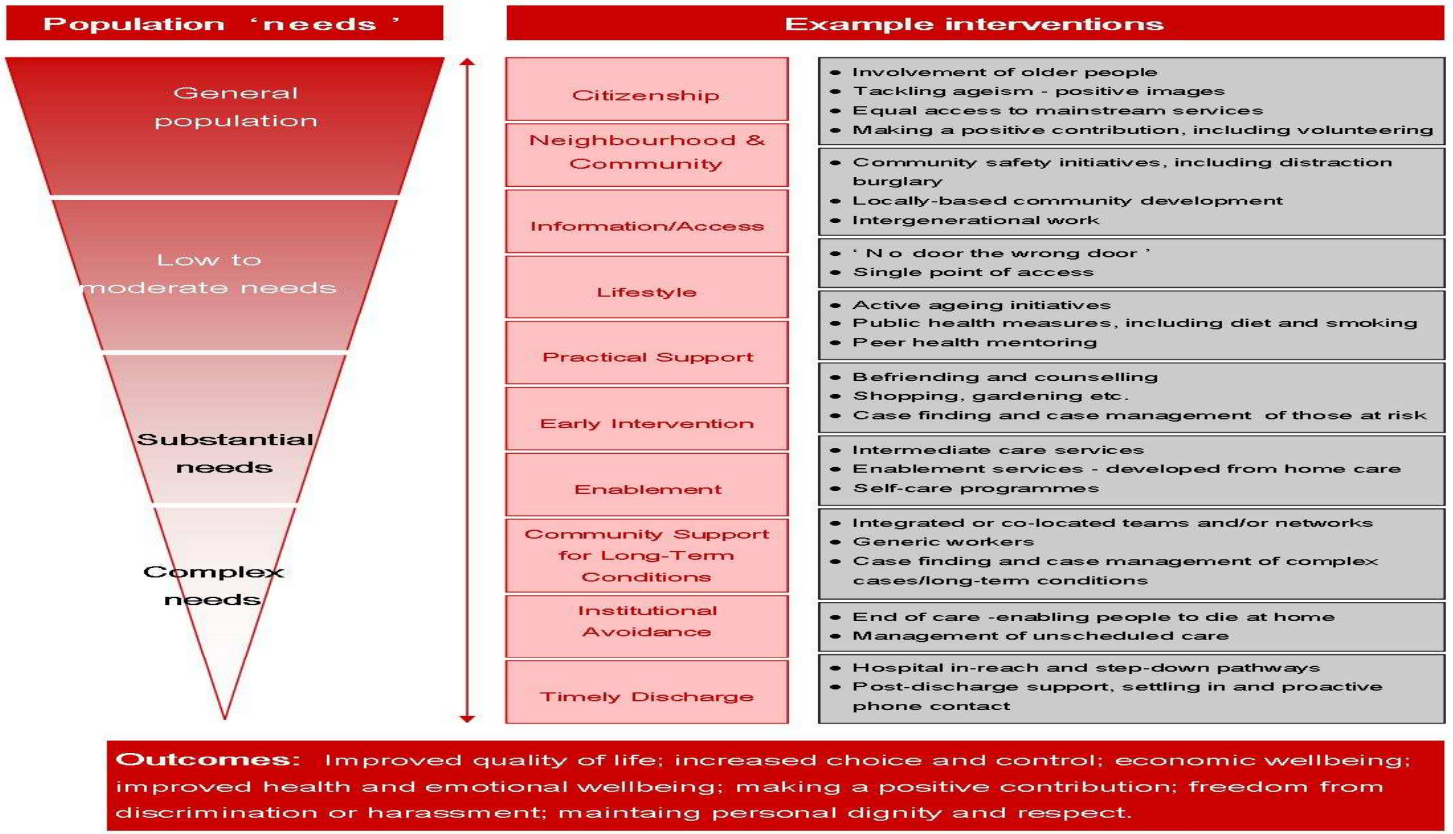

The Spectrum of Prevention

(Reference: 'Improving care and saving money: learning the lessons on prevention and early intervention for older people' DH, January 2010)

Council Duties and Policy Framework

This commissioning strategy is guided by the requirements of legislation and national policy drivers. (see Appendix 7 Policy Digest for details). The key legislation and policy includes:

- The Care Act 2014
- Health and Social Care Act 2012
- Equality Act 2010
- Autism Act 2009
- Valuing People (2001) and Valuing People Now: A New Strategy for People with Learning Disabilities 2007
- Aging Well 2010 – 2012
- National Dementia Strategy 2010
- National Autism Strategy
- Mental Health Act 1983
- Mental Capacity Act 2005

Cheshire East – Characteristics and Demographics

Cheshire East has a population of 372,000 and an area of 116,638 hectares. In addition to Cheshire West and Chester on the west side, Cheshire East is bounded by the Manchester conurbation to the north and east, and Stoke-on Trent to the south. It contains the major towns of Crewe, Macclesfield, Congleton and the commuter town of Wilmslow (population above 20,000). There are also a number of other significant centres of population (over 10,000) in Sandbach, Poynton, Nantwich, Middlewich, Knutsford and Alsager. With few large conurbations the borough otherwise comprises a mixture of smaller market towns and more isolated rural villages. This mixture of rural/urban presents particular challenges in delivering cost-effective services close to individuals and their neighbourhoods.

In 2010 there were 83,300 older people aged 65+ in Cheshire East (Office for National Statistics indicative population estimates 2010). Estimates suggest that in 2012 5,234 (6%) older people were living with dementia and 33,154 (40%) with a limiting long term illness. The population of Cheshire East is forecast to grow modestly over the next 30 years rising from 362,700 in 2009 to 384,000 in 2029, however, the age structure of the population is forecast to change significantly with a 8% reduction in young people (0-15), a 12% reduction in working age people (16-59 Female, 16-64 Male) and a 42% increase in people of retirement age (60/65+), with the number of older people (85+) increasing by around 92%. As the prevalence of dementia increases with age, the number of older people with dementia is anticipated to increase by 28% by 2020. The significant changes in demographic in Cheshire East will have direct implications for adult social care.

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Current Market Analysis and What Is Needed in Future

This section of the strategy provides a summary of the current market analysis, what work has been carried out to date and future requirements, with a focus on key priorities for 2014/15. Further detail providing the intelligence and background that underpins this summary is in Appendix 3 ('Detailed Commissioning Intelligence and Background')

Information and Advice/Self-Help

Service Mapping and Need

There are many sources of information but no simple route for customers and carers to get the information they need quickly and easily. Information is offered by many different organisations but the quality is variable; customers say that some of the best sources are from the voluntary sector. The Council's website is not easy to navigate and does not provide a comprehensive set of information on community support available.

The commissioning intentions driving developments in this area are:

Improving self reported wellbeing –it should be no surprise that our first priority, in line with our corporate objective, is that people live well and for longer. We want to support people to remain independent for as long as possible, delaying and in some cases avoiding the need for ongoing social care services. The Council actively wants to engage with and listen to communities as equal partners to make a difference. By actively participating in finding solutions for how we make stronger communities now and in the future and by building on local working and existing networks and good practice we will help people to understand the role that they have to play in staying fit and healthy and reduce dependency on services. One way in which we will measure our success is through improved self reported wellbeing – satisfied with life (PHOI 2.23i)

Commissioned Provision

Adult Social Care has commissioned a number of specialist services from the independent sector that provide information and advice to a variety of areas within the community e.g. support and advice for people with a loss of hearing/sight; support for older people in rural communities to help them become engaged in the community; these are in place with the majority of services receiving 3 year contracts to enable secure business planning, which is particularly important for the Voluntary, Community and Faith sector. These services are currently being monitored to ensure that outcomes are being met and feedback can be used to further develop services going forward.

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Services are not yet as streamlined as they could be and the Care Bill requires the development of effective advice and information as a key to helping people to help themselves to be independent and healthy.

What we will do in 2014/15

- Develop joint community, health, public health and social care advice and information services including the development of a Resource Directory, both on-line and other easily accessible ways
- Develop easy access routes to this advice and information, including but not exclusively the internet.

- Work with CECAP (Cheshire East Co-ordinated Advice Project) as an associated partner to bring together the advice services of the following organisations:-

    - Cheshire East Citizens Advice Bureau North
    - Cheshire East Citizens Advice Bureau Ltd
    - Cheshire, Halton & Warrington Race & Equality Centre (CHAWREC)
    - Disability Information Bureau (DIB)
    - Just Drop In
    - Visyon

These organisations are also working closely on this project with Age UK Cheshire East and other associated partners are Plus Dane Housing Group, Peaks & Plains Housing Trust and Wulvern Housing.

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Prevention and Early Intervention

Service Mapping and Need

Prevention and early intervention in Cheshire East has been developing over the last 18 months with a move to contracting these services based on priority outcomes rather than the grants that had previously been in place. These services are contracted for a 3 year period, with an innovation fund available for new initiatives. This is providing for a better market fit with the direction of travel and increased focus of support.

Through the Health and Well-being Strategy and with public health and health there is a recognition that universal health promotion activities must develop greater impact on the ability of people to avoid ill-health and retain independence. Adult social care will need to play a part in that development. (Health and Well-being Strategy).

There is also a need to ensure that informal community facilities and groups play a part in helping people to access them. This is a substantial resource in Cheshire East which is not yet fully understood or maximised strategically to achieve the outcome of living well and for longer. Over the next 3-5 years this area of investment needs to be enhanced through all possible routes, including local businesses. Adult social care will work with Resilient Communities to help facilitate this.

The commissioning intentions driving developments in this area are:

- Stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes.
- people should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this.

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Commissioned Services

Adult Social Care has recently commissioned a number of services from the independent sector that provide prevention and early intervention; these are now in place and are being monitored to inform future commissioning. Services include:-Carers support services

- Peer support for older people to remain independent
- Early help for those starting to develop deafness to avoid deterioration and dependence
- Community agents in isolated/rural communities to target social isolation and other needs
- Advocacy support to help people access universal services
- Specialist support and advice to people with visual impairment

This market development needs to be embedded and closely monitored to ensure it is meeting desired outcomes. There is also a need to seek innovative ways to encourage and help customers, carers to self-help earlier to avoid future dependency. There is also a role for local businesses to develop support and services that people can buy themselves.

What we will do in 2014/15

- Closely monitor the impact of the adult social care newly commissioned services ensuring that expected outcomes are being met
- Launch a second year opportunity for the third sector and community groups to gain seed-funding to establish sustainable prevention and early help work (through the 'Innovation Fund')
- Pilot an innovative approach to promoting universal access to assistive technology and aids to living (equipment).
- Commission jointly with the Head of Communities and the Director Public Health to ensure all potential resources are contributing effectively to prevention and early intervention

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- Commission jointly with health to ensure all potential resources for prevention and early help are identified, maximised and increased over time.

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Community Based Services

Community based services are designed to support or reable people to live independently at home and avoid the need for admission into long-term residential or nursing care. These areas of service will need to be continuously reviewed to ensure they can meet the future direction of travel. There are priority changes needed and these will be the focus of this year's commissioning work.

These services include:

Domiciliary Care (Home Care)

Service Mapping and Need

In 2011/12 995,000 hours of domiciliary care were delivered to 764 service users at a cost of £16.5 million. 97% of these hours were provided by the independent sector. As at December 2013 2,464 older people are being supported by 71 domiciliary care providers; of these the council directly commission the care for 1,414 older people. A further 1,050 people currently receive cash payments to organise their own support, the majority of which are spending their personal budgets on traditional social care services, particularly domiciliary care. The Council has already removed the domiciliary care block contract arrangements to widen the available supply

The uptake of domiciliary care increased through the last financial year. To continue this trend the Council wants to make it easier for existing and new providers to enter the market and work with us via framework agreements. We also expect the amount Cheshire East spends via cash payments to increase together with the demand for a more personalised service offer as the market expands and expectations of future generations change and they move away from traditional care services.

The commissioning intentions driving developments in this area of support are:

Increasing the proportion of community-based service users able to stay in their own home - in addition to providing reablement for people leaving hospital we will continue to provide community reablement for all appropriate new people requiring social care support. Over 1,123 older people completed a reablement package in 2012/13 and we are actively exploring how predicted increases in future demand for this service can be met. We have been successfully promoting assistive technology and are beginning to see that this is having an impact in improving independence and reducing the need for on-going services. We believe that providers should be incorporating assistive technology as part of their offering to service users and will seek provider views on how we can incentivise this approach. We will also continue to increase the proportion of council expenditure that is used to purchase Domiciliary Care, the range of care and support services provided in peoples own home to enable them to remain independent.

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- Develop rapid response 7 day support in the community to avoid health deterioration and the risk of an emergency admission to hospital.
- Greatly increase the choices of support available for social care needs so that it can be tailored to particular needs and individual's preferences – personalising support.
- Develop further the range and scale of community based wrap-around support to keep people living well at home and avoid the risk of needing long-term residential or nursing home care.

Commissioned Services

In response to customer demand the Council are committed to developing this type of care provision as an alternative to residential based care services.

What we will do in 2014/15

- create a new quality assurance service to monitor all domiciliary care
- review the use of this market during 2013/14 to identify any further developments needed
- Prepare for the procurement of a new framework for providers of this care to widen the choice of supply and provide for developments of the range of support
- promote personalised care including flexibility, choice and control for customers
- procure a Rapid Response service in conjunction with Health to assist with Winter Pressures following this pilot assess the need for 7 day care responses across the health and social care system.

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Daytime Activities (including Day Care)

Service Mapping and Need

There is a range of services that provide for daytime activity, this includes some specialist day care commissioned by adult social care, but also a wider range of community activities that can also be accessed. The specialist day care is in a limited number of locations and it can have the unintended consequence of excluding people from the community. Because this specialist day care is whole group based it is difficult to tailor activity to individual needs and preferences. Customers tell us that some activities offered now are not appropriate for them and that more opportunities in the community need to be available. (TLAP).

The commissioning intentions driving developments in this area of support are:

- People should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this.
- Greatly increase the choices of support available for social care needs so that it can be tailored to particular needs and individual's preferences – personalising support.

Commissioned Services

In house services are currently available and several day care options in the community are available for people to access e.g. gardening for adults with learning disabilities.

What we will do in 2014/15

- Map and review the current opportunities in the community for daytime activities
- publish a Resource Directory of daytime activities so that people can choose activities for themselves
- stimulate informal support, working with the Council's Head of Communities and other partners

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Community Based Reablement

Service Mapping and Need

Cheshire East has increased the use of reablement services to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or social abilities of daily living which has led to increased support needs. Over 1,123 older people completed a period of reablement in 2012/13, of which 40% achieved a positive outcome of either needing no on-going support, or having reduced care needs on completion. Currently the reablement services respond well to a range of needs. However there are potential specialist skills that could be enhanced so that the particular needs of those with dementia or stroke patients have even better outcomes.

The commissioning intentions driving future developments are:

- Further develop support that helps people to gain or regain the capacity to live well independently
- Develop the range and focus of the health, social care and community support for people with dementia and their carers.
- Improve the outcomes of the rehabilitation/reablement of those affected by specific conditions to ensure individuals live well for longer.

Commissioned Services

Reablement is offered to individuals who can benefit and is delivered for up to 6 weeks within the persons own home to restore people's ability to perform usual activities and improve their perceived quality of life. We believe the success of telecare and reablement has contributed to the reduced demand for lower level home care services.

There is a specialist reablement team for those recovering from serious mental illness. The customers of the service have good outcomes and the approach is viewed as best practice and there is an opportunity to consider how to enhance this approach.

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What we will do in 2014/15

- A pilot dementia reablement approach will be trialled
- Potential new stroke rehabilitation approach will be considered with health partners.
- Existing support will be targeted and managed to ensure those who can most benefit receive the service they need
- An interim review of reablement will commence and begin to consider the future models including Intermediate care (health)

Supported Accommodation

Service Mapping and Need

Under the development of the Vulnerable People Housing Strategy a range of services have been mapped (see details in Appendix 3 - Detailed Intelligence and Background). There is currently sufficient to meet current demand but future demand both in scale and type means plans need to predict further. As A large proportion of accommodation in Cheshire East for people with learning disabilities is in shared houses (48%). Whilst an option that works for some people to work effectively resident composition must be carefully matched. There is a need to consider whether the mix of options needs to include more single occupancy accommodation in a supported setting.

The commissioning intentions driving this area are:

Delivering home adaptations for older and/or disabled residents - 1624 older people received adaptations in 2012/13, of which 431 were self funded. We will continue to deliver home adaptations for older and/or disabled residents to enable them to live independent, healthier and more fulfilled lives.

- Work with CEC housing through the vulnerable people strategy to ensure housing supply and use enables those with disabilities to live as independently as possible.

Commissioned Services

As of July 2013, Cheshire East has the capacity to house 409 people with a varied range of learning disabilities in supported accommodation across the borough. Support is provided through a range of providers. Cheshire East has worked with providers to move towards more single occupancy units.

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What we will do in 2014/15

- with CEC housing colleagues consider the feedback of customers and carers to the strategy to inform future planning
- ensure through the Learning Disability Lifecourse commissioning review that innovative ideas for the future are developed to offer a range of choices for living in the community, including Shared Lives adult placements with families.
- ensure sustainability of accommodation for vulnerable groups as a key preventative measure.

Assistive Technology

The Council have increased the use of assistive technology each year for the last three years as a means to increase independence, provide safety for customers and reassurance for carers. The range of opportunities presented by assistive technologies is expanding.

Commissioned Services

The use of assistive technology is a growth area and as well as traditional telecare such as alarms, fall sensors etc . a service has been commissioned where people with mental health issues can receive support via their laptops if they are located in rural areas or find meeting with professionals face to face difficult.

The commissioning intentions driving this area are:

Increasing the percentage of people enabled to remain living independently in the community - we will commission with health partners to prevent unnecessary admissions into hospital. The majority of older people who require intensive social care support have come to us via a hospital admission and we plan now to commission services to avoid this. As a result we will be commissioning many of these services jointly to prevent avoidable hospital admission and services that successfully maintain people in their own homes. We will also commission with health partners services and support that promote an earlier safe discharge from hospital including intermediate care and reablement services.

Increasing the proportion of community-based service users able to stay in their own **home** - in addition to providing reablement for people leaving hospital we will continue to provide community reablement for all appropriate new people requiring social care support. Over 1,123 older people completed a reablement package in 2012/13 and we are actively exploring how predicted increases in future demand for this service can be met. We have been successfully promoting assistive technology and are beginning to see that this is having an impact in improving independence and reducing the need for on-going services. We believe

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that providers should be incorporating assistive technology as part of their offering to service users and will seek provider views on how we can incentivise this approach. We will also continue to increase the proportion of council expenditure that is used to purchase Domiciliary Care, the range of care and support services provided in peoples own home to enable them to remain independent.

Delivering home adaptations for older and/or disabled residents - 1624 older people received adaptations in 2012/13, of which 431 were self funded. We will continue to deliver home adaptations for older and/or disabled residents to enable them to live independent, healthier and more fulfilled lives.

- Expand awareness of and access to assistive technology to ensure those with disabilities can maximise their personal independence
- Stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes.
- Consider option of increasing choice and control as a safe means to access to suppory whilst promoting privacy and independence

What we will do in 2014/15

- pilot an innovative approach to raising awareness and access to assistive technology and equipment in the wider population to enable self-help and self management for prevention and early help
- pilot the use of assistive technologies for people with learning disabilities to increase independence
- focus on increasing use of assistive technology as part of new and future contractual arrangements

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Long-term Residential and Nursing Care

Service Mapping and Need

Cheshire East has a large market supply of residential and nursing care for older people, overall there is sufficient current capacity which enables choice for customers. The direction of travel seeks to increase the proportion of older people who can stay living at home rather than enter long-term residential care. However there will always be a need for good quality residential and nursing care.

The demographic trends and their associated increase in the prevalence of dementia will mean that the future need for this type of care needs careful planning. It is clear that the complexity of need will grow, including the need for specialist dementia care, and this is likely to require some growth in the nursing home market to meet the needs in 2020. There are 102 care homes with 4032 registered care beds available for older people in Cheshire East. As at December 2013 Cheshire East support 1319 older people in residential or nursing care. Spend on permanent admissions into registered care for older people has reduced by 3% from £31,910,195 in 2011/12 to £30,963,381 in 2012/13 and there has been a corresponding increase on spend on community services. The average age on admission into a registered care setting is 83.

The commissioning intentions driving this area: Reducing the number of Council supported permanent admissions to residential and nursing care per 100,000 population– The numbers of older people supported by Cheshire East in registered residential and nursing care has reduced by 3% since 2012, despite increased demographic pressures, with people being admitted later in life and staying for shorter periods. Whilst we do not believe that we need more residential care we may need to consider the models of care that is provided and how it is distributed throughout Cheshire East. We are unlikely to support planning applications for registered care homes in areas where we believe there is an already an over-supply unless the application is to remodel existing provision to make it more fit for purpose, or the proposed development will better meet specific unmet needs within the area. As part of our on-going engagement with the market we would welcome discussions with providers about their ideas for potential developments so that we can give an early indication about whether we are likely to support an application and hence avoid unnecessary costs to providers at a later stage. We will also seek to utilise residential and nursing care home capacity to provide respite breaks for carers, where this has been assessed as an eligible need through a carer's assessment, or short term placements to avert a crisis or provide a period of recuperation from hospital or illness.

Supporting good quality registered nursing care is available for physically and mentally frail older people who need it –the supply of nursing care will need to match the increasingly complex needs of people requiring registered care. We will look to commission this service in partnership with health colleagues wherever possible.

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- Greatly increase the choices of support available for social care need so that it can be tailored to particular needs and individual's preferences – personalising support.
- Develop the range and focus of the health, social care and community support for people with dementia and their carers.

Commissioned Service

The Council is commissioning 40% the available beds in the market in Cheshire East, and 60% are being commissioned by self funders or other authorities.

Cheshire East Council has worked with providers to improve quality whilst retaining value for money. Adult Services have also worked with Housing and Planning to oversee development of services in this area.

What we will do in 2014/15

- create a new quality assurance service to monitor all regulated care provision and ensure personalised care is available within residential and nursing home settings.
- reduce the admissions to residential services
- evaluate the use of this market during 2013/14 to identify any developments needed, particularly in nursing home provision
- consider the potential impact on this market of a need to develop 7 day care responses across the health and social care system

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Assessment and Care Management

Assessment and care management is the service which ensures that individuals needs are understood and allocates resources to meet their eligible needs. The assessment and care management processes and procedures need to reflect the future requirements of the Care Bill.

The commissioning intention driving this area:

Increasing the number of social care clients receiving self-directed support - 1050 older people receiving on-going care services are receiving their personal budget via a direct payment and arranging their own care, however the majority of older people are using their money to purchase traditional domiciliary care services and we believe that there is an opportunity to work with the market to increase open choice and to develop a truly personalised offer to consumers. Improved access to information will be supported by Council investment in a high speed broadband network for Cheshire. The Connecting Cheshire Partnership will ensure that 80,000 (96%) of rural homes and businesses will have access to high-speed broadband by 2016.

- Redesign assessment and care management processes and systems to ensure customers receive a timely, effective, outcome- focused service.
- Ensure assessment and care management response is focused on independence and self-management within overall context of positive risk taking and safeguarding

What we will do in 2014/15

- options for the assessment and care management arrangements will be developed that ensure appropriate customer responses including:
- providing support to people who fund their own social care
- providing effective advice and information to enable independence
- ensuring those with complex needs receive specialist responses
- ensuring people can access financial planning support

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Current Customer Grouped Support and What is Needed in Future

As well as understanding the current markets for provision of various types of support as above it is important to understand particular groups of customer needs. Bringing these together in this strategy ensures that all developments deliver the necessary range of support to meet the differing aspects of meeting individual needs.

- All adults
- Frail Older People
- Older People with Dementia
- Adults with Learning Disabilities
- People with Mental Health Problems
- People with Physical and Sensory Disabilities
- Carers of people with social care needs including young carers

All adults:

Ensuring all adults are supported to have fulfilled and healthy lives is the core goal of social care. This Commissioning Strategy identifies areas where support may need to change or where there are gaps that need to be addressed to continue to meet that goal effectively.

There are some common aspirations for all adults that this strategy has identified as commissioning intentions as below

- provide support that informs, advises and encourages self-help and self-management to maintain healthy independence
- stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes
- greatly increase the choices of support available for social care need so that it can be tailored to particular needs and individual's preferences – personalising support

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- adults should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this. Social isolation and loneliness blights lives and must be addressed urgently.
- Further develop support that helps people to gain or regain the capacity to live well independently.
- Enable access to support which affords adults protection from harm and safeguards them appropriately

Additional specialist developments are required for some groups as follows:

Frail Older People

Service mapping and need

The complexity and frailty of older people is increasing as people live longer with multiple health conditions. This changing level of complexity is resulting in the increased risk of people entering residential or nursing care rather than being able to live at home. To address this services need to be redesigned and shaped to ensure deterioration is prevented and hospital admissions are avoided as this lead to a greater risk of loss of independence. Many of the existing services are the appropriate services, what needs to change is the speed with which they can be accessed in a crisis and the streamlining of the options for a support package that is comprehensive. In addition resources currently invested in hospital care need to be reinvested into community support which will be more preventative and keep people at home.

The additional commissioning intentions driving this area are:

Increasing the percentage of people enabled to remain living independently in the community - we will commission with health partners to prevent unnecessary admissions into hospital. The majority of older people who require intensive social care support have come to us via a hospital admission and we plan now to commission services to avoid this. As a result we will be commissioning many of these services jointly to prevent avoidable hospital admission and services that successfully maintain people in their own homes. We will also commission with health partners services and support that promote an earlier safe discharge from hospital including intermediate care and reablement services.

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- Develop rapid response 7 day support in the community to avoid health deterioration and the risk of an emergency admission to hospital.
- Develop further the range and scale of community based support to keep people living well at home and avoid the risk of needing long-term residential or nursing home care.
- Ensure support is flexible and skilled to respond to people with complex and multiple needs.

What we will do in 2014/15

Develop service specifications and commissioning with health to enable changes to the system to begin the necessary changes. Changes are required that can lead to the release and re-direction of current investments to increase effective support around and 7 day working in future e.g. Develop specifications for rapid response services to avoid health deterioration and possible admissions to hospital and jointly commission community based services of social care and health to ensure that a suitable range of skilled support is co-ordinated around a frail older person.

Older People with Dementia

The predicted increase in dementia is already emerging but as yet is not fully understood locally as diagnosis levels appear lower than comparators. The local Dementia Strategy is being further developed by social care and health with customers central to that work. This then needs to be used to influence commissioning priorities. There are already some key things that customers want us to do better and these are informing this commissioning strategy. In 2010 there were 83,300 older people aged 65+ in Cheshire East (Office for National Statistics indicative population estimates 2010). Estimates suggest that in 2012 5,234 (6%) older people were living with dementia. As the prevalence of dementia increases with age, the number of older people with dementia is anticipated to increase by 28% by 2020.

The commissioning intentions driving this area are:

Supporting people with dementia to retain their independence for as long as possible and enjoy a good quality of life – The growth in people experiencing dementia presents probably the greatest challenge for health and social care services. Having a workforce with the skills and knowledge to support people with dementia is therefore a requirement for all providers working with older people. Supporting people in the familiar settings of their own homes can reduce the numbers prematurely entering long term care. Providers can play an important role working alongside health professionals to ensure the early identification of dementia, and the provision of appropriate support to delay and minimise the impact of this condition. For people in the later stages of dementia, registered care settings play an important role in supporting people to live well and with dignity.

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- Further develop support that helps people to gain or regain the capacity to live well independently.
- Develop the range and focus of the health, social care and community support for people with dementia and their carers.
- Support the need for early diagnosis and specialist interventions/treatment.

Commissioned Services

A variety of services have been commissioned with the VCFS sector to help and support older people with dementia including an information and advice service provided by the Alzheimer's Society.

What we will do in 2014/15

- Update and publish a new local Dementia Strategy together with our health partners
- Cheshire East to become a member of the Dementia Alliance – with the aim of making Cheshire East dementia friendly
- Pilot a dementia reablement approach to seek ways to mitigate against the impact of dementia
- Commission respite support to enable carers to have regular breaks from their caring role

Adults with Learning Disabilities

The Commissioning intentions driving this area are:

- Develop a more effective joint health and social care approach to support adults with complex needs, including challenging behaviour. The complexity of needs is growing in the group of young adults who transition from children's services
- Community inclusion to be developed further to ensure that day time and social opportunities encourage and enable access for adults with learning disabilities, including voluntary work and employment.
- Clarify and plan for a suitable range of housing options for the future, with strategic housing in the Council.

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Commissioned Services

Early intervention and prevention services have been commissioned for Adults with Learning Disabilities including social groups in the evening throughout Cheshire East.

What we will do in 2014/15

- the Council, in partnership with health, has established a commissioning review of support for people with a Learning Disability to consider how support from birth to end of life needs to be re-designed for the future. This review is on-going in 2014/15 and will provide a longer-term vision by summer 2015 to inform future investment choices and direct commissioning intentions.
- a joint commissioning plan for challenging behaviour will be developed between social care and health.
- map the current opportunities in the community activities
- publish a Resource Directory of opportunities so that people can choose their preferences
- stimulate informal support, working with the Council's Head of Communities and other partners

Mental Health (not dementia)

Service Mapping and Need

Cheshire East social care services provides support at any one time to around 600 people with a substantial or severe mental health issue (based on Oct 13 data).

Social care work in partnership with health services to provide multi-disciplinary community mental health specialist teams. There is a specialist reablement team for those recovering from serious mental illness. The customers of the service have good outcomes, the approach is viewed as best practice and there is an opportunity to consider how to enhance this approach. There is also a need to consider how to ensure that recovery is sustained by developing community inclusion and networks that enable this. Some supported housing is provided for those with lower level support needs.

The Director of Public Health's report 2012 – 2013 has identified that Cheshire East has one of the highest excess mortality rates for adults under 75 with a serious mental illness.

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The Commissioning intentions driving this area:

- Adults should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this. Social isolation and loneliness blights lives and must be addressed urgently.
- Develop the preventative support to people at risk of and experiencing mental health issues by working with Public Health and Health.
- Ensure that informal support is developed and encouraged to provide better community and social inclusion for those recovering from serious mental illness.
- Focus on prevention by influencing in areas linked to wider determinants of health.

Commissioned Services

A variety of services both accommodation based and in the community are available for people with mental health issues including a service specifically targeted at carers with a mental health problem.

What we will do in 2014/15

- Work with health and public health to better meet the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness (Health and Well-being Strategy)
- map the current opportunities in the community for activities
- publish a Resource Directory of opportunities so that people can choose their preferences
- stimulate informal support, working with the Council's Head of Communities and other partners

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Physical and Sensory Disabilities

Social care provides support to around 400 people with a physical or sensory disability aged 18 -64 (based on data at Oct 13). Census projections anticipate only a small rise in the overall numbers of adults aged up to 64 with a moderate or severe physical disability by 2030. However the over 65s with disabilities which are considered in other parts of this strategy also will grow in line with the demographic changes predicted for older people. This will increase need but is likely to be complex need because of the growing numbers of people with multiple conditions. There are opportunities to provide a different health and social care response to illnesses that can result in disability, such as stroke and COPD.

The commissioning intentions driving this area:

- Improve the outcomes of the rehabilitation/reablement of those affected by specific conditions to ensure individuals live well for longer.
- Expand awareness of and access to assistive technology to ensure those with disabilities can maximise their personal independence.
- Work with Housing through the vulnerable people housing strategy to ensure housing supply and use enables those with physical disabilities to live as independently as possible.

Commissioned Services

Specific services have been commissioned to meet the needs of people with both hearing and sight difficulties. Also a service for carrying out assessments for deaf people over 50 is provided by Deafness Support Network.

What we will do in 2014/15

- Pilot/experiment with innovative outreach to better understand how we can enable people to self-help using assistive technologies and equipment. This pilot evaluation will inform a commissioning review in 2015/16 to commission a model for the future
- Potential new stroke rehabilitation approach will be considered with health partners
- Work with housing to ensure that housing and complementary support are coherent

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Carers

Adult social care currently support carers in a number of ways including carers assessments, respite for carers to have a break from caring and early help and prevention support in the community. Some carers say that they are not always receiving the focus and support they need (TLAP). The role of carers is a critical one that adult social care recognises should be well supported. It is difficult to estimate the true number of carers in Cheshire East as many are not in contact with social care services. It is also difficult to estimate how many carers access informal support. One of the key messages from the carers survey is that many carers (around 60%) do feel reasonably satisfied with their support; but this leaves 40% who do not feel satisfied. There are some elements of the current support that have been identified as needing to change. There will be further developments in future years as commissioning intelligence and review increases our understanding of what is needed. In 2012/2013 we assessed the needs of 2,912 carers. Of those who were assessed 2,252 cared for someone aged 65 and over. Carers tell us that they need a range of support from advice and information; practical help; support to enable them to continue with employment and learning; and breaks that allow them to sustain their caring role. In 2012/13 the Council spent £533,032.65 on carer's services in the voluntary and community sector which consisted of 17 direct access schemes focused exclusively on supporting carers. The Council will also seek to increase the use of carer direct payments. The impact of these measures will be reported in improved Carer reported quality of life.

The commissioning intentions driving this area are:

Improving Carer reported quality of life - in 2012/2013 we assessed the needs of 2,912 carer. Of those who were assessed 2,252 cared for someone aged 65 and over. Carers tell us that they need a range of support from advice and information; practical help; support to enable them to continue with employment and learning; and breaks that allow them to sustain their caring role. In 2012/13 the Council spent £533,032.65 on carer's services in the voluntary and community sector which consisted of 17 direct access schemes focused exclusively on supporting carers. The Council will also seek to increase the use of carer direct payments. The impact of these measures will be reported in improved Carer reported quality of life.

- Increase the range of respite care choices available to ensure that carers can have periodic respite from their caring roles that meets their particular needs and preferences.
- Redesign assessment and care management processes and systems to ensure customers receive a timely, effective, outcome- focused service.
- Increase the range of early advice, information and support to people new to the caring role.
- Enable carers to develop skills and expertise to assist them in their caring role.

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Commissioned Services

Grants are in place to provide breaks for carers as well as training and advice services covering a diverse range of areas including support with reablement, training opportunities and employment support.

What we will do in 2014/15

- Increase the range of respite choices available
- Review carers assessments and support to develop a service model to improve outcomes and deliver the Care Act requirements including information, advice and training to be confident to care and know when to call on specialist help.
- Update and publish a new Strategy for Carers in conjunction with health partners

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Appendix 1

Adult Social Care Strategic Commissioning Delivery Plan 2014/15

Theme **Information and Advice/Self Help**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing	Develop joint community, health, public health and social care advice and information services including the development of a Resource Directory, both on-line and other easily accessible ways	CCGs Public Health	Strategic Commissioning	31 March 2015	Development of a resource directory
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing	Develop easy access routes to advice and information, including but not exclusively the internet		Strategic Commissioning	31 March 2015	Improved access to advice and information
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing	Work with CECAP (Cheshire East Co-ordinated Advice Project) as an associated partner to bring together advice services	CECAP	Strategic Commissioning	Ongoing	Work with CECAP to deliver more coordinated advice services

Theme **Early Intervention and Prevention Services**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing	Closely monitor the impact of the adult social care newly commissioned services ensuring that expected outcomes are being met.		Strategic Commissioning	Ongoing	Monitor early intervention and prevention services to ensure that expected outcomes are being met
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing	Launch a second year opportunity for the third sector and community groups to gain seed-funding to establish sustainable prevention and early help work (through the 'Innovation Fund')		Strategic Commissioning	Completed	Enable more third sector and community groups to gain seed-funding to establish sustainable prevention and early help work (through the 'Innovation Fund')
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing	Pilot an innovative approach to promoting universal access to assistive technology and aids to living (equipment).		Strategic Commissioning	31 March 2015	Implementation of universal assistive technology and aids to living pilot
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing	Commission jointly with the Head of Communities and the Director Public Health to ensure all potential resources are contributing effectively to prevention and early intervention.	Communities Public Health	Strategic Commissioning	Ongoing	Support the development of Community Hubs
Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their wellbeing.	Commission jointly with health to ensure all potential resources for prevention and early help are identified, maximised and increased over time.	CCGs	Strategic Commissioning	31 March 2015	Jointly review CCG funding of Early Intervention and Prevention services

Theme **Domiciliary Care Services**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	Create a new quality assurance service to monitor all domiciliary care.		Strategic Commissioning	1 Oct 2014 – 31 March 2015	New Quality Assurance function established
Enable people to live at home and as independently as possible	Review the use of this market to identify any further developments needed.		Strategic Commissioning	1 Oct 2014 – 31 March 2015	Review of domiciliary care market
Enable people to live at home and as independently as possible	Prepare for the procurement of a new framework for providers of this care to widen the choice of supply and provide for developments of the range of support.		Strategic Commissioning	31 March 2015	New domiciliary care market framework
Enable people to live at home and as independently as possible	Promote personalised care including flexibility, choice and control for customers.		Strategic Commissioning	31 March 2015	New domiciliary care market framework
Enable people to live at home and as independently as possible	Procure a Rapid Response service in conjunction with Health to assist with Winter Pressures.	CCGs	Strategic Commissioning	31 March 2015	Establish a new Rapid Response Service

Theme **Daytime Activities**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to fully contribute to and be supported in strong and supportive communities	Map and review the current opportunities in the community for daytime activities.		Strategic Commissioning	31 March 2015	Map and review of daytime activities
Enable people to fully contribute to and be supported in strong and supportive communities	Publish a Resource Directory of opportunities to increase choice.		Strategic Commissioning	31 March 2015	New resource directory
Enable people to fully contribute to and be supported in strong and supportive communities	Stimulate informal support, working with the Council's Head of Communities and other partners	Communities CCGs Public Health Housing Childrens Services Education	Strategic Commissioning	Ongoing	Support the development of Community Hubs

Theme **Community Based Reablement**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	A pilot dementia reablement approach will be trialled	CCGs	Strategic Commissioning	31 March 2015	Implementation of dementia reablement pilot
Enable people to live at home and as independently as possible	Potential new stroke rehabilitation approach will be considered with health partners	CCGs	Strategic Commissioning	31 March 2015	Joint review of future models for stroke rehabilitation
Enable people to live at home and as independently as possible	Existing support will be targeted and managed to ensure those who can most benefit receive the service they need	CCGs	Strategic Commissioning	Complete	Review of existing community based reablement service
Enable people to live at home and as independently as possible	An interim review of reablement will commence and begin to consider the future models including Intermediate care (health)	CCGs	Strategic Commissioning	31 March 2015	Review of future models for a community based reablement

Theme **Supported Accommodation**

Outcome	Action	Joint Commissioning	Lead	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	With CEC housing colleagues consider the feedback of customers and carers to the Vulnerable People Housing Strategy to inform future planning.	Housing	Housing	Ongoing	Contribute to the implementation of the Vulnerable People Housing Strategy
Enable people to live at home and as independently as possible	Ensure through the Learning Disability Lifecourse commissioning review that innovative ideas for the future are developed to offer a range of choices for living in the community, including Shared Lives adult placements with families.	CCGs Childrens	Strategic Commissioning	Ongoing	Ensure that supported accommodation is considered as part of the Learning Disability Lifecourse commissioning review
Enable people to live at home and as independently as possible	Ensure sustainability of accommodation for vulnerable groups as a key preventative measure.	Housing	Housing	Ongoing	Contribute to the implementation of the Vulnerable People Housing Strategy

Theme **Assistive Technology**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	Pilot an innovative approach to raising awareness and access to assistive technology and equipment in the wider population to enable self-help and self management for prevention and early help.		Strategic Commissioning	31 March 2015	Implement Assistive Technology and equipment pilot
Enable people to live at home and as independently as possible	Pilot the use of assistive technologies for people with learning disabilities to increase independence.	CCGs Housing	Strategic Commissioning	31 March 2015	Implement Assistive Technology and equipment pilot
Enable people to live at home and as independently as possible	Focus on increasing use of assistive technology as part of new and future contractual arrangements.		Strategic Commissioning	31 March 2015	Include a contractual requirement to use assistive technology in all new and future contractual arrangements

Theme **Long Term Residential and Nursing Care**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live well and for longer	Create a new quality assurance service to monitor all regulated care provision within residential and nursing home settings.		Strategic Commissioning	1 Oct 2014 – 31 March 2015	New Quality Assurance function established
Enable people to live well and for longer	Reduce the admissions to residential services.		Individual Commissioning	31 March 2015	Reduced admissions to residential services
Enable people to live well and for longer	Evaluate the use of this market during 2013/14 to identify any developments needed, particularly in nursing home provision.		Strategic Commissioning	31 March 2015	Review of residential and nursing care market
Enable people to live well and for longer	Consider the potential impact on this market of a need to develop 7 day care responses across the health and social care system.		Strategic Commissioning	31 March 2015	Review of residential and nursing care market to include the potential impact of a need to develop 7 day care responses

Theme **Assessment and Care Management**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live well and for longer	Options for the assessment and care management arrangements will be developed that ensure appropriate customer responses.		Individual Commissioning	31 March 2015	Implementation of new assessment and care management arrangements

Theme **Frail Older People**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	Develop service specifications and commissioning with health to enable changes to the system to begin the necessary changes. Changes are required that can lead to the release and re-direction of current investments to increase effective support around and 7 day working in future. (See Actions 13 and 30)	CCGs	Strategic Commissioning	31 March 2015	Development of joint plans to introduce 7 day working

Theme **Older People With Dementia**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	Update and publish a new local Dementia Strategy together with our health partners.	CCGs	Strategic Commissioning	31 March 2015	New joint Dementia Strategy
Enable people to fully contribute to and be supported in strong and supportive communities	Cheshire East to become a member of the Dementia Alliance – with the aim of making Cheshire East dementia friendly.		Strategic Commissioning	Complete	Cheshire East to become a member of the Dementia Alliance
Enable people to live at home and as independently as possible	Pilot a dementia reablement approach to seek ways to mitigate against the impact of dementia. (See Action 17)		Strategic Commissioning	31 March 2015	Pilot Dementia reablement
Enable carers of people to live well and be supported to fulfil their caring role	Commission respite support to enable carers to have regular breaks from their caring role.		Strategic Commissioning	Ongoing	Commission respite support for older people with dementia

Theme **Adults with Learning Disabilities**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	Carry out a commissioning review of support for people with a Learning Disability.	CCGs	Strategic Commissioning	Ongoing	Complete a commissioning review of support for people with a Learning Disability
Enable people to live well and for longer	A joint commissioning plan for challenging behaviour will be developed between social care and health.	CCGs	Strategic Commissioning	Ongoing	Develop a joint commissioning plan for challenging behaviour
Enable people to fully contribute to and be supported in strong and supportive communities	Map the current opportunities in the community activities		Strategic Commissioning	31 March 2015	Map community activities
Enable people to fully contribute to and be supported in strong and supportive communities	Publish a Resource Directory of opportunities to increase choice		Strategic Commissioning	31 March 2015	Development of a resource directory

Theme **Mental Health (Not Dementia)**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to fully contribute to and be supported in strong and supportive communities	Work with health and public health to better meet the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness. (Health and Well-being Strategy)	CCGs Public Health	Strategic Commissioning	Ongoing	Contribute to the delivery of the Health and Well-being Strategy
Enable people to fully contribute to and be supported in strong and supportive communities	Map the current opportunities in the community for activities		Strategic Commissioning	31 March 2015	Map community activities
Enable people to fully contribute to and be supported in strong and supportive communities	Publish a Resource Directory of opportunities to increase choice		Strategic Commissioning	31 March 2015	Development of a resource directory
Enable people to fully contribute to and be supported in strong and supportive communities	Stimulate informal support, working with the Council's Head of Communities and other partners. (See Actions 15 & 41)	Communities CCGs Public Health Housing Childrens Services Education	Strategic Commissioning	Ongoing	Support the development of Community Hubs

Theme **Physical and Sensory Disabilities**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable people to live at home and as independently as possible	Pilot/experiment with innovative outreach to better understand how we can enable people to self-help using assistive technologies and equipment.	CCGs	Strategic Commissioning	31 March 2015	Implement Assistive Technology and equipment pilot
Enable people to live at home and as independently as possible	Potential new stroke rehabilitation approach will be considered with health partners.	CCGs	Strategic Commissioning	31 March 2015	Joint review of future models for stroke rehabilitation
Enable people to live at home and as independently as possible	Work with housing to ensure that housing and complementary support is coherent.	Housing	Housing	Ongoing	Contribute to the implementation of the Vulnerable People Housing Strategy

Theme **Carers**

Outcome	Action	Joint Commissioning	Lead Responsibility	Timescales	How will success be measured?
Enable carers of people to live well and be supported to fulfil their caring role	Increase the range of respite choices available.		Strategic Commissioning	31 March 2015	Commission respite support
Enable carers of people to live well and be supported to fulfil their caring role	Review carers assessments and support to develop a service model to improve outcomes.		Individual Commissioning	31 March 2015	Implementation of new carers assessment process
Enable carers of people to live well and be supported to fulfil their caring role	Update and publish a new Strategy for Carers in conjunction with health partners.	CCGs	Strategic Commissioning	31 March 2015	Publish a new joint strategy for Carers

Appendix 2

Adult Social Care Outcomes Framework (ASCOF) and Council Adult Social Care Measures

Measure Ref:	Measure Description	Latest Outturn*
ASCOF 1a	Social care-related quality of life (score out of 24)	19.1
ASCOF 1b	Proportion of people who use services who have control over their daily life	78.4%
ASCOF 1c(i)	Proportion of people using social care who receive self-directed support***	34.7%
ASCOF 1c(ii)	Proportion of people using social care who receive direct payments***	14.7%
ASCOF 1d	Carer-reported quality of life (score out of 12)	8.6**
ASCOF 1e	Proportion of adults with learning disabilities in paid employment***	8.8%
ASCOF 1f	Proportion of adults in contact with secondary mental health services in paid employment	9.9%
ASCOF 1g	Proportion of adults with learning disabilities who live in their own home or with their family***	85.7%
ASCOF 1h	Proportion of adults in contact with secondary mental health services who live independently, with or without support	61.9%
ASCOF 1i(i)	Proportion of people who use services who reported that they had as much social contact as they would like	45.4%
ASCOF 1i(ii)	Proportion of carers who reported that they had as much social contact as they would like	New measure from 2014/15
ASCOF 2a(i)	Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population	17.6
ASCOF 2a(ii)	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	613.3

Appendix 2

Measure Ref:	Measure Description	Latest Outturn*
ASCOF 2b(i)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	86.6%
ASCOF 2b(ii)	Proportion of older people aged 65 and over offered reablement/rehabilitation services following discharge from hospital	2.7%
ASCOF2 c(i)	Delayed transfers of care from hospital per 100,000 population	10.6
ASCOF 2c(ii)	Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	0.7
ASCOF 2D	The outcome of short term service: sequel to service	New measure from 2014/15
ASCOF 3a	Overall satisfaction of people who use services with their care and support	66.4%
ASCOF 3b	Overall satisfaction of carers with social services	49.0%**
ASCOF 3c	Proportion of carers who report that they have been included or consulted in discussion about the person they care for	75.9%**
ASCOF 3d(i)	Proportion of people who use services who find it easy to find information about services	75.7%
ASCOF 3d(ii)	Proportion of carers who find it easy to find information about services	New measure from 2014/15
ASCOF 4a	Proportion of people who use services who feel safe	69.2%
ASCOF 4b	Proportion of people who use services who say that those services have made them feel safe and secure	85.6%

* Unless otherwise indicated, this is the 2013/14 outturn. 2013/14 outcomes are still classed as 'provisional' by the Health and Social Care Information Centre

** These measures are based on data from the Carers Survey which is undertaken every two years. There was no survey held in 2013/14. Therefore, the outturn detailed is the latest figure from 2012/13

Appendix 2

*** The Department of Health has revised the definition of these measures from 2014/15. Therefore, performance in 2014/15 may not be comparable to previous years.

Appendix 2

Other Council Adult Social Care Measures

Measure Ref:	Measure Description	Latest Outturn
NW1	Number of clients aged 65+ receiving a reablement or intermediate care intervention (per 10,000 pop)	372.8
NW2*	Number of service users and carers receiving self-directed support as a proportion of people who would benefit from self-directed support	68.6%
NW3	Number of carers receiving a carers specific service (per 10,000 population)	3.3
NW5	Proportion of service users in receipt of a community based service	78.7%
NW6*	Proportion of service users with a completed review in the year	60.2%
M1	Timeliness of social care assessment	90.4%
M5	Percentage of Personal Budgets taken as Direct Payments	42.1%
M6	Percentage of carers declining an assessment	33.9%
NI141	Percentage of vulnerable people achieving independent living	72.9%
NI142	Percentage of vulnerable people who are supported to maintain independent living	98.7%
MLIL003	Average length of time waiting for minor adaptations from assessment to work beginning (weeks)	1.6
MLIL004	Average length of time waiting for major adaptations from assessment to work beginning (weeks)	13.7

* Due to changes in data recording requirements of the Department of Health, these measures are to be reviewed

Detailed Commissioning Intelligence and Background

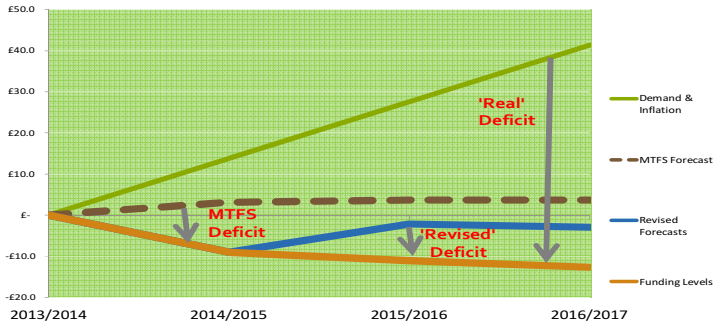
Key Evidence Sources

- Census 2011
- Joint Strategic Needs Analysis
- Red Quadrant Report
- Ageing Well in Cheshire East – A Plan for People Aged 50 and Over 2012 – 2017
- Wanless Review 2006
- Carers Strategy
- Dementia Strategy
- Vulnerable People Draft Housing Strategy
- Better Care Plan
- Joint Dementia Care Event – 14th November 2013
- Think Local Act Personal Survey
- Carers Survey
- Adult Social Care Survey

Challenges and Opportunities

The council is facing unprecedented challenges. Cheshire East Council receives lower levels of funding from central government than other comparable councils and the budget available to the council for social care is diminishing. At the same time we are forecasting growth of 49% in the number of people aged 65 and older in Cheshire East in the next 16 years. The demographic growth will not be matched by public funding meaning that the current pattern of services and investment is unsustainable.

This challenge is illustrated in the graph below.



Graph 1 – illustrates how demand from demographic growth will not be matched by public funding meaning that the current pattern of services and investment is unsustainable and must change

Current and Future Demand

Cheshire East has a population of 372,000 and an area of 116,638 hectares. In addition to Cheshire West and Chester on the west, Cheshire East is bounded by the Manchester conurbation to the north and east, and Stoke-on Trent to the south. It contains the major towns of Crewe, Macclesfield, Congleton and the commuter town of Wilmslow (population above 20,000). There are also a number of other significant centres of population (over 10,000) in Sandbach, Poynton, Nantwich, Middlewich, Knutsford and Alsager. With few large conurbations the borough otherwise comprises a mixture of smaller market towns and more isolated rural villages. This mixture of rural/urban presents particular challenges in delivering cost-effective services close to individuals and their neighbourhoods.

In 2010 there were 83,300 older people aged 65+ in Cheshire East (Office for National Statistics indicative population estimates 2010). Estimates suggest that in 2012 5,234 (6%) older people were living with dementia and 33,154 (40%) with a limiting long term illness. The population of Cheshire East is forecast to grow modestly over the next 30 years rising from 362,700 in 2009 to 384,000 in 2029, however, the age structure of the population is forecast to change significantly with a 8% reduction in young people (0-15), a 12% reduction in working age people (16-59 Female, 16-64 Male) and a 42% increase in people of retirement age (60/65+), with the number of older people (85+) increasing by around 92%. As the prevalence of dementia increases with age, the number of older people with dementia is anticipated to increase by 28% by 2020. The significant changes in demographic in Cheshire East will have direct implications for adult social care.

Age band	2012	2015	2020	2025	2030	% increase 2012 to 2030
65-69	23,100	24,800	22,100	23,600	27,800	20
70-74	17,000	19,200	23,400	21,000	22,500	32
75-79	14,000	15,100	17,500	21,500	19,400	39
80-84	10,400	11,000	12,700	15,000	18,600	79
85-89	6,500	7,100	8,200	9,800	11,800	82
90 and over	3,700	4,300	5,400	7,000	9,100	146
65 and over total	74,700	81,500	89,300	97,900	109,200	46
75 and over total	34,600	37,500	43,800	53,300	58,900	70

Source: Office for National Statistics (ONS) www.poppi.org.uk

Currently Cheshire East Council supports 5635 older people with social care needs. This is defined as people having difficulty with or requiring help with domestic or personal care tasks. There are estimated to be a further 3500 older people with care needs who are supported by family and friends, or who are privately funding their own care.

The financial circumstances of the older population will have an impact on the proportion of the social care market that is “council funded” and the proportion that people purchase themselves without council financial support. 11,130 of older people in Cheshire East were claiming pension credits (Department of Work and Pensions, May 2013). To be eligible for this additional benefit you must be a pensioner with an income of less than £145.40 for single people or £225.05 for couples. These residents are therefore more likely to be reliant on some form of council funding should they need social care services.

90.6% of retired residents in Cheshire East are estimated to be owner occupiers. There will be opportunities for local businesses to develop innovative, personalised, care services for this potential market as more people consider how they can utilise their assets to plan for their future care needs.

Social isolation is a key determinant in people requiring social care support and we estimate that 37% of those aged 65+ and 50% of those aged 75+ are living alone. Whilst living on your own does not necessarily equal social isolation it is an important factor alongside others. The community and voluntary sector has an important role in supporting people within their communities and tackling social isolation. The number of people living alone in large properties also presents opportunities to consider how these assets could be better utilised to support people who feel isolated – i.e. through moving to more communal living environments. Local research tells us that widowhood is often a factor in people entering registered care as people struggle to take on the tasks their spouses used to undertake whilst also coping with their loss. We believe that there is an opportunity for providers to develop services to support people through this difficult period of their life.

Our research also suggests that there is a general lack of knowledge about the services and support available to older people, particularly at the critical stages of their lives. Information and advice needs to be tailored and available at the right time for people throughout their life and be available for all including those funding their own care, and the Council is actively engaged in commissioning such services.

Local Supply and Commissioning

The Council spent £123 million (net) on social care services in 2012/13, of which 88% was spent on the direct provision of care services. This expenditure is similar to other comparable local authorities. £31 million (25%) was spent on residential and nursing care services for older people, £27 million (19%) on learning disability services,

£17.5 million (14%) on Care4CE (in house provider services), £14.3 million (12%) on cash payments, £8.2 million (7%) on domiciliary care, £7.5 million (6%) on housing support services and £2.5 million (2%) on transport to and from services. In addition to this Cheshire East spent £3.4 million (3%) on early intervention and prevention services, with community and voluntary organisations in 2012/13. We would like to continue to shift this balance so that a greater proportion of the budget is spent on preventative services and through cash payments, and a smaller proportion is spent on registered care. We are moving into a time where increasing numbers of people are taking cash payments, and joining the substantial amount of “self funders” in Cheshire East to purchase services directly from the market. As a result we need to redefine our relationship encouraging a competitive market that offers greater open choice and control for consumers.

The Council undertook 3838 new assessments for older people during the year 2012/13. The average age on which a service user enters the social care system is 73. The number of older people Cheshire East is supporting has remained consistent over the last three years; however the needs of the people we are supporting appears to have changed with the proportion of people requiring care packages of more than 15 hours per week increasing.

Telecare, equipment and adaptations

- Telecare, equipment and adaptations are critical in supporting people to remain independent for as long as possible and reducing the need for on going care and support.
- 1624 older people received adaptations in 2012/13, of which 431 were self funded, whilst a further 1260 received equipment.
- 1250 customers currently receive telecare in Cheshire East and it is projected that there will be a steady increase to 2,250 customers by March 2016.

Reablement

- Cheshire East has also increased the use of reablement services to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or social abilities of daily living which has led to increased support needs.
- Reablement is our first response offer to individuals who access adult social care and is delivered for up to 6 weeks within the persons own home to restore people's ability to perform usual activities and improve their perceived quality of life.
- Over 1,123 older people completed a period of reablement in 2012/13, of which 40% achieved a positive outcome of either needing no support, or having reduced care needs on completion.
- We believe the success of telecare and reablement has contributed to the reduced demand for lower level home care services.

Domiciliary Care

- Cheshire East Council is committed to helping people to stay in their own homes and remain as active and independent as possible.
- Domiciliary Care is one of the range of care and support services provided in peoples own home to enable them to remain independent. These services can range from a short call to assist with medication up to 24 hour live-in care.
- In 2011/12 995,000 hours of domiciliary care were delivered to 764 service users at a cost of £16.5 million. 97% of these hours were provided by the independent sector.
- In response to customer demand the Council are committed to developing this type of care provision as an alternative to residential based care services.
- As at December 2013 2,464 older people are being supported by 71 domiciliary care providers.
- Of these the council directly commission the care for 1,414 older people
- A further 1,050 people currently receive cash payments to organise their own support, the majority of which are spending their personal budgets on traditional social care services, particularly domiciliary care.

- Having already removed the domiciliary care block contract arrangements and increased the uptake of domiciliary care through the current financial year the Council wants to make it easier for existing and new providers to enter the market and work with us via framework agreements.
- We also expect the amount Cheshire East spends via cash payments to increase together with the demand for a more personalised service offer as the market expands and expectations of future generations change and they move away from traditional care services.

Residential and Nursing Care

- There are 102 care homes with 4032 registered care beds available for older people in Cheshire East.
- This is more than double the rate per head of the population (21 beds per 1,000 people aged 65+) compared to the national average (45.2 beds per 1,000).
- The Council is commissioning 40% the available beds in the market in Cheshire East, and 60% are being commissioned by self funders or other authorities.
- This poses a risk to the authority with self-funders risk falling back on council provision if they run out of money, or if they make poorly informed decisions.
- Historically Cheshire East has had a comparably higher spend on residential and nursing care than the average for similar authorities but our expenditure on registered care is beginning to fall.
- Currently at December 2013 Cheshire East support 1319 older people in residential or nursing care.
- Spend on permanent admissions into registered care for older people has reduced by 3% from £31,910,195 in 2011/12 to £30,963,381 in 2012/13 and there has been a corresponding increase on spend on community services.
- The average age on admission into a registered care setting is 83.

The table below shows the distribution of all registered residential care placements for older people by the locality of the registered care home.

Lap Area	Total number of homes	Total number of beds	Total number of nursing beds	Total number of residential beds
Congleton	27	888	495	393
Crewe	16	591	440	151
Knutsford	7	491	451	40
Macclesfield	24	812	475	337

Nantwich	11	445	297	148
Poynton	10	439	244	195
Wilmslow	7	366	308	58

Table 2 - Distribution of all registered residential care placements for older people by the locality of the registered care home.

Demand

Older People Demographic Pressure

England's population is rapidly ageing. The number of old people nationally will grow from 10 million to nearly 17 million by 2035, and 60% of all new household growth by 2033 will be those aged over 65, and 21% will be those aged over 85. Trends in household composition are compounding these pressures: across all ages groups there is a penchant for smaller households and therefore a greater risk of under-occupancy and inefficient stock usage. Indeed, households are now forming at twice the rate that houses are being built. Older people are chief contributors to this issue, with 60% possessing multiple bedrooms despite having no dependent children. Therefore, increased provision of specialist accommodation is recognised as a means to trigger positive market forces: older people have more accommodation designed for their needs, whilst general housing is freed up for young people and families.

Cheshire East is due to experience a disproportionately acute accommodation demand for older people. The extant proportion of older people in Cheshire East is already above the national average and is set to rise at a heightened rate compared with the rest of England. The projected increase in the population over 65 by 2030 is 43% for England and 46% for Cheshire East. Although many people aged 75 and over live relatively independently, this is the age group with the highest demand for accommodation, care, and health services; therefore this projected increase in the size of the population will have significant implications for the Council's housing stock and care budgets. An increase of 70% in the population aged 75 and over is forecast between 2012 and 2030.

Moreover, health standards and life expectancy in Cheshire East consistently exceed national averages, indicating that people in the Borough will live longer and require prolonged access to care and appropriate accommodation. The average life expectancy for males in Cheshire East is 80.1 compared to a national average of 78.9; similarly, females tend to live until 83.3 rather than 82.9 nationally.[1]

Public Health England, Health Profile 2013: Cheshire East, 24 September 2013, http://www.apho.org.uk/resource/item.aspx?RID=126943

Age band	2012	2015	2020	2025	2030	% increase 2012 to 2030
65-69	23,100	24,800	22,100	23,600	27,800	20
70-74	17,000	19,200	23,400	21,000	22,500	32
75-79	14,000	15,100	17,500	21,500	19,400	39
80-84	10,400	11,000	12,700	15,000	18,600	79
85-89	6,500	7,100	8,200	9,800	11,800	82
90 and over	3,700	4,300	5,400	7,000	9,100	146
65 and over total	74,700	81,500	89,300	97,900	109,200	46
75 and over total	34,600	37,500	43,800	53,300	58,900	70

Source: Office for National Statistics (ONS) www.poppi.org.uk

Nationally, the majority of older people live in owner occupied housing, and 20% of general needs social housing is occupied by an older person. In Cheshire East, there is more owner-occupation amongst the older populace. Based on the 2001 census, 78% of the population of Cheshire East and 75% of pensioners are owner occupiers. This is higher than the national average of 68%. A much lower percentage are in social rented accommodation with 11.5% of pensioners and 12.5% of the population as a whole in the social rented sector compared with 17% and 19% across England as a whole.

Learning Disability

Cheshire East Adult Social Care provided 768 people with a learning disability with care and support in the community throughout 2012-13, enabling them to live with friends, family or on their own (this figure includes those in supported accommodation as well as those in their own homes

900 of the 1159 adults (78%) with a learning disability known to the Council have learning disability assigned as their primary care type – meaning it is adjudged by social care to be their chief care requirement, potentially amongst a range of other needs. Accommodation status data (see table below) is available for those 900 adults with a learning disability assigned as their primary care type. This data records the accommodation status of these customers.

Client Living Status (LD as primary care type)	Total
Unknown	39
Acute/Health/Hospital	1
Adult Placement Scheme	9
Family/Friends Settled	281
Family/Friends Short-Term	3
Lives Alone	4
Living with Relative (Not Parent)	1
Other Temporary Accommodation	1

Owner Occupied/Shared	12
Registered Care Home	71
Registered Nursing Home	20
Sheltered/Extra Care Housing	4
Supported Accommodation	368
Tenant (Private Landlord)	41
Tenant (Local Authority)	45
Total	**900**

Source: Cheshire East PARIS Data (Oct 2013)

From

- It is important to note the people not captured by this data. It is anticipated that many more people with learning disabilities live in the community unknown to social care, supported by their families. This is problematic if care needs rise or carers age or die.

Supported Accommodation

As of July 2013, Cheshire East has the capacity to house 409 people with a varied range of learning disabilities in supported accommodation across the Borough. Care and support in these arrangements is provided through a range of providers.

LAP Area	Bungalow 33%		Flats 19%		House 48%		Total 100%	
	Capacity	Filled	Capacity	Filled	Capacity	Filled	**Capacity**	**Filled**
Congleton	45	43	3	3	35	32	**83**	**78**
Crewe	20	18	12	12	41	33	**73**	**63**
Knutsford	13	12	2	2	27	24	**42**	**38**
Macclesfield	27	25	56	55	56	51	**139**	**131**
Nantwich	11	10	3	3	21	19	**35**	**32**
Poynton	0	0	0	0	0	0	**0**	**0**
Wilmslow	18	16	1	1	11	9	**30**	**26**
Total	**134**	**124 (93%)**	**77**	**76 (99%)**	**191**	**168 (88%)**	**402**	**368 (92%)**

Source: Cheshire East Learning Disability Supported Accommodation Register (July 2013)

- A large proportion of accommodation in Cheshire East for people with learning disabilities is in shared houses (48%). Whilst an option that works for some people to work effectively resident composition must be carefully matched; this does not always sustain.

- There is a need to consider whether the mix of options needs to include more single occupancy accommodation in a supported setting. This increases privacy and independence and avoids potential mismatches of individuals.

- Currently accommodation is unevenly distributed, with Poynton, Wilmslow, Nantwich, and Knutsford possessing significantly less supported accommodation for people with learning disabilities than the major population centres of Macclesfield, Crewe, and Congleton.

89% of local authorities agree there has been an increase in the number of people with a learning disability requiring housing support in the last three years. While 82% of the local authorities surveyed agree there is a shortage of housing for adults with learning disabilities, more pressingly, 94% of local authorities surveyed agree that more needs to be done to meet the housing needs of adults with learning disabilities. Based on current accommodation trends and population growth, it is estimated that there will need to be 19,860 new registered care places and at least 14,222 extra supported accommodation places in England and Wales over the next 15 years.[2]

It is anticipated that the sustained growth of the population and better medical care will result in an annual increase of those with a learning disability that equates to between 3.2% and 7.94% of those currently requiring social care services.[3] This was evidenced between 2010 and 2011, with an increase of 3% in those with a learning disability known to social care services nationally. As with the general population, people with learning disabilities are also living longer: by 2030 the number of people with a learning disability aged between 65-74 years is projected to increase by 33.5%, those aged between 75-84 years are projected to increase by 53%, whilst those aged over 85 will increase by 103%. The need for support and care for people with learning disabilities will reciprocally increase, with Mencap predicting that there will be the need for an additional 1,324 care home places and 941 supported living placements per year nationally. This equates to around a 3% increase annually of people with learning disabilities who will require housing with care or support.[4]

Cheshire East is experiencing these national pressures distilled at local level to varying degrees. It is important to note that, whilst data has been compiled from a number of sources to establish the following profile of local demand, there is considerable difficulty in determining a single and universally-agreed figure for people with a learning disability. Cheshire East can draw conclusions from the data held by social care, but work is required to establish a figure for the wider group of people with learning disabilities, those who have no current support from social care.

By comparison nationally Cheshire East has a greater prevalence of people with learning disabilities know to the Council. However, there is a lower prevalence rate for both children with learning difficulties known to schools and adults with learning disabilities known to GPs.[5] 1159 adults with a learning disability are known to social care. The

[2] Mencap, September 2011

[3] Emerson and Hatton, 'Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England' (2008)

[4] Mencap, 'Housing for People with Learning Disabilities'.

[5] Public Health England, 'Learning Disabilities Profile 2013 – Cheshire East'

total estimated population of adults with a learning disability in Cheshire East was 1408 in 2012, giving an indication of a potential gap of 249 between social care customers and the total number of adults with a learning disability in the Borough.

As with older people, it is anticipated that the number of people with a learning disability who will require specialist accommodation will increase significantly: by around 10% between 2013 and 2030. Cheshire East currently has sufficient supported accommodation for people with a learning disability until 2030, if current uptake ratios are projected forward using population growth estimates. However, this does not reflect any unmet demand from people who would ideally like to move to supported accommodation from other settings, such as their family.

	2013	2015	2020	2025	2030
Projected 18 + Population with LD	1408	1431	1468	1508	1554
Projected 18 + Population with LD known to CEC	900	914	937	962	991
Projected 18 + Population with LD known to CEC in need of Supported Accommodation	368	374	383	393	405

Source: Office of National Statistics (ONS): POPPI; PANSI

Future planning needs to take account of a range of factors such as children with learning disabilities in preparation for adulthood (transition) i.e. 14-18 year olds. A portion of future housing demand will come from those with learning disabilities whose carers have either died or are no longer able to effectively care. 83% of parents nationally whose son or daughter has a learning disability report not having planned for a time when they are no longer able to provide care.[6] 56% of parents over 70 whose son or daughter has a learning disability have not established a plan for the future.

[6] Mencap, 'Housing for People with Learning Disabilities'

Mental Health Issues

Chapter Summary

Background

Everybody has an oscillating state of mental health that changes according to experiences and events. Cheshire East Council looks to help and support those whose mental health nadirs impact on their ability to live healthy and safe lives. As such, mental health occurs across a spectrum of severity and condition; it captures depression, anxiety, schizophrenia, psychosis, dementia, and many other conditions pertaining to mental state. Notably, there is a distinction between dementia and other mental health issues: the Council systematically looks to enable recovery and rehabilitation in the bulk of mental health ailments; however, dementia is by nature degenerative, shifting the emphasis slightly towards enabling maximal independence and quality of life at a given time.

Mental health issues are common across the population and, in many cases, can be managed through robust support networks and stable lifestyles, allowing the majority of those with a low frequency mental health disorder to live independently in the community in general needs housing. As such, Cheshire East primarily aims to provide preventative, rehabilitative or short-term care and support to people with mental health issues, in the hope of supporting them to overcome their condition and return to a fulfilling life within the community. Such a support network is largely delivered by the CWP (Cheshire and Warrington Partnership): a public health partnership involving Cheshire East that commissions mental health services and aspires to engender continual improvement within these.

For people with heightened or enduring mental health issues who are unable to be housed safely within the community (for example, acute depression, bipolar disorder, schizophrenia, and including dementia) the right mixture of specialist and supported accommodation is critical. These people have more specific and acute care needs, and can often fall victim of social isolation unless properly accommodated. This can entail sheltered accommodation or institutional schemes; however, Cheshire East, as with other client groups, aims to reduce reliance on residential care as a long-term solution, and aspires to instead maximise use of supported accommodation to enable individuals live independently.

Cheshire East strives fundamentally for a recovery and rehabilitation model of mental health care delivered through a phased programme; ultimately this chapter recommends that accommodation and support needs to be mapped to this process to ensure there is adequate housing to deliver the desired outcomes at each stage of a client's progress.

Key Findings

- Numbers of mental health clients tend to remain fairly constant; however, there is a large increase projected in dementia clients in coming years.
- Given the diverse spectrum of mental health issues, the majority of clients are able to live independently within the community with an appropriate package of care and support. Stable accommodation is beneficial for mental health clients, so there is added onus on adaptive support services being able to reach them in situ. This is more easily achieved in a sheltered or extra care scheme, but can be realised in the community with appropriate floating support.
- However, for those with more acute mental health needs (such as dementia clients) nursing and residential care remain the most commonly used provision, although consultation suggests that sheltered housing or extra care schemes can deliver superior outcomes for mental health client with complex needs.

- There is a greater degree of institutional provision for dementia clients within the Borough, whilst greater numbers of high-need, non-dementia clients are placed outside of the Borough.
- Current supported accommodation stock predominantly encompasses shared and sheltered units, with the former being the most prevalent – despite sheltered housing being deemed the better paradigm. To bolster the supply of supported accommodation, a combination of available units and flexible support services are required in equal importance, enabling individuals to receive the appropriate level of care without moving.

Strategic Priorities

- Where possible, use accommodation and support packages to reinforce the StAR treatment process in situating recovery at the heart of mental health treatment, creating an extended and supported pathway for clients from primary care, through recovery and review, and into aftercare.
- This will involve mapping accommodation and support service provision to different stages of clients' treatment journeys to ensure that accommodation can flex to each stage of the process and changing needs. This will inform a detailed needs analysis and the creation of an ideal accommodation specification for commissioning that will involve the exploration of assessment flats for heightened episodes.
- Establish a mental health strategic working group to forward these actions and ensure full integration of accommodation strategy into a bolstered strategic approach to mental health in the Borough, including raising awareness of mental health issues and early intervention.
- Continue to raise awareness about the importance of mental health, promoting preventative thought and early intervention and/or presentation.

Key Evidence Sources:

- Moving Forward – Cheshire East Housing Strategy 2011 - 2016
- Cheshire East Strategic Housing Market Assessment (SHMA)
- Cheshire East SHMA Extra Care Housing Report
- Red Quadrant Report
- Census 2011
- Joint Strategic Needs Assessment
- CWP Data
- No Health Without Mental Health
- Social Services Monitoring Data (PARIS)
- Cheshire East Monitoring Data for Specialist Mental Health Supported Accommodation
- Cheshire East Monitoring Data for Institutional Care Facilities
- Supporting People Needs Analysis

- Social Services Expenditure Return
- NOMIS (Office of Labour Market Statistics)
- PANSI and POPPI projections

Detailed Findings

National and Local Policy Context

The Government's strategy 'No Health without Mental Health' set the tone in emphasising the importance of prevention and recovery in mental health treatment, as opposed to previous trends of institutional management of mental health issues. The strategy heavily connects housing to these outcomes, stressing the importance of equality of access and highlighting the role of appropriate housing as a preventative and convalescent measure.

In terms of trends in treatment, medical advances are allowing for better means to chemically address mental imbalances and reduce side-effects. However, an increasing emphasis is placed on non-medical factors in mental health: diet, exercise, sociability, employment, family stability, etc. This creates a more nuanced picture of cause and treatment, connecting an individual's mental health to things such as fluctuations in the economy, society, and personal circumstance. This ultimately supports the recent impulse towards holistic and preventative support, where mental health is treated most effectively by early intervention, raising awareness, and supporting people to negotiate contingent hardship or alienation. These are distinctly non-medical factors that are captured in large part by the Council's wider objectives to improve prosperity and well-being in the Borough.

Many mental health issues are caused or exacerbated by contingent and transient circumstance; support during difficult periods is therefore vital and ultimately beneficial, as proportionate intervention can stymie the effects of difficult conditions and curtail the chance of a condition escalating. As such, support, care, and housing services must be flexible and scalable to meet the uniquely fluctuating nature of mental health: it is important that services do not fall into a 'one-size fits all' operating model and can adapt to (often rapidly) changing needs.

Cheshire East Council currently does not have a holistic commissioning strategy for people with mental health issues, though there is a Joint Commissioning Strategy for people with dementia. The Council aims to explore the construction of a wider strategic document as an outcome of this strategy, to unify the objectives of mental health services and better inform a detailed specification of accommodation requirements. This strategy will build upon the work of the Council's individual commissioning wing and calcify the issues raised in this strategy.

However, there is a strong history of joined-up partnership working – reified in the CWP – and joint commissioning for elements such as dementia. Throughout its partnerships and commissioning, Cheshire East recognises that people with mental health issues should be given every opportunity to live a fulfilling life within the community, with ready access to accommodation and services that facilitate this across a spectrum of needs. As such, the Council champions a concerted focus on recovery and rehabilitation – or, in the case of dementia, a phased management of the condition that seeks to mitigate degenerative effects and maximise quality of life. Cheshire East's individual commissioning follows a Stepped Approach to Recovery (StAR) Model, and has a throughput process taking those with mental health needs through a single-point of access for services, to a recovery team who look to stabilise a client's condition through intensive services, followed by a review procedure of transitional and lower-intensity services, to aftercare and move-on. It is important that accommodation provision is aligned to this process, with the appropriate supported accommodation available to realise the individuals care needs.

Consultation Response

- Consultation feedback attested that the majority of people with mental health needs were able to live in the community and benefit from being allowed to flourish in an independent setting.
- Stability is an important issue for mental health patients, and it is important that, where possible, individuals can remain in one setting with support and care that wraps around them. This requires a flexible stock of accommodation that can meet a range of client and service needs.
- It was recognised that this group are high users of institutional care, and this needs to be rebalanced where possible. Supported accommodation will always be needed and can help combat the isolation and loneliness that many people with mental health issues experience.
- The provision of assessment flats was thought to be a progressive concept, where clients experiencing a crisis or emergency could be housed temporarily. This negates compatibility and social issues that can emerge during times of crisis.
- The provision of accommodation is the key issue. Cheshire East can provide the appropriate support, provided that there is a property in which to house the mental health client.
- The specific requirements of high-needs and dementia clients were highlighted. It was felt that adaptations and assistive technologies can achieve great results for the complex end of the needs spectrum, and extra-care and sheltered housing schemes can be put to greater use as an effective alternative to institutional care.

Current Pathways to Care and Support

Supporting People

Supporting People provides a range of accommodation and floating services for people with mental health issues who have lower care requirements and are not eligible for social care. Floating support is designed primarily to assist individuals to integrate effectively into the community and manage long-term independent tenancies. Accommodation support takes the form of short-term hostel services that serve as a mid-point between intensive care and independent living, aiding the transition between the two. These services are therefore vital in stopping low-level mental health conditions escalating, supporting individuals to negotiate heightened episodes, and providing transitional support for those recovering from a more severe mental condition.

Data from Supporting People indicates that mental health services are currently under considerable demand and do not have the capacity to meet this. The anticipated demand figures are predicted to be relatively consistent, reflecting both the throughput demanded of providers and a negligible anticipated growth in the number of people with non-dementia mental health issues.

Mental Health Services	Need 2020	Supply 2013	Gap
Accommodation Support	143	87	-56
Floating Support	150	100	-50

Source: Supporting People Needs Analysis

Social Care

Cheshire East social care looks to enable people with a substantial or severe mental health issue to remain in their homes through a number of care types – be these floating home care services or prescribed adaptations. Where this is not possible, the Council endeavours to place people in specialist housing that enables them to remain independent or is short-term or intermediate. The following table surveys the number of care interventions (individual units of care) received by people with a range of mental health issues. These figures capture all kinds of intervention, both short and long-term, and chart the number of times a service is delivered – potentially multiple times to the same client.

They demonstrate:

- Amongst the clients of social services, care at home or in the community is still the most viable and desired option for those members of this client group – including those with dementia. This demonstrates the importance of flexible support services first and foremost in delivering supported accommodation that enables enduring independence.

- For those individuals who cannot be safely cared for within the community due to high or complex needs, residential and nursing care are the most common recourse, and occur at a significant frequency (31%) compared with other client groups. The majority of those are dementia sufferers, but 18% of non-dementia clients are still utilising institutional care. This reflects the historic proclivity to treat mental health with intensive institutional care, focusing on managing a condition rather than recovery. It is therefore important that nursing care is used appropriately as a stage in a wider rehabilitation process, and Cheshire East will continue to review its assessment processes and move-on protocols to reduce the relatively high usage of institutional care when compared to other client groups to ensure that there is not an overreliance on institutional care.

Care Type	Dementia	Non-Dementia	Total
Day care	43	21	**64**
Direct payments	33	165	**198**
Equipment and adaptations	17	6	**23**
Extra care housing	6	15	**21**
Family based care	8	33	**41**
Home care	92	297	**389**
Intermediate care	14	13	**27**
Mental health day care	1	3	**4**
Nursing	136	44	**180**
Other	81	42	**123**
PCMH	1	1	**2**

Professional support	0	3	**3**
Residential	106	76	**182**
Respite nursing	3	1	**4**
Respite residential	18	14	**32**
Grand Total	**559**	**734**	**1293**

Source: Social Services Monitoring Data (PARIS)

Reablement

In addition to the work of Supported People, Care4CE operates a mental health reablement service designed to impart the skills required effectively transition back into community living and maintain a general needs tenancy. This service is targeted for when clients are leaving the review stage of their care process, but performs work with clients earlier in their programme depending on their level of need. The service operates well, though Cheshire East needs to review the prospect of bolstering such provision, drawing on best practise in other authorities to operate an aftercare team that facilitates a phased recovery plan for 12 months after a client's care plan expires.

Supply

Accommodation provision for people with mental health issues currently takes a number of formats, ranging from institutional care to supported housing options. The picture is complicated by the fact that some residents of Cheshire East (especially those placed by adult social care) are housed outside of the Borough; this applies mainly to institutional care but there are a small number of external supported accommodation placements funded by Cheshire East.

Institutional Accommodation

The below table details the number of institutional placements that Cheshire East funds both inside and outside the Borough. The majority (66%) of these placements are for people with dementia, which frequently requires a residential or nursing setting given the degenerative nature of the ailment. The remaining 34% are for non-dementia sufferers with high care needs. As aforementioned, it is important that Cheshire East looks to reduce dependency on institutional care to encourage rehabilitative outcomes and lower social care costs, with the non-dementia cohort especially being targeted for community care or supported accommodation as a priority.

The preponderance of institutional care is within the Borough, with just 15% of institutional care for people with mental health issues located outside of Cheshire East, which is low in comparison to other client groups. However, a higher proportion of non-dementia clients receive institutional care outside of the Borough compared with dementia clients, indicating that Cheshire East is better equipped to accommodate dementia sufferers than other high-level mental health issues.

	Provision Type	Dementia	Non-Dementia	Total
Provision in CEC	Nursing	120	33	153
	Residential	94	60	154
	Respite Nursing	3	1	4
	Respite Residential	11	2	13
	Total	228	96	324
Provision Outside CEC	Nursing	13	11	24
	Residential	9	16	25
	Respite Nursing	1	0	1
	Respite Residential	0	7	7
	Total	23	34	57
CEC Provision (Care4CE)	Nursing	0	0	0
	Residential	0	0	0
	Respite Nursing	0	0	0
	Respite Residential	6	2	8
	Total	6	2	8
Grand Totals	**Nursing**	**133**	**44**	**177**
	Residential	**103**	**76**	**179**
	Respite Nursing	**4**	**1**	**5**
	Respite Residential	**17**	**11**	**28**
	Total	**257**	**132**	**389**

Source: Cheshire East Monitoring Data for Institutional Care Facilities

Supported Accommodation

The following table summarises the kinds of supported accommodation provision available within Cheshire East. Supported accommodation for people with mental health issues is a delicate business, given that this client group above all others requires careful monitoring of social developments, and are often the most combustible in a shared environment.

As such, whilst more primary research is required, consulted operational staff are wary of utilising shared housing as an a priori position for clients with higher needs – or those in the early, recovery phases of their StAR programme: without close monitoring from a warden or care workers, people with mental health issues can easily develop social dependencies or are an risk of incendiary relationships. Moreover, clients with mental health issues respond better to a stable tenancy which is wholly their own and is unlikely to change. As such, the preferred approach where possible is self-contained accommodation where each individual has their own front door, combined with routine monitoring and support that can adapt to care needs, rather than the individual having to relocate. This suggests that optimal results for people with mental health issues can be realised in sheltered housing or extra care schemes, thereby combining individual properties with regular and adaptive support. Alternatively, this could be realised in a dispersed manner if appropriate accommodation can be sourced and floating support services put in.

The current provision is well-divided between shared properties (arrangements where a small community of clients receives floating and on-demand support) and sheltered housing (where there is 24 hour support in place). The

latter paradigm is more intensive but, as per the above analysis, is often deemed the most preferable composition for clients with higher needs. A number of extra care schemes also admit individuals with mental health issues (including dementia) with good outcomes. It is therefore important that a range of accommodation and support services are appropriately designated and mapped to evolving care needs. Consultation has also suggested the creation of a number of assessment flats in conjunction with RPs for providing intensive treatment for mental health clients going through heightened episodes, so that such episodes are not exacerbated or allowed to jeopardise recovery.

Whilst the distribution of unit types is relatively even, the spread across localities is not. Congleton LAP area (comprising Congleton, Middlewich, and Sandbach) possesses the majority of supported accommodation for people with mental health. The bulk of specialist stock in Congleton is shared accommodation, whilst Crewe and Macclesfield have a monopoly on sheltered accommodation. This distribution is an issue that needs to be considered with providers as part of the on-going commissioning cycle.

Location	Units
Congleton	30
Middlewich	23
Sandbach	7
Macclesfield	55
Crewe	29
Alsager	4
Total	**148**

Source: Cheshire East Monitoring Data for Specialist Mental Health Supported Accommodation

It is evident that Cheshire East's accommodation provision and approach for people with mental health issues has been inherited from the legacy authorities and has evolved organically over time with minimal strategic direction: there is not currently a mental health strategy within Cheshire East, for instance. The emphasis on recovery and the StAR methodology provides a strong girding in terms of outcomes for people with mental health issues, but there are strategic developments to be bolstered around this.

Crucially, it is important that accommodation provision is mapped to the StAR process, reflecting its stages and facilitating them with appropriate combinations of accommodation and support at each rubric. This will require the designation and distribution of supported accommodation placements to specifically address each stage of the process. This entails a formal distinction between, say, intensive and transitional packages of accommodation and support for people at the recovery and review stages of the StAR process respectively. The creation of such a specification follows sector best practise, following on from the vaunted pathways approach of Camden and Oxford, which create a holistic process for a range of care needs supported by stratified routes through different accommodation types.

Demand

Prevalence of Dementia:

There is a direct correlation between those suffering from dementia and increasing levels of old age. The occurrence of dementia starts to increase over the age of 65. Dementia is most common in people in their eighties (10-20% affected) and nineties (30% affected). Women are about 30% more likely than men to develop dementia.[7] Dementia

[7] Cheshire East Joint Strategic Needs Assessment, Dementia and its Impacts, September 2012

costs the UK economy £17bn a year and this will increase to £50bn in the next 30 years.[8] There is a predicted 78% increase in dementia sufferers in Cheshire East by 2030, which will place considerable strain on current accommodation, care capacity, and funding. The Joint Commissioning Plan for Dementia sets out a range of actions to be taken locally in meeting the needs of people with dementia; chiefly, as explained throughout this chapter, there is a need to utilise a transitional accommodation when treating dementia where possible, using a range of accommodation options to deliver superior quality of life and lower care bills rather than turning to institutional care at an early stage.[9]

Age Band	2012	2015	2020	2025	2030	% increase
People aged 65-69	289	308	274	293	346	20
People aged 70-74	465	528	640	575	617	33
People aged 75-79	820	884	1,023	1,251	1,127	37
People aged 80-84	1,250	1,304	1,516	1,784	2,213	77
People aged 85-89	1,311	1,428	1,633	1,967	2,339	78
People aged 90 and over	1,105	1,281	1,605	2,046	2,693	144
Total population aged 65 and over	**5,240**	**5,732**	**6,690**	**7,915**	**9,335**	**78**

Source: Office for National Statistics (ONS) www.poppi.org.uk

Social Care

Cheshire East social services currently provide for the following number of people with mental health issues. These figures capture only those who have presented to social care and are FACs eligible, meaning that these figures do not capture all the people with a low or moderate mental health needs; these people are better visible through the CWP and Supporting People data.

As above, the number of people with dementia is expected to rise significantly in coming years and will pose a major challenge to the Council. Dementia clients are higher users of institutional care (see previous section on 'Supply'), which poses a cost risk should the expanding demand continue to be met through this kind of provision. As identified in the Joint Commissioning Plan for Dementia, it is therefore increasingly important to adopt an early-intervention and staged approach to care with dementia clients, to ensure that, where appropriate and safe, institutional care is relied on less frequently or only at the latter stages of an individual's care programme, with escalating demand managed through better preventative measures and phased, transitional housing.

Non-dementia clients within this group are anticipated to remain relatively steady given the fluctuating nature of mental health issues and the ability to recover from low frequency ailments. However, mental health issues are tied to wider societal factors, and have experienced an upturn during the recent recession. The vagaries of the economy will therefore largely determine non-dementia mental health issues, making prediction an inexact science – though at the time of writing economic forecasts state low-level recovery, which is a positive augur.

Total Mental Health Clients (Oct 2013)	Dementia	Non-Dementia
1035	431	604

[8] Audit Commission, 'Under Pressure: Tackling the Financial Challenges for Councils of an Ageing Population' (2010)

[9] http://www.cheshireeast.gov.uk/social_care_and_health/health_advice/memory_issues/dementia_strategy.aspx

Source: Social Services Monitoring Data (PARIS)

The below table shows the location in which social care clients with mental health issues reside within Cheshire East. Living patterns are congruent between dementia and non-dementia clients, and are roughly mapped to the greatest population centres – which also contain the majority of institutional care places.

Locality	Total
Congleton	229
Crewe	286
Knutsford	35
Macclesfield	227
Nantwich	98
Northwich and Rural North	4
Unknown	55
Poynton	40
Rural West	2
Wilmslow	48
Winsford and Rural East	11
Grand Total	1035

Source: Social Services Monitoring Data (PARIS)

The accommodation status of this client group is a relatively incomplete dataset given that there is no statutory obligation to record it as part of a client's records. However, it can give us a snapshot of the accommodation requirements and preferences of this client group. The sample of 134 social care clients whose accommodation status is recorded demonstrates the preponderance (74%) live in the community, with the single largest group living alone.

The below table suggests that people with mental health issues prefer to live in the community within their own homes, and that community care and support can effectively enable this. A significant proportion resides in institutional care, and Cheshire East aims to ensure that any institutional placement is part of a structured care plan that aspires to rehabilitate rather than simply manage an ailment.

Accommodation status	Total
Family/friends settled	19
Lives alone	41
Living with relative not parent	9
Unknown	901
Owner occupied/shared	17
Registered care home	15
Registered nursing home	18
Sheltered/extra care housing	2
Supported accommodation	4
Temp la accommodation	1
Tenant (la)	6
Tenant (private landlord)	2
Grand total	**1035**

Source: Social Services Monitoring Data (PARIS)

Physical and Sensory Disabilities

Chapter Summary

Background

Disabled people are twice as likely as non-disabled people to be social housing tenants and 25% of disabled people needing adapted housing are living in unsuitable accommodation. These figures demonstrate that people with a physical disability occupy a unique middle ground on the accommodation spectrum: their care needs are frequently not substantial enough to require long-term placement by social services, yet general or supported housing is often ill-suited to their needs or in short supply: a pattern that emerges in Cheshire East.

As such, this vulnerable group benefit most acutely from ambient support rather than dramatic intervention, with the majority capable of independent living if the right enabling mechanisms are in place. Cheshire East therefore aims to deliver more accessible design specifications for general access housing, a sophisticated offering of adaptations and assistive technologies to enable independent living in as many cases as possible, a robust menu of support services that facilitate a shift to independence or aging in place, whilst limiting the length of stay needed in residential or nursing care to rehabilitative and transitional.

Key Findings

- This client group can be enabled to live independently with access to the right services and support. Chiefly, the majority of this group can benefit from home adaptations, largely provided by the Council through Disabled Facilities Grants and the Care & Repair team. Such adaptations allow individuals to live safely and independently at home, negating the need for costly care and accommodation options later in life.

- Medical and care advances are ensuring that many disabled children are living healthily and for longer. It is anticipated that this will create an upsurge in demand from disabled children, with younger people increasingly requiring home adaptations and specialist accommodation offerings.

- There are many disabled people whose disability is the result of frailty borne of old age. It is therefore a challenge to unpick those individuals or young people with a long-term disability who have a need for specialist accommodation.

- Those individuals who cannot be enabled to live independently through adaptations chiefly receive care packages at home, or go to live in institutional care, extra care, or sheltered housing schemes. There is a relative lack of supported housing for those with physical disabilities; moreover, access to supported accommodation is limited for younger or long-term disabled people.

Strategic Priorities

- Continue to promote DFGs, Care & Repair, and the Handypersons service as widely as possible, targeting more young people and proactive, private adaptations. This will allow adaptations to be increasingly used as a preventative measure, lowering the potential

dependence on care downstream, and will enable more people to 'future proof' their homes to enable independence in situ.

- Conduct reviews of the Care & Repair and Handypersons Services to ensure they take the optimal model to meet the changing needs of clients.

- Continue to promote general accessibility standards through planning processes, to ensure that as many new build homes as possible are fit for disabled habitation.

- Continue to promote, review, and support Telecare services.

- Create a service pathway for clients with physical and sensory disabilities including the above adaptive and preventative services and supported accommodation.

- This will prioritise improving access to supported housing for younger people with physical disabilities. This will help counter the anticipated rise in demand, and will entail exploring the possibility of lowering entry ages into the likes of extra care schemes, which are well-suited to cope with physical disabilities.

Key Evidence Sources

- Moving Forward – Cheshire East Housing Strategy 2011 - 2016
- Cheshire East Strategic Housing Market Assessment (SHMA)
- Cheshire East SHMA Extra Care Housing Report
- Improving the Life chances of Disabled People (2005)
- Putting People First: A shared vision and commitment to the transformation of adult social care (2007)
- Red Quadrant Report
- Census 2011
- Joint Strategic Needs Assessment
- Valuing People
- Social Services Monitoring Data (PARIS)
- Cheshire East Monitoring Data for Institutional Care Facilities
- Supporting People Needs Analysis
- Social Services Expenditure Return
- NOMIS (Office of Labour Market Statistics)
- PANSI and POPPI projections

Detailed Findings

National and Local Policy Context

In 2005 the Government published 'Improving the Life chances of Disabled People'. This created a vision that disabled people should have the same opportunities and choices as non-disabled people to improve their quality of life and be respected and included as equal members of society. This involves giving disabled people access to support services and accommodation that enabled them to live independently and make informed choices about their care.

In 2007 'Putting People First: A shared vision and commitment to the transformation of adult social care' was published. At its heart was a pledge to ensure that all public bodies work together towards a society that enables individuals to have maximum choice and control over their lives, unlocking their ability to contribute and be fulfilled.

These strategies encourage choice and empowerment in accommodation options, and Cheshire East aims to allow disabled people to have access to a wide range of housing provision suitable to their needs and a robust menu of support services that allow care and adaptations *in situ*; these impulses will guide us to become a Borough where disabled people are facilitated to grasp independent living arrangements, remaining safe and comfortable in their homes and as central agents in the community. These goals are ratified in our commissioning intentions.

Consultation Response

- Feedback reflected the need to ensure that, as prevalently as possible, general needs housing is increasingly able to accommodate disabled people in its accessibility and design. This will largely be enforced in new build developments through planning policy and the Local Plan, with an appropriate proportion of Lifetime Homes and higher accessibility standards prescribed in accordance with local needs.

- Regarding existing stock, groups asserted the importance of refreshing and upgrading stock to make it safer, more accessible, and ultimately more liveable in the long term for disabled people. The chief means of realising this are adaptations through home improvement agencies and the Disability Funding Grants. These mechanisms allow individuals to invest in physical alterations as well as assistive technologies. The latter allow community homes to better tolerate care and support without the need for intensive care packages of relocation of clients, and their expanded usage was advocated by attendees.

- Workshop feedback also noted that other kinds of supported housing can offer benefits for those with physical disabilities, despite a lack of specialist accommodation available for this client type currently. Extra care schemes are by nature built with disability in mind and can accommodate those people with higher-level physical disabilities without the need for institutional care. Indeed, the admittance of the physically disabled into extra care schemes was deemed a positive thing by focus groups, as the diverse nature of this group can inject a greater range of ages and needs, helping forge a more varied and aspirational community. Moreover, shared living and sheltered housing can create an amenable environment for a number of disabled people; such properties are more expensive to construct but offer a cheaper alternative to institutional care in the long term.

- Much comment was made on the need to prevent and predict some of the demand by addressing physical and sensory disability from a young age. Attendees suggested that DFGs could be increasingly used to invest to save, installing adaptations and equipment that will enable a child to learn to negotiate their disability independently in their home. Furthermore, it was thought that extra care schemes, which usually impose a minimum age of 55 could be expanded to include younger people: allowing the physically disabled access to better, more independent facilities, whilst improving the age and need mixture in each scheme.

Current Pathways to Care and Support

More so than other client groups, adaptations and accessibility make a huge difference in the lives of people with a physical or sensory disability. This client group can generally be catered for effectively through adaptations or support services, rather than requiring intensive (and expensive) social care, negating the need for complex home care packages and stays in institutional care. Such services are delivered through a variety of means, whose character and performance are discussed in this section. This is reflected in the high number of disabled people who utilise adaptations, assistive technologies, and floating support; moreover, of those who do require social care, the majority can be treated at home rather than requiring residential or nursing care packages.

<u>Disabled Facilities Grants (DFGs)</u>

As such, adaptations and handyperson services are a cornerstone of Cheshire East's strategy for this client group. The Council has an annual budget of around £1 million for Disabled Facilities Grants (DFGs) to ensure that disabled people are able to maintain independent living and receive the care and support that they need in the home of their choice.

Disabled Facilities Grants (DFGs) are the Council's statutory funding provision for major adaptations. These means-tested grants of up to £30,000 fund around 160 adaptations each year, including ramps to enable safe access into and out of the property, stair lifts and vertical lifts to enable people to access their bedroom or bathroom, conversion of bathrooms to enable people to shower safely, and extensions to provide ground floor sleeping accommodation. The average value of a DFG is £5,600 – when compared to the potential annual cost of a residential care placement of £19,500, or a home care package of £4,153, the value for money of DFGs is demonstrably high.

The following table breakdowns the comparative DFG expenditure on different age groups. Expenditure on adaptations for children with physical disabilities is proportionately higher than other age groups. Children and young people represent 11% of DFG beneficiaries, but have received 23% of the funding. Conversely, older people represent 48% of DFG beneficiaries but only 37% of the funding. Whilst adaptations for young people are more expensive per case, they are critical in preventing care issues and funding pressures downstream, acting as a preventative influence that will enable individuals to remain at home with lower care needs. This is especially important given the greater number of children living with disabilities as a result in advances in medical care, meaning that accommodation and care services will struggle to cope with the increases (covered under 'Demand').

Age Group	Spending 2010-2013	Cases	Average spend per case
Children and Young People	£ 591,300	56	£ 10,559
Adults	£ 1,067,300	205	£ 5,206
Older People	£ 972,400	241	£ 4,035

Source: Private Sector Housing Reporting Data

Care and Repair

An integral part of delivering DFGs is the Care & Repair service, which provides support to people living in their own home to ensure that their property is fit for purpose and they can continue living independently in their community for as long as possible. The service provides support to deliver major adaptations to users of social care services (whereby adaptations can form a part of their rehabilitation or care package) as well as to private customers who have identified the need and the funding for adaptations themselves. Care & Repair provides information, advice and support to repair and adapt the built environment, whilst engaging a holistic approach to considering the client groups' needs by signposting and making referrals to other support services. The service is targeted to homeowners, but through partnership working with Registered Providers the service is extended to delivering adaptations in a wider range of properties. Given the central importance of accessibility to people with a physical or sensory disability, this client group accounts for the bulk of Care & Repair's work. Cheshire East recognises the importance of Care & Repair as an enabler of independent living and peace of mind for those with disabilities.

Moreover, the Council's vision is for these services to be used in an increasingly preventative capacity across all client groups: continuing to branch out beyond those with social care requirements to deliver more proactive repairs and adaptations for those whose care needs are lower but are at risk of increasing with time, or as a result of inhabiting an unsafe property. Around 400 minor adaptations are provided each year to private clients, and the Council aims to grow this number to ensure as many properties are accessible for disabled people across the Borough.

Many individuals (largely families containing disabled children) are choosing to manage the DFG process themselves to broker adaptations that best suit their needs. For these fluctuating reasons there is a need to continually review and improve the Care & Repair services to ensure its delivery best meets the changing needs of DFG clients.

Handyperson Service

Handyperson services provide low-level practical support that is highly valued by older people and people with physical disabilities, delivering 'that little bit of help' that that disabled individuals may not be able to perform themselves. Handyperson services support initiatives to reduce unnecessary hospital and care admissions, facilitate the timely transfer of care from hospital to home, prevent more costly future repairs, reduce opportunities for cold callers and rogue traders, and improve physical and mental health and well-being. Such services deliver a range of minor adaptations for this client group, such as grab rails and hand rails on the stairs to facilitate safe movement around the home, 'key safes' to enable the provision of care at home, and alterations to steps to facilitate safe access into and out of the home. Cheshire East's handyperson services are augmented by similar programmes that are run locally by housing providers on their own properties.

Community Equipment Service

Similar facilitative and preventative outcomes are driven by the Community Equipment Service, which provides specific pieces of small equipment that can make all the difference to a disabled person's livelihood – such as an adapted toilet seat. The service vastly improves the accessibility and comfort of homes whilst lowering the risk involved in day-to-day activities, thereby enhancing the associated viability of independent living in situ.

Supporting People

Supporting People provide a range of short-term accommodation and floating support services to people with a physical disability with lower care needs, who can be supported to realise community living or self-sufficiency. Capacity is comparatively low compared with larger groups with greater care needs (such as older people), but the figures indicate that existing supply for support services is overstretched, and that there is a need (albeit a slim need) for both short and long-term supported accommodation places tailored specifically to the needs of people with a physical or sensory disability.

Physical and Sensory Disability Services	Need 2020	Supply 2013	Gap
Accommodation Support	16	0	-16
Floating Support	34	20	-14

Source: Supporting People Needs Analysis

Demand

Current Demand

Demand is difficult to gauge for people with a disability given that it overlaps heavily with other client groups – particularly older people, which captures many of the frail elderly who develop a physical or sensory impairment by virtue of their age. As such, throughout this section, comparisons have been made between the number of people with a physical disability over 65 and the number of people under 65, in order to give an indication of how many people have a long-term disability, and how many have developed physical or sensory conditions in the latter stages of their lives.

The number of people possessive of a physical or sensory disability and an active social care plan is detailed in the table below. The figures demonstrate that, as suspected, the majority of people with a physical or sensory disability are over 65 – and, moreover, fall within the 'frail/temporary illness' category. This implies that the number of people with a long-term physical or sensory disability (and thus a specialist housing need prior to old age) is relatively low: estimated to be around 414.

Client Type	Total	Under 65	65 and Over
Dual Sensory Loss	9	1	8
Frail/Temporary Illness	2256	87	2169
Hearing Impairment	34	1	33
Other Phy/Sen Impairment	908	321	587
Visual Impairment	76	4	72
Grand Total	3283	414	2869

Source: Social Services Monitoring Data (PARIS)

The next table attempts to fathom the accommodation requirements and preferences of this client group. This is difficult, given that there is no obligation for the living status of people with physical or sensory disabilities to be captured by social care workers in case records.

Accommodation Status	Grand Total	Under 65	Under 65 %	65 and Over	65 and Over %
Adult Placement Scheme	**2**	2	0.5	0	0.0
Family/Friends - Settled	**42**	21	5.1	21	0.7
Family/Friends – Short Term	**2**	0	0.0	2	0.1
Lives Alone	**378**	31	7.5	347	12.1
Living With Relative (Not Parent)	**20**	2	0.5	18	0.6
Not Known	**2587**	327	79.0	2260	78.8
Other Temporary Accommodation	**3**	1	0.2	2	0.1
Owner Occupied/Shared	**62**	6	1.4	56	2.0
Registered Care Home	**47**	2	0.5	45	1.6
Registered Nursing Home	**43**	6	1.4	37	1.3
Sheltered/Extra Care Housing	**48**	3	0.7	45	1.6
Supported Accommodation	**11**	4	1.0	7	0.2
Temporary Accommodation	**1**	0	0.0	1	0.0
Tenant (Local Authority)	**29**	5	1.2	24	0.8
Tenant (Private Landlord)	**8**	4	1.0	4	0.1
Grand Total	**3283**	**414**	**100.0**	**2869**	**100.0**

Source: Social Services Monitoring Data (PARIS)

As such, the residence of those who receive care is not an expansive dataset. However, it can still shed some illuminating conclusions:

- Although around 80% of living statuses have not been recorded, of the sample that remains (696) the majority (87%) reside within the community rather than in residential or nursing care. Within this group, the preponderance (54%) live alone, implying that community care services can be effective in enabling someone from this client group to live independently – even without the support of friends or family.

- There are some interesting differences between the under and over 65s. Proportionately, more people over 65 live alone, whereas more people under 65 live with friends or family; this probably reflects the fact that the support network of those over 65 may have dwindled as carers die or move into care themselves.

- Those over 65 are more likely to reside within institutions or care schemes - be that residential, nursing, sheltered, or extra care – whilst those under 65 tend to reside within the community. However, the percentage of people under 65 with a physical or sensory disability who reside in nursing homes is comparable to those over 65, implying nursing care is the likeliest destination for those under 65 with a severe long-term physical disability.

- It is important to note, however, that the vast proportion of people with a physical or sensory disability (regardless of age) are not known to social care, given that the majority of

this client group do not have substantial care needs and can be adequately supported in the community.

- In sum, there are relatively low number of people with a physical or sensory disability that is not a result of advanced years. Of those whose impairment is not captured under provision for older people – those with long term disabilities acquired earlier in life - the majority are best served by support services, adaptations, and community care, and are preponderantly able to function effectively in an independent environment if properly enabled. However, there are a small number of these people with severe needs that can only be catered for in institutional or scheme placement (residential, nursing, sheltered, or extra care). Evidence suggests that nursing care is, in this small number of cases, the most used, and the Council must ensure this is accessible and suitable. The Council needs to examine the number of long-term placements it is supporting for those with severe needs and, where possible, ensure provision is weighted towards sheltered or Extra Care models rather than institutional care, given the superior well-being and reablement outcomes such provision can realise.

Future Demand (Adults):

Projections from the Office of National Statistics (utilising prevalence rates from the Health Survey for England 2001) indicate that a small rise is anticipated in the number of adults with a moderate and serious disability in Cheshire East by 2030. However, this figure is not an exponential increase, and is predicted to ebb and flow on a yearly basis whilst equating to an aggregated increase by 2030.

Moderate disability	**2012**	**2015**	**2020**	**2025**	**2030**
People aged 18-24	1,091	1,058	963	959	1,054
People aged 25-34	1,655	1,798	1,907	1,835	1,739
People aged 35-44	2,761	2,554	2,531	2,873	3,024
People aged 45-54	5,529	5,665	5,286	4,627	4,637
People aged 55-64	7,167	7,122	7,986	8,567	8,016
Total population aged 18-64 predicted to have a moderate physical disability	18,202	18,196	18,674	18,862	18,469

Serious disability	**2012**	**2015**	**2020**	**2025**	**2030**
People aged 18-24	213	206	188	187	206
People aged 25-34	158	171	182	175	166
People aged 35-44	838	775	768	872	918
People aged 45-54	1,539	1,577	1,472	1,288	1,291
People aged 55-64	2,790	2,772	3,109	3,335	3,120
Total population aged 18-64 predicted to have a serious physical disability	5,537	5,502	5,718	5,857	5,700

Source: Office for National Statistics (ONS) www.pansi.org.uk

Future Demand (Children):

To accurately gauge and map the appropriate type and quantity of accommodation required for this client group, it is necessary to anticipate the number of children with physical disabilities who may present an accommodation need as they age.

Year	Cheshire East Disability Living Allowance Claimants By Age				
	Under 5	5-11	11-16	16-17	Total
2007/Q1	190	540	610	190	**1530**
2008/Q1	200	580	620	220	**1620**
2009/Q1	220	610	670	220	**1720**
2010/Q1	220	640	720	240	**1820**
2011/Q1	220	630	740	250	**1840**
2012/Q1	240	670	760	270	**1940**
2013/Q1	230	700	770	250	**1950**

Source: NOMIS (Office of Labour Market Statistics), Benefits: Disability Living Allowance

These figures demonstrate that the numbers of children claiming Disability Living Allowance in the Borough is rising – and rising more steeply than the projections for disabled adults would suggest. The numbers of children transitioning into adulthood is comparable across the two datasets; however, whilst the adult projections predict a smaller year on year rise in the number of disabled people (amounting to a 2% increase between 2012 – 2030), the children's figures show a total increase in the number of disabled children by 22% in the six year period between 2007 and 2013 alone. This rise can perhaps be explained by rising population levels and advancements in medical care ensuring that more disabled children survive at birth and live for longer.

In practical terms this amounts to an additional 10-30 people with a physical disability each year who are transitioning from childhood to adulthood, and this extra demand must be met with suitable housing provision. This is a slight rather than an exponential increase, but implies that, contrary to adult projections, there is a growing housing need from people with physical disabilities coming through future generations that must be addressed.

As with other client groups, work is required to engage more proactively and earlier with members of this client – especially in their childhood to encourage adequate future planning and build a better primary dataset for anticipating housing need. Moreover, there is a need to work across strategic housing, Adults Services, and Children's Services to review the current model of provision in the Borough and ensure that it is optimally tailored to achieve best outcomes. For instance, members of this client group consulted indicated that an Extra Care scheme seemed like a desirable and progressive option, and the Council needs to develop this concept as part of a formal specification for people with a physical disability.

Supply

The following table surveys the number of care interventions (individual units of care) received by adults with a range of physical or sensory disabilities. These figures capture all kinds of intervention, both short and long-term, and chart the number of times a service is delivered – potentially multiple times to the same client.

Care Type	Count of Provision Interventions				
	Grand Total	Under 65	Under 65 %	65 and Over	65 and Over %
Day care	**185**	34	6	151	4
Direct payments	**609**	203	33	406	10
Equipment and adaptations	**65**	6	1	59	1
Extra care housing	**311**	20	3	291	7
Family based care	**86**	24	4	62	1
Home care	**1161**	148	24	1013	24
Home care block contract	**1**	0	0	1	0
Intermediate care	**509**	34	6	475	11
Mental health day care	**2**	2	0	0	0
Network care	**3**	3	0	1	0
Nursing	**432**	24	4	408	10
Other	**873**	97	16	776	18
PCMH	**1**	0	0	1	0
Professional support	**19**	3	0	16	0
Residential	**414**	8	1	406	10
Respite nursing	**66**	3	1	62	1
Respite residential	**112**	8	1	104	2
Grand Total	**4849**	617	100	4232	100

Source: Social Service Monitoring Data (PARIS)

There are a number of conclusions that we can glean from this data:

- Care at home remains the most preponderant accommodation provision for this client group, emphasising their ability to live within the community with the correct care packages. However, home care still outweighs adaptations. If a higher frequency of adaptations were made earlier, this will negate the need for intensive care services to be provided at home. This compounds the aim of the Care & Repair service to encourage greater proactive engagement with adaptations from an earlier age – especially seeing as the majority of adaptations prescribed through social care are only being delivered for those over 65.

- Under 65s are substantially more likely to engage with direct payments and take greater control of their own care, whereas the older category prefer to have the Council broker their care plan.

- More over 65s received long-term residential and nursing care placements, made greater use of adaptations (corroborated in the DFG data), and were more likely to receive care in a sheltered or extra care scheme. This highlights that younger people with a physical or

sensory disability (those that are likely to have a lifelong disability or one brought on by an accident) are better able to live in the community than older people with a disability (for whom their condition is a by-product of their frailty and wider mobility issues). This could also indicate that there are fewer options for younger people with physical disabilities.

- There is a comparable percentage of over 65 clients living in extra care schemes as institutional schemes. This reflects the purpose-built physical amenity of these schemes as a suitable living arrangement for the physically disabled, giving them an intermediate and independent housing option between the community and institutional homes. However, very few individuals aged under 65 with a physical disability are found within extra care schemes, largely reflecting the lower age limit of 55 imposed in most of these schemes. This frequently curtails the options of those individuals under 65 with higher needs, resulting in a higher uptake of nursing home placements or expensive home packages. Extra care has the potential to yield benefits for younger people with physical disabilities, and this should be explored in the development of any future schemes. The presence of younger people in such schemes could also serve to enliven and diversify the communities there.

- This analysis is corroborated in the following section on institutional care provision, which demonstrates primarily that the majority of under 65s with higher care needs are utilising nursing care, with a large proportion having to leave the Borough to access this type of provision. This implies that a wider range of options (of which extra care is one) need to be more readily accessible for younger people with physical disabilities.

- The need to provide a wider range of options for younger people with physical disabilities is particularly acute given the high number of children with disabilities projected downstream. Currently, a much lower percentage of people under 65 are receiving adaptations than those over 65, and accommodation provision for those under 65 is polarised into home or institutional care.

Institutional Care

The below table indicates that the bulk of institutional care caters for those over 65, supporting the assessment that the majority of people with a physical or sensory disability have acquired this impairment with age. The majority of people under 65 with a severe physical or sensory disability utilise nursing care provision; those over 65 equally use residential and nursing provision – but in much greater quantities. The table demonstrates that, for those under 65, 36% of their total provision (and 42% of their nursing care – their most used type) is found out of Borough; this represents a huge disparity with the over 65s, for whom 88% is located within the Borough. This suggests that Cheshire East is better provisioned to deal with older people with frailties and impairments than it is to deal with the long-term severely disabled, for whom appropriate care is found outside of the Borough – at greater cost to social services.

	Provision Type	Under 65	65 and Over	Total
Providers In CEC	Residential	3	363	366
	Nursing	14	342	356
	Respite Residential	2	59	61
	Respite Nursing	3	52	55
	Total	22	816	838
Providers Outside CEC	Residential	5	31	36
	Nursing	10	52	62
	Respite Residential	1	3	4
	Respite Nursing	0	8	8
	Total	16	94	110
CEC Provision (Care4CE)	Residential	0	0	0
	Nursing	0	0	0
	Respite Residential	6	40	46
	Respite Nursing	0	0	0
	Total	6	40	46
Grand Totals	**Residential**	**8**	**394**	**402**
	Nursing	**24**	**394**	**418**
	Respite Residential	**3**	**62**	**65**
	Respite Nursing	**3**	**60**	**63**
	Total	**38**	**910**	**948**

Source: Cheshire East Institutional Care Monitoring Data

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Appendix 4

Adult Social Care and Independent Living — REVENUE

Summary

2014/2015 Revised Budget	Employees	Premises	Transport	Supplies & Services	Payments to Service Providers	Grant Payments	Gross Expenditure	Customer & Client Receipts	Specific Grants	Reimburse-ments & Contributions	Internal Recharges	Total Income	TOTAL NET BUDGET
	0****	1****	2****	3****	4****	5****		83-85***	81***	82***	87***		
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Adults Social Care	9,979	0	244	2,098	434	0	12,755	0	0	-981	0	-981	11,774
Unallocated Pay & Pensions Increase and Savings Target	0	0	0	602	0	0	602	0	0	0	0	0	602
Adults Care Packages	239	0	5	4,193	75,772	0	80,209	-16,088	0	-6,839	0	-22,927	57,282
Care4CE (Internal Care Provision)	17,413	70	488	718	0	0	18,689	-206	0	-1,434	-1,200	-2,840	15,849
Prevention and Support	622	0	6	16,146	3,399	0	20,173	0	-4,125	-8,452	-678	-13,255	6,918
Adults Initiatives	0	0	0	2,230	0	0	2,230	0	0	0	0	0	2,230
Total Budget 2014/2015	28,253	70	743	25,987	79,605	0	134,658	-16,294	-4,125	-17,706	-1,878	-40,003	94,655
Policy Proposals and Cost of Investment Items Included Above													
Adults Social Care	-63	0	0	1,215	-228	0	924	0	0	-264	0	-264	660
Unallocated Pay & Pensions Increase and Savings Target	0	0	0	629	0	0	629	0	0	0	0	0	629
Adults Care Packages	0	0	0	0	1,266	0	1,266	-200	0	0	0	-200	1,066
Care4CE (Internal Care Provision)	-80	0	0	0	0	0	-80	0	0	0	0	0	-80
Prevention and Support	0	0	0	-120	1,457	0	1,337	0	0	-2,135	0	-2,135	-798
Adults Initiatives	0	0	0	0	0	0	0	0	0	0	0	0	0
Impact of Policy Proposals	-143	0	0	1,724	2,495	0	4,076	-200	0	-2,399	0	-2,599	1,477
Adults Social Care	0	0	0	0	0	0	0	0	0	0	0	0	0
Commissioning Reviews	0	0	0	0	0	0	0	0	0	0	0	0	0
Adults Care Packages	0	0	0	0	0	0	0	0	0	0	0	0	0
Care4CE (Internal Care Provision)	0	0	0	0	0	0	0	0	0	0	0	0	0
Prevention and Support	0	0	0	0	0	0	0	0	0	0	0	0	0
Adults Initiatives	0	0	0	2,230	0	0	2,230	0	0	0	0	0	2,230
Cost of Investment Items	0	0	0	2,230	0	0	2,230	0	0	0	0	0	2,230

Appendix 4

Adult Social Care and Independent Living
Adults Social Care **REVENUE**

These services are responsible for the care / financial assessment and care management of vulnerable adults. Support to social care also provide the financial transaction processing support to the service.

2014/2015 Revised Budget													
	Employees	Premises	Transport	Supplies & Services	Payments to Service Providers	Grant Payments	Gross Expenditure	Customer & Client Receipts	Specific Grants	Reimburse-ments & Contributions	Internal Recharges	Total Income	TOTAL NET BUDGET
	0****	1****	2****	3****	4****	5****		83-85***	81***	82***	87***		
Adults Social Care	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Individual Commissioning Manager	389		3	1,666			2,058					0	2,058
SMARTS	6,379		164	234			6,777			-159		-159	6,618
Specialist Teams	1,205		43	23			1,271			-19		-19	1,252
Delayed Discharge				139	172		311					0	311
Intermediate Care	463		12	11	262		748			-803		-803	-55
Support to Social Care	1,482		22	25			1,529					0	1,529
Legal Services	61						61					0	61
Total Budget 2014/2015	**9,979**	**0**	**244**	**2,098**	**434**	**0**	**12,755**	**0**	**0**	**-981**	**0**	**-981**	**11,774**
Policy Proposals and Cost of Investment Items Included Above													
Assessment Review													
Implementation of new Care Assessment System				300			300					0	300
Safeguarding quality assurance				400			400					0	400
Commissioning Reviews													
Impact of Review of Learning Disability Pooled budget				600			600					0	600
Review costs and charges of jointly commissioned services with the two Clinical Commissioning Groups							0			-264		-264	-264
Utilisation of the S256 funding for services delivering health benefits					-228		-228					0	-228
Commissioning Reviews													
Business Systems and Processes to support the front line	-63			-17			-80					0	-80
Share of cross service saving - reduce car mileage to HMRC Rates				-44			-44					0	-44
Share of cross service saving - supplies and services review				-24			-24					0	-24
Impact of Policy Proposals	**-63**	**0**	**0**	**1,215**	**-228**	**0**	**924**	**0**	**0**	**-264**	**0**	**-264**	**660**
Cost of Investment Items	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Appendix 4

Adult Social Care and Independent Living
Unallocated Pay & Pensions Increase and Savings Target — **REVENUE**

A holding page for items due to be allocated out within Adult Social Care and Independent Living.

2014/2015 Revised Budget	Employees	Premises	Transport	Supplies & Services	Payments to Service Providers	Grant Payments	Gross Expenditure	Customer & Client Receipts	Specific Grants	Reimburse-ments & Contributions	Internal Recharges	Total Income	TOTAL NET BUDGET
	0****	1****	2****	3****	4****	5****		83-85***	81***	82***	87***		
Unallocated Pay & Pensions Increase and Savings Target	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Allocation for Savings Targets				-299			-299					0	-299
Allocation for Pay and Pensions				901			901					0	901
Total Budget 2014/2015	0	0	0	602	0	0	602	0	0	0	0	0	602
Policy Proposals and Cost of Investment Items Included Above													
Allocations													
Indicative allocation of Pay and Pensions				928			928					0	928
Service Efficiencies													
Share of cross service saving - pay budget savings				-299			-299					0	-299
Impact of Policy Proposals	0	0	0	629	0	0	629	0	0	0	0	0	629
Cost of Investment Items	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 4

Adult Social Care and Independent Living
Care Packages

REVENUE

The service page for Care Packages.

2014/2015 Revised Budget	Employees	Premises	Transport	Supplies & Services	Payments to Service Providers	Grant Payments	Gross Expenditure	Customer & Client Receipts	Specific Grants	Reimburse-ments & Contributions	Internal Recharges	Total Income	TOTAL NET BUDGET
	0****	1****	2****	3****	4****	5****		83-85***	81***	82***	87***		
Care Packages	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Individual Commissioning Manager					3,577		3,577			-1,000		-1,000	2,577
Specialist Teams				193			193					0	193
Intermediate Care					527		527					0	527
Traditional Care Package					58,812		58,812	-16,088		-75		-16,163	42,649
Direct Payments					12,847		12,847					0	12,847
LD Health Contracts	239		5	4,000	9		4,253			-5,764		-5,764	-1,511
Total Budget 2014/2015	239	0	5	4,193	75,772	0	80,209	-16,088	0	-6,839	0	-22,927	57,282
Policy Proposals and Cost of Investment Items Included Above													
Assessment Review													
Joint funding/continuing healthcare assessments - adults					-150		-150					0	-150
Commissioning Reviews													
Respite care improvements in efficiency					-500		-500					0	-500
Review existing supported living support using the care fund calculator.					-300		-300					0	-300
Shared Lives - investment in service to recruit new carers to provide additional range of long term placements as a viable and cost effective alternative to long term care residential care					166		166					0	166
Social Care Demand													
Commissioning Reviews					1,300		1,300					0	1,300
Increasing Demand including Children in Transition					750		750					0	750
Review of Fairer Charging Policy – fees, charges and subsidies							0	-200				-200	-200
Impact of Policy Proposals	0	0	0	0	1,266	0	1,266	-200	0	0	0	-200	1,066
Cost of Investment Items	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 4

Adult Social Care and Independent Living
Care4CE

REVENUE

The Care4CE service provides community support reablement, day care, community support and deals with social inclusion.

2014/2015 Revised Budget													
	Employees	Premises	Transport	Supplies & Services	Payments to Service Providers	Grant Payments	Gross Expenditure	Customer & Client Receipts	Specific Grants	Reimburse-ments & Contributions	Internal Recharges	Total Income	TOTAL NET BUDGET
	0****	1****	2****	3****	4****	5****		83-85***	81***	82***	87***		
Care4CE	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Social Inclusion	6,909		134	56			7,099			-277		-277	6,822
Community Support Reablement	3,349	1	245	151			3,746			-660		-660	3,086
Day Services (Adults)	3,198	69	18	191			3,476	-141		-8		-149	3,327
Community Support Centres (CSC's)	2,947		8	186			3,141			-19		-19	3,122
Intermediate Care	812		39	35			886			-458		-458	428
Day Services (Older)	670		5	51			726	-65		-12		-77	649
Provider Management	427		16	26			469				-1,200	-1,200	-731
Shared Lives	289		15	9			313					0	313
Respite	256		8	13			277					0	277
Business Review	-1,444						-1,444					0	-1,444
Total Budget 2014/2015	17,413	70	488	718	0	0	18,689	-206	0	-1,434	-1,200	-2,840	15,849
Policy Proposals and Cost of Investment Items Included Above													
Commissioning Reviews							0					0	0
Review commission of mobile nights	-80						-80					0	-80
Impact of Policy Proposals	-80	0	0	0	0	0	-80	0	0	0	0	0	-80
Cost of Investment Items	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 4

Adult Social Care and Independent Living
Prevention and Support **REVENUE**

The service includes supporting people, prevention and early intervention contracts and extra care housing.

2014/2015 Revised Budget	Employees	Premises	Transport	Supplies & Services	Payments to Service Providers	Grant Payments	Gross Expenditure	Customer & Client Receipts	Specific Grants	Reimburse-ments & Contributions	Internal Recharges	Total Income	TOTAL NET BUDGET
	0****	1****	2****	3****	4****	5****		83-85***	81***	82***	87***		
Prevention and Support	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Supporting People				7,329			7,329					0	7,329
Prevention and Early Intervention Contracts	368			1,850			2,218			-209		-209	2,009
Extra Care Housing	79			4,812			4,891		-4,125	-170		-4,295	596
Telecare (s256)	10				506		516					0	516
Community Equipment Store (CES)	165		6	1,660			1,831			-1,424		-1,424	407
Healthwatch				243			243					0	243
Information systems development				121			121					0	121
Home Improvement Agency				103			103					0	103
Handyperson				28			28					0	28
Public Health Integration							0				-678	-678	-678
NHS Section 256					2,893		2,893			-6,649		-6,649	-3,756
Total Budget 2014/2015	622	0	6	16,146	3,399	0	20,173	0	-4,125	-8,452	-678	-13,255	6,918
Policy Proposals and Cost of Investment Items Included Above													
Better Care Fund													
Better Care Fund (Section 256) - Funding transfer from NHS to social care					1,457		1,457					0	1,457
Better Care Fund (Section 256) - Funding transfer from NHS to social care - increase in service income							0			-1,457		-1,457	-1,457
Commissioning Reviews													
Housing & Adults Services - New delivery model for Housing, via integration with Adults Services				-120			-120					0	-120
Public Health Integration to deliver improved outcomes by jointly commissioning services							0			-678		-678	-678
Impact of Policy Proposals	0	0	0	-120	1,457	0	1,337	0	0	-2,135	0	-2,135	-798
Cost of Investment Items	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 4

Adult Social Care and Independent Living
Adults Initiatives **REVENUE**

The Adults Initiatives will be focused on delivering the cost of investment proposals required to support the delivery of the 2014/2015 budget policy proposals.

2014/2015 Revised Budget	Employees	Premises	Transport	Supplies & Services	Payments to Service Providers	Grant Payments	Gross Expenditure	Customer & Client Receipts	Specific Grants	Reimburse-ments & Contributions	Internal Recharges	Total Income	TOTAL NET BUDGET
	0****	1****	2****	3****	4****	5****		83-85***	81***	82***	87***		
Adults Initiatives	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Adult Initiatives - Cost of Investment				2,230			2,230					0	2,230
Total Budget 2014/2015	0	0	0	2,230	0	0	2,230	0	0	0	0	0	2,230
Policy Proposals and Cost of Investment Items Included Above													
Impact of Policy Proposals	0	0	0	0	0	0	0	0	0	0	0	0	0
Commissioning Reviews				1,410			1,410					0	1,410
Social Care Bill				770			770					0	770
Service Efficiencies				50			50					0	50
Cost of Investment Items	0	0	0	2,230	0	0	2,230	0	0	0	0	0	2,230

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Appendix 5

CHESHIRE EAST COUNCIL

Cabinet

Date of Meeting: 4 February 2014
Report of: Director of Adult Social Care and Independent Living, Brenda Smith.
Subject/Title: Adult Social Care – Strategic Direction of Travel – Informal Support to Address Prevention and Early Intervention

Portfolio Holders: Cllr Janet Clowes, Health and Adult Care

1.0 Report Summary

The Direction of Travel for Informal Support to Prevention and Early Intervention

1.1 The vision for the future is for the Council and partners to enable adults to be self-reliant and healthy for as much of their lives as possible. The goal is to make Cheshire East a place where strong empowered communities, including businesses, create that self-reliance.

1.2 In this context the informal support for vulnerable adults and their carers needs to change to maximise the opportunities for self-reliance, independence, and healthy lives. This report summarises the proposed strategic direction of travel for informal support to address prevention and early intervention for people with social care eligible needs.

1.3 The recommendations within this report support the delivery of the Cheshire East Council Three Year Plan:

Outcome 1: Our Local Communities are Strong and Supportive
Outcome 2: Cheshire East has a Growing and Resilient Economy
Outcome 5: Local People Live Well and for Longer

1.4 Quality informal support is needed that meets the objectives of:

encouraging prevention of ill-health or dependency
accessing early help and advice to maintain or regain health and independence
promoting self-reliance and community inclusion to increase well-being
personalisation and promoting open choice

1.5 This paper seeks endorsement of the strategic the direction of travel for this informal support to ensure its contribution to these objectives. Changes are needed to the ethos and objectives of informal support to help more citizens to avoid or delay a loss of independence. It will also enhance well-being both physical and emotional. The majority of vulnerable adults express a wish to be as independent as possible. This requires:

A substantially increased range of options in a diverse market that enable self-help, self-reliance and healthy lives
A wide range of options so that personalised open choices can be made
An ethos that positively promotes self-reliance and healthy lives
Access to quality, timely, information and advice to encourage effective and personalised open choices
Personalised budgets – so that individuals with eligible social care needs can buy what they prefer to meet those needs
Commissioning with or seeking alignment from a range of partners and service areas who can also refocus (redesign) their resources to contribute to the self-reliance and healthy lives objectives. This must maximise all of the assets in Cheshire East including commercial enterprises as well as public, voluntary and faith sectors.

1.6 To deliver on the direction of travel strategic commissioning capacity will focus on developing:-

A wider range of appropriate support options in all localities, for different needs and preferences and using all potential providers/contributors in a diverse market
Personalised budgets
Accessible, quality advice and information

1.7 Market development needs to maximise all potential routes for support including for example existing commercial businesses, new businesses, social enterprises (and similar), voluntary groups, faith groups, interest groups, tenant groups, civic societies, town and parish councils etc.

1.8 It is well-established that prevention and early intervention is the best means of contributing to healthy lives. The wider determinants of health include transport, noise, violence, housing, fuel poverty and use of outdoor space. In addition social isolation is recognised as a factor that will increase the likelihood of a need for support. The market developments will ensure all these factors are addressed within the informal support system.

1.9 The principles of personalisation as reiterated in the Care Bill enable the right options to be available to meet the individual's needs and preferences thus increasing the achievement of good outcomes. Those principles include:-

Personal budgets so that people can choose support that helps them meet the outcomes they want to achieve
A wide range of choices for support to ensure real choice and tailoring to an individual
Less services that are for 'a group', more that are individualised

1.10 The Care Bill includes specific responsibilities for Local Authorities in respect of Prevention and Early Intervention which this direction of travel will address.

Specifically the Care Bill requires that Local Authorities:

ensure services are available to prevent care needs becoming more serious

ensure people can access information to make decisions about care and support

ensure people have a good range of providers to choose from

2.0 Recommendations

2.1 That Cabinet full endorse and support the implementation of this clear strategic direction of travel for informal support. This addresses prevention and early intervention for adults with social care needs and delivers Council Plan outcomes.

2.2 That officers are authorised to take all necessary steps to implement the proposed strategic direction of travel.

3.0 Reasons for Recommendations

The Current Informal Support Market Position – High Level Assessment General Support for All Vulnerable Adults.

3.1 Advice and Information

Some good advice and information is available but overall this support is patchy, duplicative, silo-based and not universally accessible. It has not been subject to a strategic commissioning approach. The result is that some

vulnerable people and their carers may be missing opportunities to increase independence and well-being.

3.2 **Community Inclusion and Diverse Social Networks**

All vulnerable adults need opportunities to participate in the community and enjoy supportive and diverse social contacts. Adults who may require social care can sometimes be isolated from these opportunities because of the way that support is designed. Support can tend to group people based on their vulnerability rather than exploring ways to engage in the community.

3.3 **Older People**

3.3.1 There is a generally traditional set of options available that individuals are 'fitted into' in groups rather than options that are tailored to the individual. Often these options are designed for doing things for people rather than helping them to do themselves, this can encourage further loss of capacity and diminishing self-reliance.

3.3.2 There are only a small number of options that actively promote self-help and self-reliance, early intervention/prevention and healthy ageing.

3.3.3 There is some activity dedicated to ensuring the contribution of older people in communities is valued and that individuals can fully participate and are not socially isolated. However this is an area that needs to be expanded.

3.2 **Learning Disability**

3.2.1 Activity that increases social inclusion and community support is under-developed, but there are good examples where individuals are being supported in the community informally.

3.2.2 There are good examples of a more tailored approach using personal budgets for people with learning disability but these are relatively limited at present.

3.2.3 Individuals who could be more self-reliant, for example cooking for themselves, can instead receive care that does things for them rather than teaches them how to do for themselves. Informal support can provide new skills and learning to increase independence and well-being.

3.2.4 Assistive technologies have not yet been fully exploited to enable adults with learning disability to gain greater independence and self-reliance. A pilot of assistive technology use for these adults is about to commence.

Occupational opportunities and supported employment offers some individuals the option of work-based day activity.

3.3 **Mental Health**

3.3.1 The informal support options for people with mental health needs are under-developed. One of the key strengths locally is the use of a recovery model of intervention. However for recovery to sustain people need to then access ways of building up their skills and capacity for example so that they can gain employment. It is this type of support that could be enhanced in the new direction of travel.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 All

6.0 Policy Implications

6.1 The recommendations within this report support the delivery of the Cheshire East Council Three Year Plan:

Outcome 1: Our Local Communities are Strong and Supportive
Outcome 2: Cheshire East has a Growing and Resilient Economy
Outcome 5: Local People Live Well and for Longer

7.0 Financial Implications

The Adult Social Care departments of all Councils face the same dilemma of how to cope with increasing demand with reduced resources. Increasing self reliance and ensuring people remain healthy for longer contributes towards solving this funding problem. The direction of travel is therefore closely aligned with the financial direction of travel.

8.0 Legal Implications

8.1 'As drafted within this report, the precise legal implications have yet to be crystallized, but will likely include:

1. Issues around personal budgets and the necessity for CEC to comply with public procurement requirements when directly commissioning services.

2. Issues in respect of direct payments including the need to comply with legislation and have in place robust administration processes in respect of the same.

3. CEC's public sector equality duty under s.149 Equality Act 2010.

Detailed legal advice will be provided in due course once specific measures are identified for consideration by officers.'

9.0 Risk Management

9.1 The direction of travel proposed seeks to strongly contribute to the Council 3 year plan outcomes. There is a risk that these outcomes would not be fully achieved without this change to the adult social care direction of travel.

9.2 The implementation of any major change programmes necessary to meet this direction of travel will be managed through the Council's TEG and EMB project management processes.

10 Access to Information

10.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Ann Riley
Designation: Corporate Commissioning Manager
Tel No: 01270 371406
Email: ann.riley@cheshireeast.gov.uk

Appendix 1 – Background report on the direction of travel proposed.

Appendix 6

The Strategic Direction of Travel and Market Development for Adult Social Care Services – Promoting Open Choice

Introduction

This briefing paper focuses on the strategic commissioning and the market development of regulated social care services for people in Cheshire East. It explains how Adult Social Care and Independent Living will help to deliver the council outcomes identified within the three year plan:

Outcome 1: Our Local Communities are Strong and Supportive
Outcome 2: Cheshire East has a Growing and Resilient Economy
Outcome 5: Local People Live Well and for Longer

So what do we mean by the term strategic commissioning?
Whilst there is no one agreed definition of strategic commissioning essentially commissioning is the strategic activity of identifying need, allocating resources and securing provision to best meet that need, within available means.

What are regulated adult social care services?
Regulated adult social care services are the treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care) which are regulated by the government regulator, the Care Quality Commission (CQC) against the national standards.

Who are we commissioning these services for?
Under the Care Bill local authorities will take on new functions. The Care Bill requires the council to support a market that delivers a wide range of sustainable high-quality care and support services that will be available to our communities. This includes those assessed as having critical' or 'substantial' unmet needs under the 'Fair Access to Care' criteria (both those who are fully funded by the council and those who contribute to their care costs) and those who arrange care privately.

Why do we need to commission services differently?
To deliver the council outcomes identified within the three year plan the council recognises that we need to change the way we commission services and work with social care providers. The number of people aged 65 and older in Cheshire East Growth is forecast to increase by 49% in the next 16 years. The demographic growth will not be matched by public funding. We believe that there are changes needed in the social care market both to respond to the changing demographic and economic environment and to provide individuals with choice and control over the care that they receive.

- The paper explains how by 'doing things differently' we will do more for less to meet the growth in demand. We will encourage innovation and find new ways of delivering services so that people receive quality services which meet their care needs and deliver outcomes for individuals and for the council.

- The paper explains how by 'doing things differently' individuals will control their own care and support and make open choices about how and when they are supported to live their lives.

- The paper explains how by 'doing things differently' we will increase opportunities for local businesses to compete in the market and ensure that people have a varied care and support market to purchase from.

Appendix 6

Principles of Commissioning

It should be no surprise that our first priority, in line with our corporate objective, is that people live well and for longer. We want to support people to remain independent for as long as possible, delaying and in some cases avoiding the need for on going social care services. Encouraging people to stay healthy and supporting communities to be strong and supportive is essential as we know that poor health and social isolation are factors that lead people to require social care services.

The Council actively wants to engage with and listen to communities as equal partners to make a difference. By actively participating in finding solutions for how we make stronger communities now and in the future and by building on local working and existing networks and good practice we will help people to understand the role that they have to play in staying fit and healthy and reduce dependency on services which will be reflected in improving self reported wellbeing – satisfied with life (PHOI 2.23i).

Supporting family carers so that they can maintain their caring role is also critical. Universal services such as advice and information services, leisure and recreation play an important role in supporting people's independence. We believe that a proactive voluntary and community sector is key to supporting people in their communities. We also know that interventions such as telecare and assistive technology can provide the reassurance and support that enable people to retain their independence for longer.

Some older people will inevitably require on-going social care support. Again our priority is to support these people to regain or maintain their independence whenever possible. Services will need to focus on enabling people and move away from passive models of support that create dependencies. Reablement, through a focus on recovery, has delivered significant results helping people regain their independence and reducing demand for social care services. Enablement will be a key characteristic for all services we commission.

Our focus on prevention and enablement may seem contrary to our traditional way of working with the market where providers have been rewarded for the volume of care they provide, and not the outcomes they deliver. However we believe this is an area where the social care market can play a much greater role, and we will work with providers to share the benefits of people achieving greater independence and reducing their reliance on social care services.

Increasingly people who require on-going support are taking personal budgets as direct payments. Providers will need to consider how they will respond to the growing number of people managing their own care via direct payments in order to maximise the potential benefits from this growing market and faster method of receiving payment. We recognise that we will need to work with providers to ensure that people have the information to make informed open choices when arranging and purchasing services for themselves. Improved access to information will be supported by Council investment in a high speed broadband network for Cheshire. The Connecting Cheshire Partnership will ensure that 80,000 (96%) of rural homes and businesses will have access to high-speed broadband by 2016. For others there will still be a need for the council to arrange services on the person's behalf. The council believes that this role could also extend to people who fund their own care, so they can enjoy the same advice and support as those whose services are funded by the council.

We are also clear that personalised care and support is much wider than personal budgets. Personalisation is about how people experience the support they receive on a day to day basis, and the relationships they have with people. We believe that services and support still

have further to go to deliver personalised services which are based on needs and aspirations of the individuals receiving them.

As commissioners we need to ensure that we make best use of the public money we have available to us, and we will work hard to achieve an appropriate balance between price and quality in our contractual arrangements with the market. We see this as being central to our vision of having a sustainable competitive social care market that encourages new and innovative ways of delivering support to meet our corporate objectives that People Live Well and For Longer and that Our Local Communities are Strong and Supportive.

To meet the challenges that we face the future commissioning of all services will mean **'doing things differently'** and will be underpinned by three key principles:

1) **Doing things differently – doing more for less** and find new ways of delivering services so that we do not have to reduce services and can where possible increase capacity within our resources to meet increased demand. Qualitative research has found many examples of personal budget users finding new innovative ways to meet their care needs. There are also a range of potential approaches to larger contracts including "gain share" arrangements (the council shares any benefits of package efficiencies with providers) and "payment by results" agreements (providers are rewarded for achieving an agreed set of outcomes) that we will explore with the market

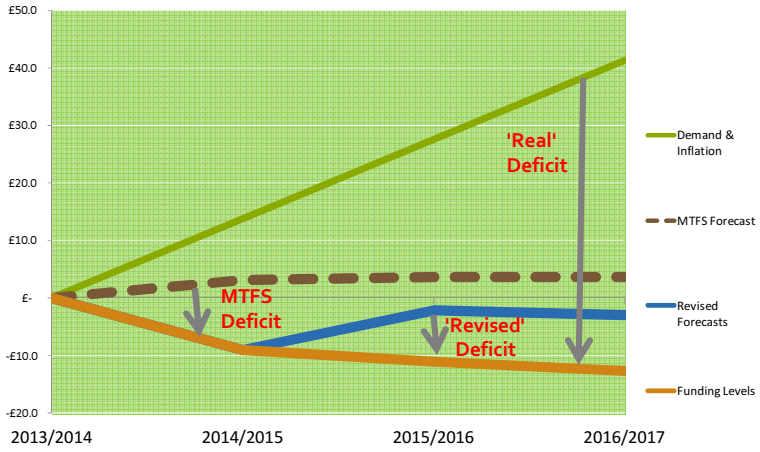
2) **Doing things differently – encouraging personalisation** both for those who come through our door and those who arrange care privately. Personalisation means thinking about public services and social care in a different way – starting with the person and their individual circumstances rather than the service. Personalisation means recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. The traditional service-led approach has often meant that people have not been able to shape the kind of support they need, or receive the right kind of help. Personalised approaches such as self-directed support and personal budgets involve enabling people to identify their own needs and make open choices about how and when they are supported to live their lives. We need individuals to be self-reliant and take personal responsibility for their quality of life within strong and supportive communities.

3) **Doing things differently – encouraging open choice for users** based on the development of a competitive provider market. This is normally seen when, as a result of market stimulation, new providers enter the market, poor performers are taken over or exit the market, and in product and service innovation. The local authority role is changing from one of delivering services directly or commissioning them to one of overseeing local care markets to ensure that they are delivering the required outcomes for individuals and the local population. We want to encourage new entrants, stimulate the development of new products, and promote competition so people have a varied care and support market to purchase from and the market is more dynamic – this will also help to ensure that Cheshire East has a strong and resilient economy. Whilst we will be looking towards competition as a means of controlling costs and improving the diversity of provision, we are also aware of the need to maintain and improve quality. The Council is committing additional resources to ensure that there is effective monitoring and quality assurance of adult social care services for the people of Cheshire East.

Appendix 6

Challenges and Opportunities

As you will be aware the council is facing unprecedented challenges. Cheshire East Council receives lower levels of funding from central government than other comparable councils and the budget available to the council for social care is diminishing. At the same time we are forecasting growth of 49% in the number of people aged 65 and older in Cheshire East in the next 16 years. The demographic growth will not be matched by public funding meaning that the current pattern of services and investment is unsustainable. This challenge is illustrated in the graph below.



Graph 1 – illustrates how demand from demographic growth will not be matched by public funding meaning that the current pattern of services and investment is unsustainable and must change

Basically unless things change dramatically the demographic change – more children, more older people – will soak up every penny the authority has with the council unable to provide any services except adult social care and children's services. No libraries, no parks, no leisure centres – not even bin collections. To effectively manage the forecast growth in demand in Cheshire East we will do more for less by stimulating the market to encourage innovation and find new ways of delivering services. By jointly developing services with the people that will use them we will increase choice and ensure that people receive personalised care. We will encourage individuals and communities to take responsibility for themselves where they can. By ensuring that people know how to stay well and healthy and where to go for early help and advice we will help people to stay in their own home. When services are needed we will ensure that these are available irrespective of whether we support people financially or if they are a self funder. We will ensure that our resources are targeted specifically to need and risk – those who are most in need will be prioritised in terms of budget and resources.

Although our budget may be decreasing, the wider social care market still presents considerable growth opportunities. We will continue to work with our partners, such as health, housing, education and employment services, sharing our solutions and areas of focus to identify and meet service user needs and outcomes whilst ensuring that they are appropriately safeguarded. As we commission more services in partnership with partners, we will coordinate our planning and activity to ensure that budgets are used in a coordinated way to make the collective pot go further and still achieve key outcomes. This will potentially open up wider funding streams for social care providers. Demographic forecasts suggest that the number of people funding and purchasing their own care will also increase. Throughout this document we have chosen to describe the issues that we face rather than prescribe the solutions. This is because we believe that the residents of Cheshire East and the social care providers of Cheshire East know what works and what doesn't and will use their knowledge and expertise to innovate and evolve services to better serve our community. By focusing on new opportunities to deliver services in a different way we will improve outcomes for people at the same time as delivering efficiencies.

Appendix 6

Current and Future Demand

Cheshire East has a population of 372,000 and an area of 116,638 hectares. In addition to Cheshire West and Chester on the west, Cheshire East is bounded by the Manchester conurbation to the north and east, and Stoke-on Trent to the south. It contains the major towns of Crewe, Macclesfield, Congleton and the commuter town of Wilmslow (population above 20,000). There are also a number of other significant centres of population (over 10,000) in Sandbach, Poynton, Nantwich, Middlewich, Knutsford and Alsager. With few large conurbations the borough otherwise comprises a mixture of smaller market towns and more isolated rural villages. This mixture of rural/urban presents particular challenges in delivering cost-effective services close to individuals and their neighbourhoods.

In 2010 there were 83,300 older people aged 65+ in Cheshire East (Office for National Statistics indicative population estimates 2010). Estimates suggest that in 2012 5,234 (6%) older people were living with dementia and 33,154 (40%) with a limiting long term illness. The population of Cheshire East is forecast to grow modestly over the next 30 years rising from 362,700 in 2009 to 384,000 in 2029, however, the age structure of the population is forecast to change significantly with a 8% reduction in young people (0-15), a 12% reduction in working age people (16-59 Female, 16-64 Male) and a 42% increase in people of retirement age (60/65+), with the number of older people (85+) increasing by around 92%. As the prevalence of dementia increases with age, the number of older people with dementia is anticipated to increase by 28% by 2020. The significant changes in demographic in Cheshire East will have direct implications for adult social care.

Currently Cheshire East Council supports 5635 older people with social care needs. This is defined as people having difficulty with or requiring help with domestic or personal care tasks. There are estimated to be a further 3500 older people with care needs who are supported by family and friends, or who are privately funding their own care.

The financial circumstances of the older population will have an impact on the proportion of the social care market that is “council funded” and the proportion that people purchase themselves without council support. 11,130 of older people in Cheshire East were claiming pension credits (Department of Work and Pensions, May 2013). To be eligible for this additional benefit you must be a pensioner with an income of less than £145.40 for single people or £225.05 for couples. These residents are therefore more likely to be reliant on some form of council funding should they need social care services.

90.6% of retired residents in Cheshire East are estimated to be owner occupiers. There will be opportunities for local businesses to develop innovative, personalised, care services for this potential market as more people consider how they can utilise their assets to plan for their future care needs.

Social isolation is a key determinant in people requiring social care support and we estimate that 37% of those aged 65+ and 50% of those aged 75+ are living alone. Whilst living on your own does not necessarily equal social isolation it is an important factor alongside others. The community and voluntary sector has an important role in supporting people within their communities and tackling social isolation. The number of people living alone in large properties also presents opportunities to consider how these assets could be better utilised to support people who feel isolated – i.e. through moving to more communal living environments. Local research tells us that widowhood is often a factor in people entering registered care as people struggle to take on the tasks their spouses used to undertake whilst also coping with their loss. We believe that there is an opportunity for providers to develop services to support people through this difficult period of their life.

Our research also suggests that there is a general lack of knowledge about the services and support available to older people, particularly at the critical stages of their lives. Information and advice needs to be tailored and available at the right time for people throughout their life and be available for all including those funding their own care, and the Council is actively engaged in commissioning such services.

Local Supply and Commissioning

The Council spent £123 million (net) on social care services in 2012/13, of which 88% was spent on the direct provision of care services. This expenditure is similar to other comparable local authorities. £31 million (25%) was spent on residential and nursing care services for older people, £27 million (19%) on learning disability services, £17.5 million (14%) on Care4CE (in house provider services), £14.3 million (12%) on cash payments, £8.2 million (7%) on domiciliary care, £7.5 million (6%) on housing support services and £2.5 million (2%) on transport to and from services. In addition to this Cheshire East spent £3.4 million (3%) on early intervention and prevention services, with community and voluntary organisations in 2012/13. We would like to continue to shift this balance so that a greater proportion of the budget is spent on preventative services and through cash payments, and a smaller proportion is spent on registered care. We are moving into a time where increasing numbers of people are taking cash payments, and joining the substantial amount of "self funders" in Cheshire East to purchase services directly from the market. As a result we need to redefine our relationship encouraging a competitive market that offers greater open choice and control for consumers.

The Council undertook 3838 new assessments for older people during the year 2012/13. The average age on which a service user enters the social care system is 73. The number of older people Cheshire East is supporting has remained consistent over the last three years; however the needs of the people we are supporting appears to have changed with the proportion of people requiring care packages of more than 15 hours per week increasing.

<u>Telecare, equipment and adaptations</u>

- Telecare, equipment and adaptations are critical in supporting people to remain independent for as long as possible and reducing the need for on going care and support.
- 1624 older people received adaptations in 2012/13, of which 431 were self funded, whilst a further 1260 received equipment.
- 1250 customers currently receive telecare in Cheshire East and it is projected that there will be a steady increase to 2,250 customers by March 2016.

<u>Reablement</u>

- Cheshire East has also increased the use of reablement services to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or social abilities of daily living which has led to increased support needs.
- Reablement is our first response offer to individuals who access adult social care and is delivered for up to 6 weeks within the persons own home to restore people's ability to perform usual activities and improve their perceived quality of life.
- Over 1,123 older people completed a period of reablement in 2012/13, of which 40% achieved a positive outcome of either needing no support, or having reduced care needs on completion.
- We believe the success of telecare and reablement has contributed to the reduced demand for lower level home care services.

<u>Domiciliary Care</u>

- Cheshire East Council is committed to helping people to stay in their own homes and remain as active and independent as possible.

Appendix 6

- Domiciliary Care is one of the range of care and support services provided in peoples own home to enable them to remain independent. These services can range from a short call to assist with medication up to 24 hour live-in care.
- In 2011/12 995,000 hours of domiciliary care were delivered to 764 service users at a cost of £16.5 million. 97% of these hours were provided by the independent sector.
- In response to customer demand the Council are committed to developing this type of care provision as an alternative to residential based care services.

- As at December 2013 2,464 older people are being supported by 71 domiciliary care providers.
- Of these the council directly commission the care for 1,414 older people
- A further 1,050 people currently receive cash payments to organise their own support, the majority of which are spending their personal budgets on traditional social care services, particularly domiciliary care.
- Having already removed the domiciliary care block contract arrangements and increased the uptake of domiciliary care through the current financial year the Council wants to make it easier for existing and new providers to enter the market and work with us via framework agreements.
- We also expect the amount Cheshire East spends via cash payments to increase together with the demand for a more personalised service offer as the market expands and expectations of future generations change and they move away from traditional care services.

Residential and Nursing Care

- There are 102 care homes with 4032 registered care beds available for older people in Cheshire East.
- This is more than double the rate per head of the population (21 beds per 1,000 people aged 65+) compared to the national average (45.2 beds per 1,000).
- The Council is commissioning 40% the available beds in the market in Cheshire East, and 60% are being commissioned by self funders or other authorities.
- This poses a risk to the authority with self-funders risk falling back on council provision if they run out of money, or if they make poorly informed decisions.
- Historically Cheshire East has had a comparably higher spend on residential and nursing care than the average for similar authorities but our expenditure on registered care is beginning to fall.
- Currently at December 2013 Cheshire East support 1319 older people in residential or nursing care.
- Spend on permanent admissions into registered care for older people has reduced by 3% from £31,910,195 in 2011/12 to £30,963,381 in 2012/13 and there has been a corresponding increase on spend on community services.
- The average age on admission into a registered care setting is 83.

The table below shows the distribution of all registered residential care placements for older people by the locality of the registered care home.

Lap Area	Total number of homes	Total number of beds	Total number of nursing beds	Total number of residential beds
Congleton	27	888	495	393
Crewe	16	591	440	151
Knutsford	7	491	451	40
Macclesfield	24	812	475	337
Nantwich	11	445	297	148
Poynton	10	439	244	195
Wilmslow	7	366	308	58

Table 2 - Distribution of all registered residential care placements for older people by the locality of the registered care home.

Appendix 6

Commissioning Intentions

Cheshire East Council is committed to facilitating people to live independent, healthier and more fulfilled lives

We will do this by:

Increasing the percentage of people enabled to remain living independently in the community - we will commission with health partners to prevent unnecessary admissions into hospital. The majority of older people who require intensive social care support have come to us via a hospital admission and we plan now to commission services to avoid this. As a result we will be commissioning many of these services jointly to prevent avoidable hospital admission and services that successfully maintain people in their own homes. We will also commission with health partners services and support that promote an earlier safe discharge from hospital including intermediate care and reablement services.

Increasing the proportion of community-based service users able to stay in their own home - in addition to providing reablement for people leaving hospital we will continue to provide community reablement for all appropriate new people requiring social care support. Over 1,123 older people completed a reablement package in 2012/13 and we are actively exploring how predicted increases in future demand for this service can be met. We have been successfully promoting assistive technology and are beginning to see that this is having an impact in improving independence and reducing the need for on-going services. We believe that providers should be incorporating assistive technology as part of their offering to service users and will seek provider views on how we can incentivise this approach. We will also continue to increase the proportion of council expenditure that is used to purchase Domiciliary Care, the range of care and support services provided in peoples own home to enable them to remain independent.

Delivering home adaptations for older and/or disabled residents - 1624 older people received adaptations in 2012/13, of which 431 were self funded. We will continue to deliver home adaptations for older and/or disabled residents to enable them to live independent, healthier and more fulfilled lives.

Supporting people with dementia to retain their independence for as long as possible and enjoy a good quality of life – The growth in people experiencing dementia presents probably the greatest challenge for health and social care services. Having a workforce with the skills and knowledge to support people with dementia is therefore a requirement for all providers working with older people. Supporting people in the familiar settings of their own homes can reduce the numbers prematurely entering long term care. Providers can play an important role working alongside health professionals to ensure the early identification of dementia, and the provision of appropriate support to delay and minimise the impact of this condition. For people in the later stages of dementia, registered care settings play an important role in supporting people to live well and with dignity.

Reducing the number of Council supported permanent admissions to residential and nursing care per 100,000 population (ASCOF 2A) – The numbers of older people

supported by Cheshire East in registered residential and nursing care has reduced by 3% since 2012, despite increased demographic pressures, with people being admitted later in life and staying for shorter periods. Whilst we do not believe that we need more residential care we may need to consider the models of care that is provided and how it is distributed throughout Cheshire East. We are unlikely to support planning applications for registered care homes in areas where we believe there is an already an over-supply unless the application is to remodel existing provision to make it more fit for purpose, or the proposed development will better meet specific unmet needs within the area. As part of our on-going engagement with the market we would welcome discussions with providers about their ideas for potential developments so that we can give an early indication about whether we are likely to support an application and hence avoid unnecessary costs to providers at a later stage. We will also seek to utilise residential and nursing care home capacity to provide respite breaks for carers, where this has been assessed as an eligible need through a carer's assessment, or short term placements to avert a crisis or provide a period of recuperation from hospital or illness.

Supporting good quality registered nursing care is available for physically and mentally frail older people who need it –the supply of nursing care will need to match the increasingly complex needs of people requiring registered care. We will look to commission this service in partnership with health colleagues wherever possible.

Increasing the number of social care clients receiving self-directed support - 1050 older people receiving on-going care services are receiving their personal budget via a direct payment and arranging their own care, however the majority of older people are using their money to purchase traditional domiciliary care services and we believe that there is an opportunity to work with the market to increase open choice and to develop a truly personalised offer to consumers. Improved access to information will be supported by Council investment in a high speed broadband network for Cheshire. The Connecting Cheshire Partnership will ensure that 80,000 (96%) of rural homes and businesses will have access to high-speed broadband by 2016.

Increase alternatives to registered care by working jointly with Housing Authorities and the housing market - the Local Plan sets out the overall vision and strategy for planning in the Borough. It outlines how Cheshire East will deliver 'Sustainable, Jobs-led Growth and Sustainable, Vibrant Communities' through the development of 27,000 new homes by 2030 and 20,000 jobs in the longer-term. We will ensure that the supply of homes which meet requirements of those who are physically frail or disabled whilst the Vulnerable Persons Housing Strategy outlines how we will meet the housing needs of specific client groups within Cheshire East.

Improving self reported wellbeing – satisfied with life (PHOI 2.23i) - It should be no surprise that our first priority, in line with our corporate objective, is that people live well and for longer. We want to support people to remain independent for as long as possible, delaying and in some cases avoiding the need for on going social care services. The Council actively wants to engage with and listen to communities as equal partners to make a difference. By actively participating in finding solutions for how we make stronger communities now and in the future and by building on local working and existing networks and good practice we will help people to understand the role that they have to play in staying fit and healthy and reduce dependency on services. One way in which we will measure our success is through improved self reported wellbeing – satisfied with life (PHOI 2.23i)

Improving Carer reported quality of life (ASCOF 1D) - in 2012/2013 we assessed the needs of 2,912 carer. Of those who were assessed 2,252 cared for someone aged 65 and over. Carers tell us that they need a range of support from advice and information; practical help; support to enable them to continue with employment and learning; and breaks that allow them to sustain their caring role. In 2012/13 the Council spent £533,032.65 on carer's services in the voluntary and community sector which consisted of 17 direct access schemes

focused exclusively on supporting carers. The Council will also seek to increase the use of carer direct payments. The impact of these measures will be reported in improved Carer reported quality of life.

Improve Public Protection and Safeguarding - between April 2013 and March 2016, 90% of safeguarding indicators will be in the top 50% of England.

The background papers relating to this report can be inspected by contacting the report writer:

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ADULT SOCIAL CARE

POLICY
AND
LEGISLATION

CONTENTS

The Care Act

- Pulls together threads from about a dozen different acts into a single legislative framework for care and support.
- Now amended to enforce the pooling of health and social care budgets through the Better Care Fund (BCF). This will oblige councils and CCGs to bring together their funding to integrate care.
- The Act takes account of the Dilnot Commission on Funding for Care and Support, and the Francis Inquiry into the failings at Mid-Staffordshire Hospital.
- Introduces a new principle where the overall wellbeing of the individual is the most important thing in their care and support. Their needs, views, feelings and wishes should be considered in all aspects of their wellbeing. This to include dignity, respect, physical and mental health, employment, education, social and domestic needs, and accommodation. Assumes that the individual is the best person to judge their own wellbeing. Person-centred care should be at the heart of the process.
- The role of local authorities is widened from supporting those who have eligible needs to supporting the wider community too. Includes a requirement to prevent, delay and reduce people's needs. Also must work with local organisations to integrate services to promote wellbeing.
- A new duty on public organisations to cooperate in the planning and delivery of service users' care packages.

Key sections in the Act are:-

1. Improving information – local authorities will need to provide comprehensive information about services, facilities and resources to give the widest possible choice to the public. The aim is to improve individual wellbeing and give them more control and choice over their care. Authorities will need to write a 'market position statement' which identifies the services needed to support the population, so service providers can design appropriate solutions.
2. Entitlements to public care and support – the Act creates a new consistent way to assess eligibility for public care and support. It gives the same rights to carers. Assessments to be done by the local authority where the person usually lives. Local authority can be asked to arrange care regardless of who funds it.
3. Assessment of eligibility – The Act will give local authorities a duty to aseess everyone who appears to be in need of care and support, regardless of their financial situation. Assessment must look at needs, desired outcomes, capabilities, and support available. It must involve the individual and their carer or another nominated adult. Eligibility will be measured using national framework. The White Paper 'Caring for our Future – reforming care and support' made a commitment to introduce a minimum level of eligibility. This has yet to be decided and so is not in the draft law.

4. Personalisation – the Act will give a legal responsibility to provide a care and support plan to individuals and a support plan to carers. This must be worked out with the person and their carer. Will give a right to a Personal Budget, including full costs of their needs whether to be met by the local authority or not. Legal responsibility on local authority to review care plan to ensure needs and outcomes continue to be met.

5. Financial assessment – Following the eligibility assessment, a financial assessment will check if the client needs to contribute towards the costs of their care and support plan. There will be new regulations to ensure everyone has their finances assessed in the same way.

6. Capping costs – The Act will establish a cap on care costs around £72,000 from April 2016. The cap will be adjusted annually. Individuals will still be responsible for general living costs in care homes – around £12,000 a year. Personal budgets will show what the local authority would pay for a care and support package, and the rate at which people are approaching the cap limit. When the cap is reached the local authority will take over the full costs, but the individual will still pay the general living costs.

7. Deferred payment agreements – From April 2015 a new legal right to defer paying care home costs. The local authority will pay costs and reclaim them when the person's property is sold after their death. Local authority can charge interest on these costs.

8. Safeguarding – Formalises safeguarding arrangements. All areas must have a Safeguarding Adults Board that includes NHS, police and local authority. Must work with local people to develop plans to protect vulnerable adults. Must publish plans and review them annually. Local authorities will need to investigate if they think anyone with care and support needs is at risk, whether or not they are providing them with support. Safeguarding Adults Review must be organised where an adult has care and support needs and is suspected of experiencing abuse or neglect. No right to enter property without permission. If the Safeguarding Adults Board requests information from an individual or organisation there will be an obligation to provide what is requested.

9. Carers – For the first time carers will be given the same rights as the people they care for. Duty to provide carers with assessment of their own support needs. Eligibility assessed in the same way as for the person they care for. They will be entitled to support if: they have eligible needs, the person they care for lives in the local authority area, and there is a charge. Carer should have their own personal budget.

10. Moving areas – No-one's care should be interrupted if they move areas. The Act's guidelines for people who move between local authority areas include:- Current authority must send all relevant information to new local authority. New local authority will carry out needs assessment and carers assessment, new care and support plan should be ready on the day the person moves or, if not, need to meet needs previously established.

11. Provider failure - A new responsibilities on local authorities if care providers fail. Responsibility to ensure care continues whether residential or in the person's home, and regardless of who pays. CQC oversight of the financial stability of the 50-60'most hard to replace' care providers. CQC can request information from any provider they think is likely to fail, and will share this with local authorities to ensure care continues.

12. Transition – gives young people and their carers a right to request an assessment before turning 18. If local authority does not agree to assess they must explain why in writing and give information to prevent or delay needs occurring. Young person and carer should be told if they are eligible for any benefits when the person is 18. Should be given advice on how eligible needs could be met and what support might be available to stop needs increasing. No-one reaching 18 will suddenly find themselves without the support they need. Local authorities must continue to provide children's services until adult care is in place to fill the gap.

Health and Social Care Act 2012

Key areas

- Established a politically independent NHS Board to allocate resources and provide commissioning guidance – taking over many responsibilities previously held by the Department of Heath. Since renamed NHS England.
- Increased GPs' powers to commission services on behalf of their patients
- Strengthened the role of the Care Quality Commission
- Developed Monitor, the body that currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS
- Cut the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing Primary Care Trusts and Strategic Health Authorities.
- Moved all NHS Trusts to foundation status
- Promoted integration of health and social care, firstly to reduce delayed discharges from hospital, and also to coordinate care so that so that people spend less time in and out of hospital and are able to get the care they need at home
- Encouraged new services to be developed in the community that give people with long-term conditions better overall control
- Better outcomes for public health. Public health covers a range of things that promote general good health, such as healthy eating and drinking campaigns, good hygiene and sanitation, clean air etc
- Promoted better NHS care by encouraging competition, in pricing and in providers

Health and Wellbeing Boards (within Health and Social Care Act 2012)

- Each Local Authority required to establish a health and wellbeing board in shadow form from April 2012. Boards took on their statutory functions from April 2013.
- Minimum membership to include: a local elected council member, the director of public health for the local authority, and representatives of the local Healthwatch organisation, local clinical commissioning group, director for adult social services, director for children's services and director of public health.

- Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. This should result in more joined-up services from the NHS and local councils.
- Health and wellbeing boards will have strategic influence over commissioning decisions across health, public health and social care.
- Boards will strengthen democratic legitimacy by involving elected representatives and patient representatives in commissioning decisions alongside commissioners of health and social care. The boards will provide a forum for challenge, discussion, and the involvement of local people.

Joint Strategic Needs Assessments (JSNA)

- Health and Wellbeing Boards bring together partners from across the NHS, local government and the voluntary sector to develop a shared understanding of the current and future health and wellbeing needs of the community. They will undertake the Joint Strategic Needs Assessment and make a joint strategy to address these needs. This will include recommendations for joint commissioning and integrating services across health and care.
- Through the JSNA, the board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.
- A joint strategic needs assessment analyses the needs of populations to inform and guide commissioning of health, well-being and social care services within a local authority area.
- Producing an annual JSNA has been a statutory requirement for the NHS and local authorities since 2007.The Health and Social Care Act 2011 proposes a central role for JSNAs so that health and well-being board partners jointly analyse current and future health needs of populations.
- Examples of products of JSNAs include population-level data for GPs, a priority-setting matrix and mapping the flow of money spent on priorities.

Think Local Act Personal 2011

Think Local Act Personal is a national, cross sector leadership partnership focused on driving forward work with personalised, community-based social care. It brings together people who use services and family carers with central and local government, major providers from the private, third and voluntary sector and other key groups.

It aims for a personalised community-based approach for everyone. Achieving this will involve:-

- Integrating health and social care commissioning around agreed outcomes.
- Integrating health and social care processes, systems and resources.
- Working closely with private and social housing providers
- Engaging with local networks and community associations.
- Making and sustaining evidence=based investments.
- Developing and facilitating workforce skills.
- Making public information accessible and fully available

There is a need to build community capacity. A good supply and good choice of quality provision is also needed for those needing support. This needs to include:-

- Better ways of gathering and using market intelligence.
- A changing offer from providers.
- Full involvement of people using services, carers and families in commissioning and service development.
- Outcome-based approaches to commissioning.
- Local partners proactively managing their risks

Personalisation

- Usually via personal budgets and direct payments

Choice, Control, Efficiency – need to consider:-

- Supporting prevention and avoiding high cost admissions.
- The potential for self-directed support to deliver efficiencies in council processes.
- Provision of support planning and advice services that make more use of user-led, independent and voluntary resources.
- Encouraging greater exploration of price and affordability in the market
- Promoting the delivery of a broader range of housing / accommodation

- Supporting community capacity
- Mobilising people's own resources, skills and assets to meet their care and support needs.

Council operating systems

- Personal budgets not taken as a direct payment should be offered as a managed account.
- Councils and providers need to demonstrate they are making a difference.
- Personal budget holders need reasonable discretion in using the money.
- Help to plan and organise support arrangements.
- Carers should benefit
- Self-directed support should be available where people live, including in residential and nursing homes.
- Younger disabled people can be enabled to use self-directed support during transition into adulthood.
- Councils and providers can actively promote individuals' mental health as well as their physical well-being.
- Risk management and protection / safeguarding should be addressed in a balanced way across the whole community.

Workforce

- Support professional development and equip staff to play their part in the shift to personalisation.
- Support the development of new types of workers, and remove barriers to informal support.
- Help all providers to recruit and train staff – including people who employ personal assistants.
- Focus council care management and social work on areas that legally need local authority involvement.
- Develop the health and care workforce to work in multi-disciplinary teams.
- Facilitate the sharing of information.

Measure and support progress

- Benchmarks created that local partners can use to check progress from April 2011.

Making It Real: Marking progress towards personalised community based support 2011

Making it Real is part of the Think Local Act Personal initiative. It is a tool to check how good personalisation is in an area or organisation.

Making it Real is a set of statements from people who use care and support saying what they would expect, see and experience if personalisation is real and working well in an organisation.

These are "markers" that will help show how well an organisation is doing in transforming adult social care through personalisation and community-based support.

This is a new phase in using citizen-led information to judge success in implementing personalisation.

The “I” statements are in 6 sections as follows:-

1) Information and Advice: having the information I need, when I need it

- "I have the information and support I need in order to remain as independent as possible."
- "I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date."
- "I can speak to people who know something about care and support and can make things happen."
- "I have help to make informed choices if I need and want it."
- "I know where to get information about what is going on in my community."

2) Active and supportive communities: keeping friends, family and place

- "I have access to a range of support that helps me to live the life I want
- and remain a contributing member of my community."
- "I have a network of people who support me – carers, family, friends, community and if needed paid support staff."
- "I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities."
- "I feel welcomed and included in my local community."
- "I feel valued for the contribution that I can make to my community."

3) Flexible integrated care and support: my support, my own way

- "I am in control of planning my care and support."

- "I have care and support that is directed by me and responsive to my needs."
- "My support is coordinated, co-operative and works well together and
- I know who to contact to get things changed."
- "I have a clear line of communication, action and follow up."

4) Workforce: my support staff

- "I have good information and advice on the range of options for choosing my support staff."
- "I have considerate support delivered by competent people."
- "I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers."
- "I am supported by people who help me to make links in my local community."

5) Risk enablement: feeling in control and safe

- "I can plan ahead and keep control in a crisis."
- "I feel safe, I can live the life I want and I am supported to manage any risks."
- "I feel that my community is a safe place to live and local people look out for me and each other."
- "I have systems in place so that I can get help at an early stage to avoid a crisis."

6) Personal budgets and self-funding: my money

- "I can decide the kind of support I need and when, where and how to receive it"
- "I know the amount of money available to me for care and support needs, and I can determine how this is used (whether its my own money, direct payment, or a council managed personal budget)."
- " I can get access to the money quickly without having to go through over-complicated procedures."
- "I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this."

Personalisation through Person Centred Planning - the new Person Centred Planning Guidance 2010

The guidance is one main document and 4 workbooks.

Quick Summary

Person centred planning is a big part of government plans for personalised services. It works well for everybody - not just people with learning disabilities.

Any plans or strategies about person centred planning need to be part of the local area's plans on personalisation.

Key messages

Person centred planning and support planning are:

- practical ways to deliver personalised services and self directed support
- simple ways to ensure co-production and for people to design their own support
- shouldn't make support planning more difficult or costly

Information from person centred / outcome focused reviews will feed commissioning plans and provider development.

Strong leadership is key to creating a person centred culture within the organisation where everyone understands the vision and their roles within it.

Maximise the existing person centred planning trained staff by providing mentoring and coaching for others rather than just developing plans.

Grow person centred plans and support plans from the starting point of person centred reviews and one page profiles for all.

Key Priority Actions for councils

Provision of clear information and advice on person centred support planning. So that people can understand what support planning is, what they can spend their money on and who can help them plan

- Ensure a range of people have the skills to support planning not just care managers

- Focus on providing guides for people to plan for themselves with support from others if required
- Implement person centred reviews for everyone accessing services and outcome focused reviews for those with personal budgets
- Define leadership for person centred thinking, planning and reviews
- Invest in person centred thinking and building a local resource through champions and mentoring
- Adopt *Working Together for Change* or a similar model as a way to co-produce commissioning and strategic plans

Summary of advice for schools and transition

This is very similar to the adults guidance and is linked to the *Getting a Life* programme. The aims are:

- Person centred transition reviews with a focus on work as an outcome, preferably with indicative budgets at an early stage
- Use person centred thinking to develop individual education plans and personalised learning plans
- Use information from reviews to inform school development plans, future commissioning and transition strategies

Summary of advice for commissioners

It is a shift from traditional commissioning and contract compliance approach to co-production and partnership working with providers and the people for whom we purchase services

- Use information from person centred reviews to inform co-produced commissioning plans
- Involve people in the design, delivery and evaluation of their services
- Move to individual service fund models
- *Working Together for Change* model not only influences future commissioning but quality monitoring, development and delivery of existing services

Summary of advice for professionals

Focus on the role of staff within person centred practice, eg, person centred reviews and creating a person centred culture within the organisation

- Promotion of person centred approaches to personal health planning
- Using person centred thinking tools in everyday practice, team and organisational planning

Summary of advice for providers

As with others create a person centred culture through the organisation, eg, person centred teams, person centred thinking tools, systems and processes, etc

- Personalising support to individuals accessing their services including things like individually costed support plans, etc
- Adopt person centred reviews through to *Working Together for Change* model to feed local development plans

Welfare Reform Act 2012

Government aims to:-

- Get more people into work and off benefits.
- Protect vulnerable people.
- Make things fair for people on benefits and taxpayers.
- Cut £10 Action from welfare budget by 2017. This adds to the £18 Action cut announced in 2010.
- Stop fraud and mistakes costing over £5 Action a year.

Personal Independence Payments

- Start in April 2013 for new claims.
- Instead of Disability Living Allowance (DLA).
- People now on Disability Living Allowance will be asked to make a claim for Personal Independence Payment from October 2013 to March 2016.
- 2 parts – mobility and daily living with 2 rates for each.
- Fewer people will get the new benefit. Half a million likely to be less well off.
- Support aimed at those with “greatest need”. Will those on lower rate DLA be worse off?

Council Tax Benefit ends

- From April 2013 Councils to have a local Council Tax Support Scheme.
- Government is giving 10% less to pay for this. So new local schemes are likely to be less generous.
  Plans to save £480 million a year.
- Pensioners will be protected.
- Because the new schemes will be decided by local Councils there could be a ‘postcode lottery’ – some people better off than others.
- Council Tax Benefit ends but not included in Universal Credit calculations. Will mean a loss of income if local schemes offer less.

Benefits Cap

- Can’t get more than the Cap amount.
- From April 2013.
- So a family on benefits does not get more than an average family where people work.

- Cap £350 a week for someone living on their own.
- Cap £500 for a couple or single parent.
- Cap run by councils using Housing Benefit.
- Cap won't apply to people on Disability Living Allowance, Personal Independence Payment, Employment and Support Allowance, Attendance Allowance, Working Tax Credit.

Housing Benefits Changes

- From April 2013.
- Applies to working age people 18 – 65.
- Council and Housing Association houses only.
- Housing Benefit cut if have one or more spare bedrooms.
- 14% Housing Benefit cut if one spare bedroom.
- 25% cut if 2 or more spare bedrooms.
- Doesn't apply if have non-resident overnight care or live in adapted property.
- May have to choose to move or lose benefit.

Employment and Support Allowance

- From April 2012.
- This replaced Incapacity Benefit, Income Support (for disability) and Severe Disability Allowance.
- People put in either the 'work related activity group' or the 'support group'.
- One year time limit put on those in the 'work related activity group'. Expected to get a job in this time.
- Problems for those who are still not 'work ready'.

Community Care Grants and Crisis Loans

- Financial support for emergency costs and urgently needed items. E.g. costs of moving house.
- From April 2013 the Social Fund will end.
- The money will go to local Councils.
- Councils are not being told they have to spend this money on setting up a local grants and loans scheme.
- Councils can spend the money on anything they want.
- Possible problems for those needing short-term help with money.

Universal Credit

- From October 2013.
- A more simple system. Instead of: Income Support, Tax Credit, Housing Benefit, Job Seekers' Allowance Income Based, and Employment and Support Allowance Income Related.
- If on those benefits now will change to Universal Credit by the end of 2017.
- Means tested for people of working age.
- Claims by households not individuals.
- Payment monthly to the household.
- 2 parts to Universal Credit.
  1. A basic allowance for single people, couples, and young people.
  2. Additions for people with:-
     - A disability.
     - Caring responsibilities.
     - Housing costs.
     - Children.
     - Childcare costs.
- Some now getting Severe Disability Premium will be less well off with Universal Credit.
- Children on lower or middle rate of Disability Living Allowance now will be £27 less well off with the 'disability addition' of Universal Credit.

Universal Credit – Transitional Protection

- The Government says people will not get less money on Universal Credit if their circumstances stay the same.
- Will get a top-up to the same money they had before until the Universal Credit rate is more.
- If circumstances change, the transitional protection will end.

Online Claims

- To save money the government wants claims to be done on the internet.
- They say 74% of working age benefit claimants have a broadband connection at home. 62% said they would be willing to apply online.
- However many people on benefits can't afford a computer or a broadband connection.

- Many people, including most people with learning disabilities, would not be able to claim online without help.
- The government says there will be help with making claims if needed, but not clear what help.

Conclusion

- The Government wants a simpler system that targets those most in need.
- It wants to encourage more people to work instead of staying on benefits.
- They also want to save a lot of money.
- The changes mostly start in 2013. The changes will happen gradually if you are on benefits now. You may not see the full effect until 2017.
- Some people will be getting less in benefits in future.

Equality Act 2010

The Equality Act 2010 brought together and simplified a number of different laws about protecting people from discrimination on the grounds of:

• race
• sex
• sexual orientation (whether being lesbian, gay, bisexual or heterosexual)
• disability (or because of something connected with their disability)
• religion or belief
• being a transsexual person (where someone has changed, is changing or has proposed changing their sex – called 'gender reassignment' in law)
• having just had a baby or being pregnant
• being married or in a civil partnership (this applies only at work or if someone is being trained for work), and
• age (this applies only at work or if someone is being trained for work).

These 9 areas are called 'protected chracteristics'.

The Act makes the law stronger in some areas. So depending on your circumstances, the new Act may protect you more.

The Act strengthened the law in these areas:-

- Disabled People – the Act has a new test of what 'disability' means. It is easier for someone to show that they have difficulty carrying out their day-to-day activities, and therefore that they come under the definition of 'disabled person' and are protected under the Act. Protection against indirect discrimination where a universal policy puts disabled people at a disadvantage. 'Unlawful discrimination' means that someone who knows you are disabled treats you unfavourably because of something relating to your disability. 'Reasonable adjustments' must be made to help disabled people to do their job, if they are at a substantial disadvantage compared with other workers.
- Women being paid less than men – the Act aimed to help people to find out if they could make a claim for equal pay. Employers can't prevent workers from discussing pay rates with colleagues or unions.

- Carers – Carers of elderly or disabled people are protected from being discriminated against at work because of their association with the person they care for. The Act makes this protection clearer. In addition, direct discrimination and harassment because you care for a disabled person will be banned when:
    - you're shopping for goods or services
    - you use facilities like public libraries or cafes, and
    - you use services like public transport.
- Women who are breastfeeding or who have just had a baby – it is against the law for women who are breastfeeding to be given less favourable treatment. They cannot be asked to stop breastfeeding in public (e.g. in a cafe) or to do it somewhere more private. However there is no right to breastfeed at work. Schoolgirls who are pregnant or who have just had a baby should not be subject to discrimination.
- Transsexual people - no longer have to be under medical supervision to be protected by law from discrimination. Must not be discriminated against by someone exercising a public function. Protection from discrimination because of being associated with, or mistaken for, someone who is transsexual. Protection from indirect discrimination where rules or policies disadvantage transsexual people. Protection from discrimination as a member or guest in a private club.
- Clubs – clubs with more than 25 members can't discriminate against members unless they share a protected characteristic – e.g. clubs for women only or Turkish people.

Positive Action

Positive action means doing something specific to help someone with a protected characteristic. E.g helping or training people to apply for jobs where people with that characteristic are under-represented. Or targeting a service at people with a particular characteristic. Taking positive action is voluntary.

Harassment

Harassment is behaviour which hurts a person's pride, or which is offensive. The Act protects people from harassment if they are linked to someone with a protected characteristic, or if someone wrongly thinks they have a protected characteristic. The law protects people from harassment at work, and protects some people when they are buying goods or receiving services. If people are harassed at work the employer

will be held responsible if: they know about repeated harassment (e.g. by a customer) and do nothing to stop it happening.

Employment Tribunals

Can take problems of harassment to an employment tribunal. Could get compensation, or be reinstated if sacked because of discrimnination.

Public Sector Equality Duty

Part of the Equality Act (Section 149) that came into law in April 2011

The Equality Duty is a duty on public bodies and others carrying out public functions.1 It ensures that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees.

It encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs.

The duty applies to the 9 protected characteristics in the Act with the exception of marriage and civil partnerships. These are only included in respect of the requirement to have due regard to the need to eliminate discrimination.

The Equality Duty has three aims. It requires public bodies to have *due regard* to the need to:

• eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;

• advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

• foster good relations between people who share a protected characteristic and people who do not share it.

Having *due regard* means consciously thinking about the three aims of the Equality Duty as part of the process of decision-making. This means that consideration of equality issues must influence the decisions reached by public bodies

Complying with the Equality Duty may involve treating some people better than others, as far as this is allowed by discrimination law. For example, it may involve making use of an exception or the positive action provisions in order to provide a service in a way which is appropriate for people who share a protected characteristic – such as

providing computer training to older people to help them access information and services.

Taking account of disabled people's disabilities

The Equality Duty recognises that disabled people's needs may be different from those of non-disabled people. Public bodies should take account of disabled people's impairments when making decisions about policies or services. This might mean making reasonable adjustments or treating disabled people better than non-disabled people in order to meet their needs.

Common misunderstandings about the Equality Duty

- The Equality Duty does not impose a legal requirement to conduct an Equality Impact Assessment.
- The Equality Duty does not mean that public bodies have to examine equality issues where they are not relevant to the matter in hand.
- The Equality Duty does not require public bodies to take disproportionate action on equality.
- The Equality Duty does not require public bodies to treat everyone the same.
- The Equality Duty does not require public bodies to treat all religions as being equal or to treat all religious festivals equally.
- The Equality Duty does not require public bodies to make services homogeneous or to try to remove or ignore differences between people.

Enforcement

The Equality and Human Rights Commission is responsible for enforcing the Equality Duty. It has powers to issue compliance notices to public bodies that have failed to comply and it can apply to the courts for an order requiring compliance. The Equality Duty can also be enforced by judicial review. This can be done by the Commission or any individual or group of people with an interest.

Publish Compliance and set Equality Objectives

Public bodies are required to:

• publish information to demonstrate their compliance with the Equality Duty, at least annually; and set equality objectives, at least every four years.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

The complaints procedure for local authority adult social services is set out in regulations, which cover both the Local Authority and NHS procedures. These were introduced in April 2009 and amended for technical reasons with effect from 1 September 2009.

Anyone whose care is arranged or provided by local authorities is able to make a complaint to the local authority if they are dissatisfied with the service they receive. This includes services such as residential care where the provider is an independent organisation, as long as that care is arranged by the local authority. If someone is still dissatisfied following the local authority's response, they can take the matter up with the Local Government Ombudsman.

The procedure was reformed in 2009, and is now designed to be flexible, less bureaucratic than in the past, and responsive to the needs of individual service users or their representatives.

A new complaints scheme for people whose adult social care is not arranged or provided by local authorities came into effect on 1 October 2010. This covers some 35% of adult social care users who pay for their own care who until now have had no access to a statutory complaints procedure.

The scheme was created by the Health Act 2009, and gives the Local Government Ombudsman powers to consider complaints from social care self-funders. The individual service user, and anyone acting on their behalf, can raise a complaint with the Ombudsman. The Ombudsman is able to investigate complaints and make recommendations to the service provider.

The NHS and local authority social services complaints procedure

First stage - resolution of the complaint at a local level

To complain about any aspect of NHS treatment you've received or have been refused, or services provided by the local authority social services, go to the organisation concerned. Ask for a copy of the complaints procedure. You can do this

for any service provided by the NHS, for example, GPs, opticians, dentists, and hospitals, and local authority social services departments.

In all cases, the first stage of the procedure is to make a complaint to the practitioner concerned. A social services department must have a member of staff who deals with complaints. They are called the complaints manager. A large health centre may also have a complaints manager. A smaller practice will probably not have a complaints manager, but all NHS practices have a procedure, and someone who has responsibility for it. In most cases, the matter will be resolved at this stage.

The complaints manager can arrange for an independent conciliator or mediator to be brought in to help resolve the complaint.

Second stage – referral to an ombudsman

If you are unhappy with the decision of the complaints manager at the organisation concerned, you do not have a right of appeal. However, you can refer the matter to the Parliamentary and Health Service Ombudsman if the complaint is about the NHS, or the Local Government Ombudsman if the complaint is about social services.

Judicial review

It may be possible to challenge the final decision on your complaint by taking court action called a judicial review. Judicial review is a procedure which allows a court of law to review decisions made by public bodies.

Autism Act 2009 & Fulfilling and Rewarding Lives 2010

The Autism Act itself is very brief. The statutory guidance is all in 'Fulfilling and Rewarding Lives'.

The government's vision for autism is: "All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents."

Autism training for staff to include:

- Autism awareness training for all staff in health and social care.
- Specialist training for those involved in access to services for adults with autism: GPs, community care assessors, residential care workers, personal assistants.
- Ensure in each area some staff have expertise and training in autism.

Diagnosis and assessment of needs for services

- The vision is that adults with autism "can get a diagnosis and access support if they need it."
- Each area needs a pathway for the diagnosis of autism and the assessment of needs.
- After diagnosis NHS should inform the Local Authority. Local .Authority should offer a Community Care Assessment and Carers' Assessment. Eligibility for services cannot be denied on IQ grounds.
- NICE clinical guideline and baseline assessment tool gave further guidance in 2012.

Transition

- Young people with autism and their carers should be invited to have Community Care and Carer's Assessments as they approach transition.
- NHS need an effective way to transfer clinical care of young people with autism from children's services to adult services.

Local planning and leadership

- Need to apply Equality Act 2010 to people with autism. Mean making reasonable adjustments to make services accessible for people with autism. Complex as people with autism are all different and will have different needs to take account of.
- Need a nominated joint commissioner or senior manager with commissioning responsibility for adults with autism. Involved in local and regional planning groups.
- People with autism should have the same opportunities as others including personal budgets, advocacy, and access to community groups.
- Annual review of a local commissioning plan for services for adults with autism.

Valuing People: A New Strategy for Learning Disability for the 21st Century 2001

Valuing People White Paper defined learning disabilities:-

"learning disability includes the presence of:

A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with:

A reduced ability to cope independently (impaired social functioning);

Which started before adulthood, with a lasting effect on development."

This definition includes people with autism, only where they also have a learning disability. So it does not include people with Asperger's Syndrome.

PRINCIPLES

1. Legal and civil rights.
2. Independence.
3. Choice.
4. Social Inclusion.

AIMS

1. To tackle social exclusion and improve life chances.
2. To ensure value for money services.
3. To achieve consistent and equitable services across the country.
4. To ensure effective partnership working.
5. To ensure effective use of the person-centred approach.
6. To drive up standards.

OBJECTIVES

1. Maximising opportunities for disabled children.
2. Transition into adult life – with continuity and equality of opportunity.
3. Enabling people to have more control over their lives – involves choice, advocacy, and person-centred planning.
4. Supporting carers.
5. Good health – designed around needs, with additional support where needed.
6. Housing – with greater choice and control.
7. Fulfilling lives – purposeful lives with: community involvement, relationships, activities.
8. Moving into employment.
9. Quality – evidence of quality, good outcomes, and best value.

10. Workforce training and planning – better training for staff working with people with learning disabilities, better understanding for wider workforce.

11. Partnership working – promote holistic services through effective partnership working in commissioning and delivery of services.

Valuing People Now: A New Three-Year Strategy for People with Learning Disabilities 2007

'Valuing People Now' was published on 4 December 2007. It reviewed progress on the implementation of the Valuing People White Paper for adults with learning disabilities and outlined a new 3 year plan for change from 2008-2011. While the Strategy has now completed its 3 year plan, the priorities and needs it contains are still seen as valid points that need to be pursued for people with learning disabilities.

Valuing People Now centred around 5 main priorities:-

1. Personalisation

Giving real choice and control to people with learning disabilities. The government wants to see more use of person centred planning, direct payments, and individual budgets.

2. What people do during the day (and evenings and weekends)

The aim here is better lives for people with learning disabilities, The plan is to move away from day service modernisation to a more radical approach that puts more emphasis on jobs and being included in local communities. Includes better post-16 education. New performance indicator on employment.

3. Better Health

Equal access to health, and good quality healthcare for people with learning disabilities. A new Primary Care Service Framework will support PCTs in commissioning health checks, and will promote better access to good health for adults with learning disabilities. People should only be in hospital for assessment or treatment.

4. Access to Housing

Access to the kinds of housing that people want and need – especially home ownership and tenancies. The NHS should not be landlords for anyone. New performance indicator on housing.

5. Make sure change happens

Mechanisms need to be in place to make sure that the changes in this paper do actually happen. Proposals include strengthening partnership boards, by requiring statutory bodies to consult them. Also ensuring there is better information about the lives of people with learning disabilities to make sure that things are improving.

Other things that Valuing People now says:-

1) Advocacy – there will be a new advocacy development programme. Encourage more spending on advocacy, especially self-advocacy. Every area should have a user-led organisation.

2) Carers – the government will consult carers about their needs. It will give them more support, including in family leadership. A National Standing Commission on Carers will hear carers' voices.

3) The 'Getting a Life' Project – will encourage more joint work between job centres, colleges, and social services. Initial focus will be on young people in transition.

4) College courses should be improved – more progression, less repetition, more aimed at getting a job and a life.

5) People with complex needs – implementation should start with addressing the needs of this group.

6) Hate Crime – need to stop discrimination and crime against people with learning disabilities.

7) Transport – transport for people with learning disabilities needs to be better. Need to influence local transport plans.

8) Personal relationships – needs to be more support for full social lives, including sex, marriage, and parenthood, if people with learning disabilities choose these.

9) Transition – Valuing People Now doesn't address the needs of children, except for transition. It promotes the use of person centred plans in transition.

10) The Learning Disabilities Development Fund – continued for 3 years, but paid direct to Local Authorities instead of via Health. Key outcomes for LDDF – employment, settled accommodation, health inequalities.

11) Social Care – funding and commissioning social care for people with learning disabilities to be transferred from the NHS to local government. PCT learning disability budgets transferred, except for specialist learning disability healthcare, forensic and offender services, and general healthcare. Learning disability healthcare should be jointly commissioned.

12) Accessible Information – more information needs to be made accessible.

13) Staff training – needs to be improved. Personalisation agenda will mean a need for different skills and new roles.

14) Out of area placements – need to be reduced.

15) Better information – there is a need for better information about the lives of people with learning disabilities to check that things are improving.

16) Increasing needs – the government says it will check how many more people there are with learning disabilities, and how much money is needed for services for these people.

The Green Light Toolkit 2013

This is an update the Green Light Toolkit, which was published in 2004 to help improve mental health treatment for people with learning disabilities. Things have changed since Green Light was published, but some people still receive a poor service. The evidence suggests that many services are failing to meet their responsibilities under equalities legislation - so this is an important topic. To help mental health services take action to address this agenda the NDTi:

- Brought people together at two peer learning events to exchange issues and solutions, and inform the work
- Developed a new audit framework for use in mental health services
- Provided an easy read version of the audit so that people with learning disabilities can be full stakeholders in the process
- Built a database of reasonable adjustments

The Audit tools consist of:-

1) The Basic Audit. This will help you get started as it contains the items where most people were able to award high scores.
2) TheBetter Audit. This is more challenging, so you might want to attempt it if you are scoring well on the Basic Audit.
3) The Best Audit. This contains the issues that most services are finding hardest.

Each of the three audit tools is brief – just nine items, so you can do one at a time, or tackle the whole lot in one go.

The audit tools are self-assessments using a 'traffic light' analysis. However the guidance says that the conversation about these areas is more important than the scores. It recommends using the discussion to generate an action plan.

The report found that mental health services were good at making services for people with learning disabilities or autism better if they were already good at:

- making plans and checking things were happening
- helping staff to be leaders
- learning from things that went well, and didn't go well
- welcoming families

- working together with other services
- Being person centred

Changes recommended include:-

- Managers put things in place to make sure changes happen. All services are expected to make some changes.
- There is someone who leads on making changes to services for people with learning disabilities or autism.
- Managers help staff to make changes rather than doing it themselves.
- There is someone in every team who leads on making changes (a champion). They help other staff in the team to do this.
- There are action plans in place. The actions are clear and can be done.
- Staff are told when things go well.
- Good teams are important, and can support the local champion.
- It is good if staff teams work together for a while. This means staff get to know each other and how services work. This can help making services better for people with learning disabilities or autism
- It is helpful when staff working with people with learning disabilities or people with autism work with and train mental health staff
- It is important to have accessible information in patient areas so people can use it
- It is important to help staff understand what people with learning disabilities or autism are saying.
- Good advocacy for people with mental health problems and learning disabilities or autism is also important.
- It is important to have meetings and support for people who are trying to make things better. Meetings should be helpful and interesting.
- It is good to make links to other people or services who are trying to make things better.
- It is important to share good things that are happening, so people know why they need to change.

- It is important to get help to use good ideas locally.
- What works in one place may need to be changed before it can be used somewhere else.
- People need time to put change in place.
- Being able to talk to someone about making change happen is important. Sometimes being able to phone someone can help.
- It is helpful if people who commission services say how important it is to put changes in place for people with learning disabilities or autism. They can hold money back from services until the change is in place. This is possible via a CQUIN.
- It is helpful if many people think making services better for people with learning disabilities or autism is important. If not, things can stop happening when one person leaves.
- It is helpful if the service is used to trying new things. It is also helpful if staff can see there is a good reason to change. It is helpful if services plan for changes, and any problems that changes may cause.
- Staff have the right skills to support people with learning disabilities or autism in mental health services. Staff get training on how to change services to meet the needs of people with learning disabilities or autism.
- Staff who lead on making changes and champions are good at finding ways of making services better for people with learning disabilities or autism.

Ageing Well 2010 - 2012

DWP commissioned the 'Ageing Well' Programme and implemented it in partnership with the Local Government Association (LGA) over a 2 year period which ended in March 2012.

Over 100 single tier councils in England took part in the programme. The original aim of the programme, and now its legacy, is to support councils to provide a better quality of life for older people through local services that are designed to meet their needs now, and in the future.

The programme recognised the huge contribution that people in later life make to their local communities. An important aspect of the programme was helping to improve the efficiency of local services in the current financial climate while still maintaining quality services.

The programme says that:-

- Older people in our society deserve every opportunity to age well, in communities that value their experience.
- Local concerns need local solutions. Councils can take the lead in developing innovative ageing well approaches alongside their partner agencies.
- This is a challenging agenda. There are unprecedented reductions in public sector funding, at the same time as an unprecedented increase in the numbers of older people.
- Progress is possible and Ageing Well, despite coming to the end of its 2-year plan, still has resources available to support this. These include toolkits available on the Ageing Well Legacy website http://www.local.gov.uk/ageing-well

The toolkits cover:-
What makes a good place to grow old?

- Promoting age equality
- Involving older people
- Developing intergenerational work

How to acheive a good place to grow old

- Taking a whole place approach

- Taking a strategic approach
- Resources for leaders and members
- Preparing your workforce

How to know you have a good place to grow old

- Assessing needs and progress

Ageing Well has now become a local Cheshire East programme which aims to enable the older population of Cheshire East to:-

- Have a strong voice in influencing local policy and services
- Take and maintain responsibility for their lives
- Remain healthy and active
- Retain their independence
- Be able to access services
- Benefit from and contribute through employment, volunteering and learning
- Live in a safe environment that maintains links with family and friends
- Maintain their roles as partners, carers, grandparents, employees

National Dementia Declaration 2010

Over 80 organisations formed the Dementia Action Alliance.

They all signed up to a National Dementia Declaration. This was created in partnership with people with dementia and their carers, the Declaration explains the huge challenges presented to our society by dementia and some of the outcomes we are seeking to achieve for people with dementia and their carers. Outcomes range from ensuring people with dementia have choice and control over decisions about their lives, to feeling a valued part of family, community and civic life.

Signatories to the Declaration have published their own Action Plans setting out what they each will do to secure these outcomes and improve the quality of life of people with dementia by 2014. The Declaration aims to make the following 7 statements a reality:-

1. I have personal choice and control or influence over decisions about me
2. I know that services are designed around me and my needs
3. I have support that helps me live my life
4. I have the knowledge and know-how to get what I need
5. I live in an enabling and supportive environment where I feel valued and understood
6. I have a sense of belonging and of being a valued part of family, community and civic life
7. I know there is research going on which delivers a better life for me now and hope for the future

Organisations that have signed up to the Declaration will set out what it intends to do by 2014 (the date when the current National Dementia Strategy comes to an end) in order to deliver better quality of life for people living with dementia and their carers. Each organisation that signs the Declaration is committed to the following principles:

- Ensuring that the work they do is planned and informed by the views of people with dementia and their carers and shows evidence for this
- Being an ambassador for the National Dementia Declaration and securing commitment from partners for the second phase of the Declaration
- Reporting publicly on their progress against the plan they have set out to deliver the Dementia Declaration
- Working in partnership with other organisations to share knowledge about best

practice in dementia

- Improving understanding about dementia.

The Dilnot Report 2011

The Dilnot Commission reported on how to reform the funding system for social care.

The key proposal: a social insurance model with an excess

The centrepiece of the reform package is a proposal to share the costs of care in later life between individuals and the state, with individuals paying for their own care until they reach a 'cap', after which the state pays for their care.

An individual's lifetime contributions towards their care costs are currently potentially unlimited. Dilnot proposes capping these somewhere between £25k and £50k (Dilnot suggests £35k), after which the individual is eligible for full state support.

This is a 'limited liability' model of social insurance – whereby those of us who can afford it and who have lived long enough to accumulate wealth, are expected to pay the 'excess'. On this basis, none of us will be expected to lose all our savings and assets in order to cover the 'catastrophic' costs of sustained high-level care and support (often in residential care).

'Those who can afford it'

The report proposes an extended means test for residential (not home-based) care. In 2007. Dilnot called for the means-test threshold for residential care to be quadrupled to £100k - thereby immediately making the system feel much fairer for large swathes of home-owners in England. The combined effect of the 'cap' and the 'extended means-test' for residential care should also benefit people with lower or modest assets more. Under the current system they are liable to lose a larger proportion of their accumulated assets, should they need residential care, than most of their more affluent peers. The obvious anomaly here is that the extended means-test only applies to residential care.

'Those who have lived long enough to accumulate'

For Dilnot, there are some risks for which none of us can reasonably be expected to plan or prepare. Those are the risks we pool collectively, as a society. Hence the Dilnot report is clear that all those who enter adulthood with a care and support need should be eligible for free state support immediately, rather than being subjected to a means test. Where people develop or acquire impairment in their twenties or thirties,

the proposal is that the state pays also, on the basis that few will have had the chance to accumulate sufficient assets in this time. So, from age 40 onwards, there could be a sliding scale of liability, with the 'cap' rising each decade. In addition, and to the relief of many, universal disability benefits should continue.

From principles to practicalities

The report sets out a wide range of recommendations about the practicalities of implementing the proposed funding system. Here are some of the key points.

1. This will be a nationwide system, with a national framework for assessments and eligibility, and a degree of portability. This is not only welcome – it is essential; there really is no other way to deliver sensible and sustainable funding reform on this scale.

2. This model has the potential to encourage more investment in low-level or preventative support and services, as long as the meter is set running at a low enough level to include the sort of care and support that older people need with e.g. getting out and about, shopping or cleaning, or basic telecare). A rebranded but otherwise intact Attendance Allowance will obviously also play a key role in enabling people to access low-level support in later life. The Dilnot Commission recommends that, until the current assessment system is replaced, the threshold should, at a minimum, be set at 'substantial'.

3. How spending levels are set (pre-cap by the individual and post-cap by the state) will be calculated based on how much the state would expect to pay to meet needs at the assessed level. Dilnot also proposes that people should contribute a standard amount to cover their general living costs in residential care (like food and accommodation, around £7–10k per year). People with the means can choose to pay more, but in the knowledge that any 'top-up' payments won't count towards the 'cap' and won't be funded by the state once they are eligible for full state support.

4. How people meet the costs of their contribution can and will vary within and across generations, and will change over time – including drawing down equity from their property, purchasing insurance, unlocking pension funds. There is real potential here for the financial services to work together with older people, disabled people and others to develop products that work well for people as well as being commercially viable.

5. How people understand and navigate the system will clearly be a 'make or break' for this system. People generally know and understand little about social care. That has to change, and Dilnot is clear on this: a) an awareness campaign, and b) an endorsement of the Law Commission's proposed duty on local authorities to provide a universal entitlement to access information, advice and assistance, irrespective of whether or how you pay for care.

6. The Dilnot Commission's report highlights the importance of family and informal carers – and recommends that carers should be supported by improved assessments to ensure the impact on the carer is manageable and sustainable,

The Francis Report February 2013

This was a report into failings at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. These may have led to the deaths of hundreds of people. The report followed a public enquiry 2010 - 2011

Key recommendations from the report include:

1) The introduction of a new statutory 'Duty of Candour' requiring all NHS staff and directors to be open and honest when mistakes happen. If implemented, this will this will place a legal obligation on health service provider organisations and individual practitioners to be honest, open and truthful in all their dealings with patients and the public. The report states that provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.

2) The establishment of a single regulator for financial and care quality dealing with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.

3) More powers to suspend or prosecute boards and individuals should standards of care not be maintained. Breach should result in regulatory consequences, attributable to an organisation in the case of a system failure, and in individual accountability where individual professionals are responsible. There should be criminal liability where serious harm or death has resulted to a patient due to a breach of the fundamental standards, that the report proposed should be introduced.

4) Banning gagging clauses or non-disparagement clauses as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

5) Only registered people should care for patients. A registration system should be created under which no unregistered person should be permitted to provide direct physical care to patients in a hospital or care home setting. The system should apply to healthcare support workers. This approach is applicable to all patients but requires special attention for the elderly.

6) Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.

7) Directors should be subject to a new fit and proper person test. Such a test should include a requirement to comply with a prescribed code of conduct for directors.

8) Complaints should be published on hospital websites alongside the trust's response.

9) GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services.

10) Local authorities should be required to pass over the centrally provided funds allocated to its local Healthwatch, while requiring the latter to account to it for its stewardship of the money.

Commissioning

- Commissioners of services must ensure that those services are well provided and are provided safely.
- The minimum standards set by the CQC should not be the standard for contracting for services.
- Commissioners should aim to set standards over and above the minimum and should tackle non-compliance with these contracted standards.
- Commissioners should be the drivers for improvement in services.
- Resources are needed to adequately scrutinise the standard of services and CCGs should have the capacity to undertake audits, inspections and investigations, of individual and group cases.
- Commissioners should have powers of intervention where services are being provided which do not accord with their contracts.
- Commissioners should also consult others, as they deem necessary, including GPs and procurement expertise, to improve their commissioning arrangements.

Culture throughout the NHS

- The report asserts that the NHS and all who work for it must adopt and

demonstrate a shared culture in which the patient is the priority in everything done. It suggests that this requires:

- A common set of core values and standards shared throughout the system;
- Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff in putting into practice these values and standards;
- A system which recognises and applies the values of transparency, honesty and candour;
- Freely available, useful, reliable and full information on attainment of the values and standards;
- A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.

The government currently has 7 main policies covering social care. They are:-

1. Making sure health and social care services work together. Committed to making integrated care and support the norm over the next 5 years. Removing barriers to integration, setting out how to use existing structures for integration. Publishing a definition of integrated care. Supporting areas to be pioneers to develop innovative approaches to integration.
2. Improving care for people with dementia. Aim to increase diagnosis rates, get doctors to give information about memory services to 65 – 74 year olds and refer for assessment if needed, launch need toolkit for GPs. Get every hospital to commit to being dementia friendly. Ask care homes to sign up to Dementia Care and Support Compact. Dementia training resources provided. National Dementia Strategy 2009 set new standards for dementia care. Use of anti-psychotic drugs much reduced.
3. Helping carers to stay healthy. Help and government funding to identify carers. Training GPs to better understand carers' needs. Simplify carers assessments. Give carers a legal right to support they are eligible for. Give carers good quality information. Give breaks to carers.
4. Treating patients and service users with respect, dignity and compassion. Put people first in decisions about care. Treat people with compassion. Quality of care as important as quality of treatment. Personal health budgets introduced. Give information about health and social care services to help informed choices. Includes 'provider quality profiles' telling people about the training and qualifications of staff in social care services. Skills for Care and Skills for Health developing minimum training standards and a code of conduct for care workers – to stress importance of dignity and respect. Make it easier for staff to report concerns. Measure success through National Patient Survey Programme and NHS Outcomes Framework.
5. Making mental health services more effective and accessible. Make public services see mental health on a par with physical health in planning. Make access to mental health services better and waiting times shorter. Make reducing mental health problems a priority for Public Health England. Mental health to be part of the new national measure of wellbeing. Change how we track success in mental health to measure the things that most matter to people. Local health and wellbeing boards given responsibility to reduce health inequalities in their area, including in mental

health. National liaison and diversion service to identify offenders' mental health issues and ensure they get the right treatment.

6. Helping people make informed choices about health and social care. Give people more choice and control in health and social care. More information available. More consistent and better information about social care (as set out in 2012 White Paper 'Caring for our Future') Government is working with local authorities to encourage a wider range of organisations to offer social care services; and with social care providers, service users, and ADASS.to ensure councils have skills to identify the right services for people.
7. Improving quality of life for people with long-term conditions. Want people with long term conditions to live healthily and independently. Help people get skills to manage their own health. Agree a care plan based on their needs. Better co-ordination of care. More use of telecare and telehealth.

Other social care policies on the government's current list include:-

- Simplifying the welfare system and making sure work pays.
- Creating a fairer and more equal society.
- Helping to reduce poverty and improve social justice.
- Helping troubled families turn their lives around.
- Improving opportunities for older people.
- Helping people to find and stay in work.
- Making it easier to set up and run a charity, social enterprise, or voluntary organisation.
- Giving communities more power in planning local development.
- Giving people more power over what happens in their neighbourhood.
- Making local councils more transparent and accountable to local people.
- Giving local authorities more control over how they spend public money in their area

Social Care Legislation and Policy List

(those not in detail above)

Human Rights Act 1998

United Nations Convention on Disability Rights 2006 (UK ratified this 2009)

Mental Capacity Act 2005 and Mental Capacity Act Code of Practice 2007

Mental Health Act 1983 & Mental Health Act Code of Practice revised 2008

Mental health and social exclusion 2004

National service framework for mental health: modern standards and service models for mental health 1999

Data Protection Act 1998 & Protection and use of patient information 2000

Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own 2008

Common assessment framework for adults 2010

The Common Assessment Framework for Adults (CAFA) is a Department of Health funded project, which tests and evaluates innovative approaches for effective information sharing, aimed to improve the lives of individuals, families and carers. Ran March 2010 – March 2012. Cheshire East was one of 4 pilot sites.

Dignity in Care resources 2010

Equality Impact Assessment 2008

Improving the life chances of disabled people 2005

Living well with dementia: a national dementia strategy 2009

National Service Framework for older people and system reform 2001

No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse 2000

Safeguarding adults protocol and guidance 2009

Single assessment Process (modified 2007)

Putting People First 2007

The Local Authority Social Services and National Health Service complaints (England) regulations 2009

The NHS continuing healthcare (responsibilities) directions 2009

Transition: moving on well. A good practice guide for health professionals and their partners on transition planning for young people with complex health needs or a disability 2008

The Adult Social Care Outcomes Framework 2013/14

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The Joint Health and Wellbeing Strategy for the Population of Cheshire East 2014 - 2016

The Joint Health and Wellbeing Strategy for the Population of Cheshire East (2014 – 2016)

A Message from Councillor Janet Clowes, Chair of the Health and Wellbeing Board, Dr Paul Bowen, Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group, Dr Andrew Wilson, Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group and Dr Heather Grimbaldeston, Director of Public Health.

This is a refreshed version of the Joint Health and Wellbeing Strategy for Cheshire East. We have reviewed the priorities identified in the first edition, published in March 2013, against the Joint Strategic Needs Assessment and established that fundamentally those priorities remain the same. However we have made a few changes: specifically referencing 'Social Isolation and Loneliness' which we have identified as a significant issue amongst our older population; emphasising the need to focus upon the physical health needs of those with serious mental illness and targeting interventions to reduce childhood obesity.

This document represents a commitment by the NHS and the Local Authority to work in partnership to tackle the complex, difficult and inequitable health and wellbeing issues together.

The Government's Health and Social Care Act (2012) has set out the requirement for the establishment of Health and Wellbeing Boards and Joint Health and Wellbeing Strategies in each local authority area.

The Health and Wellbeing Strategy provides an overarching framework that will influence the commissioning plans of the local NHS, the Council, and other organisations in Cheshire East. It will be a driver for change, focussing upon those key areas that will make a real impact upon improving the health and wellbeing of all our communities.

Our vision is that the

Cheshire East Health & Wellbeing Board will work together to make a positive difference to people's lives through a partnership that understands and responds to the needs of the population now and in the future. The board will do this by:

- ***Engaging effectively with the public.***
- ***Enabling people to be happier, healthier, and independent for longer.***
- ***Supporting people to take personal responsibility and make good lifestyle choices.***
- ***Demonstrating improved outcomes within a broad vision of health and wellbeing.***

A Delivery Plan will be developed to prioritise the actions necessary to make a difference and achieve our outcomes. This will include engagement with a wide range of partners who have expressed support for the Strategy and a commitment to working with the Health and Wellbeing Board.

Councillor Janet Clowes - Chair of the Health and Wellbeing Board
Dr Paul Bowen – Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group
Dr Andrew Wilson – Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group
Dr Heather Grimbaldeston – Director of Public Health

Context

There are two Clinical Commissioning Groups in Cheshire East, the NHS Eastern Cheshire Clinical Commissioning Group and the NHS South Cheshire Clinical Commissioning Group (CCGs). These CCGs took over the control of the local NHS from the Primary Care Trust in April 2013. Representatives from these two organisations, together with Councillors, the Director of Public Health and senior managers from Cheshire East Council and a patient representative (from Healthwatch), form the core membership of the Health and Wellbeing Board. NHS England, commissioners of Primary Care services, are also represented.

In considering the strategic priorities for the area the Board has considered four key documents:

- **'Ambition for All' Cheshire East's Sustainable Community Strategy *2010 - 2025***
  Visit www.cheshireeast.gov.uk and search for 'Sustainable Community Strategy'.

- **'Living Well for Longer' The Annual Report of the Director of Public Health 2012-2013**
  Visit www.cheshireeast.gov.uk and search for Annual Public Health report 2013

- **The NHS Eastern Cheshire Clinical Commissioning Group 2014-2016 Operational Plan**
  Visit www.easterncheshireccg.nhs.uk and search for 'Annual Plan'.

- **The NHS South Cheshire Clinical Commissioning Group Operational Plan 2014-2016**
  Visit www.southcheshireccg.nhs.uk and search for 'Annual Plan'.

These are all informed by and underpinned through the evidence of the **Joint Strategic Needs Assessment** which itself has been refreshed during the course of 2013.

Through the Health and Wellbeing Board, representatives from health, public health, the Council and Local Healthwatch (representing Cheshire East residents), have committed, through this document and future Joint Health and Wellbeing Strategies to work more closely together, with a common focus of ensuring that services are jointly tailored to meet the needs of our residents. Over the last year this work has progressed well with a successful bid (with the Cheshire West and Chester Health and Wellbeing Board) to the Department of Health to become an 'Integrated Care Pioneer', demonstrating their recognition of our effective joint working and the future plans to integrate services. The two CCGS have continued to drive their individual integration programmes with the Council as an active partner in both.

Meaningful engagement with our communities, patients and carers will inform all that we do and we will commission to improve health and health/social care for our local populations and to lead the integration agenda around the needs of individuals.

Our Population and Place

In general, all partners recognise that the health and wellbeing of the residents of Cheshire East is good. However there are still very significant challenges that need to be addressed.

Amongst these are:

- Reducing the number of people leading unhealthy lifestyles;
- preparing for an increasingly ageing population (by 2029 the numbers of people aged 65 or over will increase by more than 50% to 108,000 and those aged 85 or over will more than double to 20,000);

- Improving the mental health and emotional wellbeing of residents;

- Addressing some stark differences across Cheshire East (for example a difference in life expectancy which at its worst sees a gap of 8 years for men and 9 years for women depending on which area you live in Cheshire East).

There is good practice to build upon to tackle these challenges with high quality general practice, effective NHS / local authority joint working and innovative Council led projects already in place. But we recognise that more needs to be done and the Board, through the Strategy will drive improvement in health and wellbeing.

The Joint Health and Wellbeing Strategy is an evolving document, responding to the changes that occur through these new ways of working and to new challenges that we may face in the future, the priorities will modify over time. This refreshed version follows a review of the priorities within the 2013 - 2014 Strategy against the Joint Strategic Needs Assessment and the Annual Report of the Director of Public Health 2012 – 2013.

Every community in Cheshire East is different and local solutions will reflect local challenges. But our action will be united around the four shared commitments from our **Pioneer vision**:

Integrated communities: Individuals will be enabled to live healthier and happier lives in their communities with minimal support. This will result from a mindset that focuses on people's capabilities rather than deficits; a joint approach to community capacity building that tackles social isolation; the extension of personalisation and assistive technology; and a public health approach that addresses the root causes of disadvantage.

Integrated case management: individuals with complex needs – including older people with longer term conditions, complex families and those with mental illness will access services through a single point and benefit from their needs being managed and co-ordinated through a multi-agency team of professionals working to a single assessment, a single care plan and a single key worker.

Integrated commissioning: People with complex needs will have access to services that have a proven track record of reducing the need for longer term care. This will be enabled by investing as a partnership at real scale in interventions such as intermediate care, reablement, mental health services, drug and alcohol support and housing with support options.

Integrated enablers: We will ensure that our plans are enabled by a joint approach to information sharing, a new funding and contracting model that shifts resources from acute and residential care to community based support, a joint performance framework and a joint approach to workforce development.

We recognise that the current position of rising demand and reducing resources make the status quo untenable. Integration is at the heart of our response to ensure people and communities have access to the care and support they need. Prevention to support people from needing health or care interventions will be a priority as will addressing the wider determinants of health that are significant contributors to ill health.

Our Principles

Equality and fairness – Provision of services meet need, reduce health outcome variations, and are targeted to areas which need them the most. **Proportionate universalism** will be a key tenet – the idea that health inequalities can be reduced across a community through universal action, but with a scale and intensity that is proportionate to the level of disadvantage.

Accessibility – services are accessible to all, with factors including geography, opening hours and access for disabled people and other vulnerable groups considered.

Integration – To jointly commission services that fit around the needs of residents and patients, encouraging providers to collaborate to create integrated services where appropriate. This will maximise the benefits of delivery through the Health and Wellbeing Board.

Quality – The strategy is based on sound evidence and reasoning, and focuses on quality, within our resources

Sustainability – Services are developed and delivered considering environmental sustainability and financial viability.

Safeguarding – services and staff prioritise keeping vulnerable people of all ages safe. There will be proactive and effective relationships with the Safeguarding Children and Adults Boards.

Our Priorities

What we want to achieve for 2014-2015	What we need to focus on
Outcome one - Starting and developing well… *Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive.*	Children and young people feel and are kept safe Children and young people experience good emotional and mental health and wellbeing - Reduce the levels of alcohol use / misuse by Children and Young People - Reduce the numbers of children and young people self harming. Children and young people who are disabled or who have identified special education needs have their aspirations and hopes met Targeted prevention interventions to reduce children and young people's obesity[1]
Outcome two - Working and living well… *Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough.*	Reducing the incidence of alcohol related harm. Reducing the incidence of cancer. Reducing the incidence of cardiovascular disease. Ensuring the health and wellbeing of carers to enable them to carry out their caring role Better meeting the needs of those with mental health issues, in particular to focus upon

[1] Following a review of obesity levels in children and young people during 2013, it has been identified that although Cheshire East overall is below the national average, there are some parts of the Borough where rates are significantly higher than that average. This is where activity will be targeted.

	improving the physical health of people with serious mental illness[2]. Seven day care services provision
Outcome three - Ageing well… *Enabling older people to live healthier and more active lives for longer:*	Improving the co-ordination of care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness).[3] Providing high quality palliative care service Supporting older people, their families and carers, to prepare for the rest of their lives.

It should be noted that some of the areas of focus will apply across more than one priority outcome, for example reducing social isolation and loneliness may be as applicable to some children and young people and as to older people. The Board will ensure that where this is the case appropriate actions will be put in place.

It must be emphasised that the constituent organisations of the Health and Wellbeing board will also be working themselves on other areas that they have identified as key to supporting improvements in health / health and social care.

Conclusion

The Health and Wellbeing Board is committed to ensuring that the NHS and Cheshire East Council (including Public Health) work together on areas of shared need, as expressed through this Health and Wellbeing Strategy.

[2] The Director of Public Health's report 2012 – 2013 has identified that Cheshire East has one of the highest excess mortality rates for adults under 75 with a serious mental illness.
[3] The Board has recognised the impact upon health and wellbeing of loneliness and social isolation (Holt-Lunstad et al, 2010 Social Relationships and Mortality Risk: A Meta-analytic Review) and with the growing older population of the area identified this as a new priority.

Annex One
Partner Priorities

Partner organisation	What we will do
CEC Adult Social Services	1. To have available information, advice and signposting to enable people to access information about staying well (prevention) and where to get the right help if they need it (early intervention). 2. To develop community services across all sectors to ensure care can be provided at home wherever possible (reduce admission to residential care and avoidable visits to A&E and hospital) 3. To reduce social isolation and loneliness and ensure support is available to promote social inclusion 4. To ensure that all services and organisations in Cheshire both universal and targeted understand their obligation to ensure their services safeguard those adults who may be more vulnerable 5. To ensure that people with dementia are supported to live safely in the community 6. To ensure a range of accessible community activities are available for people to stay fit and health both physically and mentally 7. To ensure a range of accessible services and support for people who take on a caring role to maintain their health and well being 8. To ensure our services are developed to provide joined up care from health and social care services 9. To ensure that people feel safe in their communities to allow them to fully access all the community has to offer 10. To ensure that people in rural communities can access the same types of support , services and activities as those in more urban areas 11. To ensure that support is available to help people gain and maintain stable employment 12. To ensure that support is available to help people secure and maintain stable accommodation
CEC Children's Services	1. Helping families earlier when problems arise 2. Improved identification of children at risk of sexual exploitation 3. Increasing the awareness amongst professionals and the public of the identification of child sexual exploitation. 4. Improving assessment of risk to children and young people including family history, especially in families where there is a history of alcohol misuse. 5. Reducing the risk in key areas such as children living in homes where domestic abuse is present. 6. Improving access to timely support for families with mental health issues. 7. Improved resilience of young people with a range of problem solving skills 8. Improving understanding of self-harming behaviour in children and young people and support services to develop skills and approaches 9. Improving access to a range of evidence based psychological

	therapies across the pathway of provision, and children and young people known to be at risk are identified and supported early 10 Improving the percentages of young people aged over 16 in drug treatment services who receive a treatment outcome profile (TOPS) assessment 11. Supporting young people to develop a range of problem solving skills and techniques 12. Supporting young people to make positive choices in respect of risk taking behaviour through awareness, information and access to services 13. Introducing a more streamlined integrated assessment process across education, health and care for children and young people with special educational needs/disabilities. 14. Introducing the new 0-25 Education, Health and Care Plan. 15. Publishing a clear and transparent local offer of services for children with disabilities. 16. Introducing personal budgets. 17. Better preparing children with disabilities for adulthood. 18. Tackling inequalities in low birth weight in order improve health outcomes in childhood and adulthood 19. Targeting approaches to young people who are or are at greater risk of not engaging in education, employment or training (NEET) 20. Continue to target the Family Nurse Partnership programme to support the most vulnerable new parents. 21. Increase the uptake of free early education for two year olds in deprived areas. 22. Narrowing the gap in educational attainment between children and young people from different socio economic backgrounds
Eastern CCG Starting & Developing Well	• Improving transition from children's to adult services – initially focussing on CAMHS 16-19 service • Empowered Children, Empowered Parents – looking into resources that encourage self-management • Monitor the progress of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) pilot • Continuing to develop the Joint Early Years and Early Help Commissioning Strategies with Public Health, NHS England, South Cheshire CCG and East Cheshire Council • Implement redesigned neuro-developmental pathways • Developing CCG capability to meet statutory responsibilities for children with Special Educational Needs
Working and living well	• Development of services to deliver "24-7" access to care • Implementation of proactive systems to identify and recall patients with serious mental illness or learning disabilities for health checks • Improved access to primary mental health services, including IAPT (Improving Access to Psychological Therapies) • Improving a range of clinical pathways and services through application of best practice evidence. This includes application of NICE guidance and working with the Academic Health Science Network

	• Redesign of ENT, Upper GI, Urology, Gynaecology and Hepatobiliary pathways
Ageing well	• Developing the Caring Together Model with "early implementation schemes" developed around wider Primary Care Services. This includes stratifying high risk patients, proactive multidisciplinary case management, sharing of relevant information through patient passports and shared records • Development of a quality framework for care homes. Expansion of the care home doctors service and development of multidisciplinary support. • A range of quality improvement projects including reducing the prevalence healthcare acquired infection of falls, pressure sores and medication errors • Developing ambulatory care services and urgent response services in order to support caring for patients closer to home rather than in a hospital setting. This includes ambulance pathfinder, urgent primary care access and • Development of dementia services and promotion of dementia friendly communities • Further development of end of life care services • Enhancement of the range of support and services available for Carers in our community • Continued development of stroke care. The CCG is engaged in the expansion of the Greater Manchester Acute Stroke Model, development of community rehabilitation and early supported discharge from hospital
NHS South Cheshire CCG **Starting Well**	• To reduce the overall number of avoidable Paediatric 'short stay' admissions and develop alternative pathway to hospital admission when appropriate. • Improved self-management, reduction in avoidable admissions/ LOS for children with LTC including use of inhalers. • Reduction in time spent in hospital by children and young people with Long Term Conditions • Implement redesigned neuro-developmental pathways • Continuing to develop the Joint Early Years and Early Help Commissioning Strategies with Public Health, NHS England, Eastern Cheshire CCG and East Cheshire Council • Developing CCG capability to meet statutory responsibilities for children with Special Educational Needs • Improving transition from children's to adult services – initially focussing on CAMHS service • Early identification of mental health problems and prevention of further ill health (mental and physical) for mother and baby ('Parity of Esteem') to reduce risks of poor mental health.
NHS South Cheshire CCG **Living Well**	• To introduce Extended Practice Teams in order to improve care for adults with one or more long-term conditions/ complex needs by treating efficiently within community setting in order to reduce fragmentation, duplication and communications between healthcare services.

	• To reduce the proportion of cancers that are diagnosed following an emergency presentation by 3% over three years. • To improve mortality rates for those with learning disabilities. • To commission a specialist community based stroke and rehabilitation services in order to improve outcomes for stroke survivors and their families. • Supported self-management of people with long term conditions including shared risk profiling for early detection. • Reduction in emergency admissions from baseline by 3% by 2015 • To increase in the proportion of people who feel supported to manage their long-term conditions(s) from baseline by 6.2% by 2015 • Development of services to deliver "24-7" access to care • To improve access to primary mental health services, including IAPT (Improving Access to Psychological Therapies)
NHS South Cheshire CCG **Ageing Well**	• Increase in the proportion of older people (65 yrs. and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services from baseline by 6% by 2015 • Reduction in the number of injuries due to falls from baseline by 2% by 2015 • To ensure the configuration and capacity of memory services is sustainable in the context of the rise in numbers with the condition. • To detect and diagnose dementia earlier and ensure appropriate support services are available. • To ensure there is sufficient and appropriate bed capacity for intermediate and transitional care services. • To develop and implement an integrated urgent care system across health and social care that is both responsive to patient need and delivers quality care in the most suitable setting. • To support the reduction in the number of direct admissions to long-term care from acute care from baseline by 2% by 2015 • Reduction in delayed transfer of care including those attributable to social care from baseline by 4% by 2015

Annex Two
Key Performance Indicators

What we want to achieve…	What we need to focus on	Proposed KPIs
Outcome one - Starting and developing well…	Children and young people feel and are kept safe	The % of cases taking 45 days or less from the start of the combined assessment Percentage of children and young people participating in their child protection plan % of children and young people who self report that they feel safe The number of children in households with reported repeat incidence of domestic abuse Number of children killed or seriously injured in road traffic accidents
	Children and young people experience good emotional and mental health and wellbeing	Number of children and young people accessing tier 2 CAMHS Number of children and young people accessing tier 3 CAMHS
	- Reduce the levels of alcohol use / misuse by Children and Young People	Number of hospital admissions for alcohol misuse for under 18s
	- Reduce the numbers of children and young people self harming.	Number of A&E attendances age 0-19 with deliberate self harm diagnosis or complaint (confirm with Guy Hayhurst)
	Children and young people who are disabled or who have identified special education needs have their aspirations and hopes met	The % of children and young people with a statement achieving 5 A*-Cs (including English and Maths) Number of young people accessing personal budgets (from Sept 2014) Number of learners with learning difficulties and/or disabilities (LLDD) in employment, education and training (EET)
	Targeted prevention interventions to reduce children and young people's obesity	Excess weight in 4-5 year olds Excess weight in 10-11 year olds

		% of pupils achieving a good level of development across the Early Years Foundation Stage Profile % of good and outstanding early years settings Achievement gap at KS4 between the lowest 20% and the rest Number of multi-agency early help assessments/CAFs per 10,000 population
Outcome two - Working and living well…	Reducing the incidence of alcohol related harm.	**To be agreed**
	Reducing the incidence of cancer.	**To be agreed**
	Reducing the incidence of cardiovascular disease.	**To be agreed**
	Ensuring the health and wellbeing of carers to enable them to carry out their caring role	• ASCOF 1D: Carer-reported quality of life (score out of 12) – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • ASCOF 3B: Overall satisfaction of carers with social services – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • Carers receiving needs assessment or review and a specific carer's service, or advice and information • Number of completed Carers Assessments
	Better meeting the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness	• Number of Mental Health service users receiving self-directed support as a proportion of Mental Health service users who would benefit from self-directed support – *N.B. This would be a disaggregation of an existing measure. This disaggregation is not currently routinely produced but data is available*

	Seven day care services provision	**To be agreed**
Outcome three - Ageing well…	Improving the co-ordination of care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness).	• ASCOF 1I (Disaggregation): Proportion of people who use services and their carers, who reported that they had as much social contact as they would like. *N.B. This is a new measure from 13/14. This is taken from an annual survey.* • ASCOF 2A: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services • ASCOF 3A (Disaggregation): Overall satisfaction of people who use services with their care and support – *N.B. This is taken from an annual survey.*
	Providing high quality palliative care service	**To be agreed**
	Supporting older people, their families and carers, to prepare for the rest of their lives.	**To be agreed**

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Overview of Cheshire East Joint Strategic Needs Assessment 2013

PH Outcomes, NHS Outcomes, Adult Social Care, East and South CCG Outcomes

	Worst quarter in the country	2nd Worst in the country	2nd Best in the country	Best quarter in the country
Improving the wider determinants of health	Adults LD housing Killed on roads	Violent crime admissions	NEET Adult MH housing Outdoor space	Pupil absence Temporary housing Youth justice Homelessness Reoffending Affected by noise Violent offences Children in poverty
Health improvement	Drug treatment Fall injury over-65	Wellbeing LAC Breastfeeding initiation Recorded diabetes Breastfeeding continuation Smoking at delivery	Teenage conception Health Check take up	Cervical screening Low birth weight Breast screening Low worth Adult smoking Overweight 4/5 Happiness Anxiety Overweight 10/11 Diabetic eye screening
Health protection		Chlamydia	Late stage HIV MMR age 2 Board plans	% deaths due to air pollution Flu jabs at risk Flu jabs 65+
Healthcare public health and preventing premature mortality	Excess death <75 serious MH Cardiac rehab 30-day death from stroke 30-day death from stroke Cardiac rehab Stroke /kidney disease in diabetics Stroke /kidney disease in diabetics Emergency liver (alcohol) admissions Potential YLL health care males Emergency readmission <30 days	Potential YLL health care males Potential YLL health care females Preventable sight loss certifications Preventable sight loss diabetic CVD death <75 <75 respiratory deaths <75 cancer deaths Life Exp at 75 f Life Exp at 75 m <75 liver deaths <75 liver deaths Emergency liver (alcohol) admissions	Suicide Hip fractures 65+ Preventable liver <75 deaths Preventable cancer <75 deaths Infant mortality Preventable sight loss AMD <75 liver deaths <75 respiratory deaths Preventable resp <75 deaths Potential YLL health care females Ambulatory admissions Ambulatory admissions Employment LTC Employment MH LD in paid work Social care quality life MH living indep with or without support	Preventable CVD <75 deaths Communicable dis deaths <75 respiratory deaths CVD death <75 <75 cancer deaths Neo deaths/ still births HPV 12/13 CVD death <75 Preventable sight loss glaucoma <75 cancer deaths Potential YLL health care males Potential YLL health care females
Enhancing quality of life, for people with LTC also with care and support needs	LD live with family or own home	Admission <19 asthma/diab/epilepsy Admission <19 asthma/diab/epilepsy Ambulatory admissions Receive self –directed support		Service user have control over their daily life Receive direct payments MH in paid employment
Delaying and reducing the need for care and support	65+ still at home 91 days after discharge	65+ offered reablement after discharge Perm admission (18-64) to residential or NH Delayed trans to care from hosp	Perm admin (65+) to residential or NH	Delayed trans to care from hospital attributable to Adult social care
Helping people to recover from ill health or injury		Readmissions within 30 days Admission children lower URTI Admissions for acute primary care Admissions for acute primary care Unnecessary admissions Admission children lower URTI Readmissions within 30 days PROMS for elective procedures (knee)	PROMS for elective procedures (hernia) PROMS for elective procedures (hernia)	PROMS for elective procedures (hips) PROMS for elective procedures (hips) PROMS for elective procedures (knee) Emergency admission children lower URTI
Ensuring people have a positive experience of care and support			Easy to find information Satisfaction with care and support Patient experience of community MH	Patient experience of GP OOH Patient experience of GP OOH
Treating and caring in a safe environment and protecting from avoidable harm (vulnerable)		Admission of full term babies to neonatal care	People who use services feel safe	People say that services have made them feel safe and secure

May 2013

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Appendix 15

Cheshire East Council

Adult Social Care Contribution in terms of commissioning activity

to the Council's Outcome 5 – People Live Well and For Longer

as at October 2013

	Council Sub Outcome		Adult Social Care Sub Outcomes	Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
1	**Information and Advice. Having the information I need when I need it.**	1.1	I have the information and support I need to remain as independent as possible		**Information & Advice Services:** Carers Mental Health Older People Physical Disabilities Brokerage CAB Universal Service	 £70,665 £59,876 £75,000 £66,199 £139,250 £250,442	App 1	↑ Increase	↔ No Change	Retendering services for April 2013. Future developments – increased targeting including self funders - increase awareness of personalisation	CCGs/PH/ Housing/ Finance
		1.2	I have access to easy to understand information which is consistent, accurate, accessible and up to date		**Information & Advice Services:** Carers Mental Health Older People Physical Disabilities Brokerage CAB Universal Service	 See1.1 See1.1 See1.1 See1.1 See1.1 See1.1	App 1	↑ Increase	↑ Increase	-Improve coordination between departments /agencies -Improve access to information. Re-develop website. Increase use of social media.	CCGs/PH/ Housing/ Finance/ICT
		1.3	I know where to get information about what is going on in my community		**Information & Advice Services:** Carers Mental Health Older People Physical Disabilities Brokerage CAB Universal Service	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1	App 1	↑ Increase	↔ No Change	As above. -Ensure that information is targeted with a community/locality focus and is available within existing local services e.g. GP surgeries /libraries / leisure centres	CCGs/PH/ Housing/ Finance/ICT/ Community Resilience/ LAPs/Place

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		1.4	I am supported to have a voice and to be actively engaged and involved in the development of local services		**IMCA** **IMHA** **ICAS** **Brokerage** **Advocacy Services** **Healthwatch**	£74,740 £38,842 £64,037 £139,250 £75,000 Jill	App 1 App 2	↑ Increase	↑ Increase	- Invest to save to embed personalisation in Individual Commissioning so that it is the default not the exception -Invest to save to support the introduction of co-production -Invest to save to develop a RAS -Increase role of Healthwatch -Development of shared advocacy services with health	CCGs – personal health budgets/ Personal budgets PH/CCGs PH/CCGs/ Resilient Communities PH/CCGs/ CWP
2	**Active and Supportive Communities. Keeping friends, family and place**	2.1	I can access a range of community activities and services that help me to live the life I want and remain a contributing member of my community		**EIP Services:** Carers EIP Carers Breaks & Training Mental Health Physical Disabilities Older People Learning Disability Advocacy Services **Innovation Fund:** Carers Generic Learning Disability Mental Health Older People Sensory Impairment	 £66,131 £100,482 £52,875 £66,199 £67,568 £64,081 £75,000 £9,357 £9,500 £10,000 £17,175 £88,713 £8,513	App 1 App 3	↑ Increase ↑ Increase	↓ Decrease ↑ Increase	-Increase access to community based options through creative care planning -Reduce reliance on directly funded traditional care services e.g. residential/nursing placements -Pump prime community based initiatives e.g. Innovation Fund -Develop the market to respond to personal budgets	 PH/CCGs/ Resilient Communities PH/CCGs/ Resilient Communities

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		2.2	I have a network of people that support me, this could include family, friends, carers, community and if needed paid support staff		**Individual Commissioning** **Domiciliary Care** **Support for Carers:** Assessments EIP Reablement Breaks & Training **Innovation Fund:** Carers Generic Learning Disability Mental Health Older People Sensory Impairment **SP Services – Accommodation Based:** Older People Learning Disability Mental Health Single People Teenage Parents & Families Ex-Offenders & Former Drug Users **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention	 £16,489,586 £44,971 See 2.1 £73,445 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 £1,074,250 £2,676,904 £543,779 £912,822 £265,354 £151,990 £119,003 £87,183 £78,944 £225,257 £271,586	 App 4 App 3 App 5	↑ Increase	↓ Decrease	-Encourage self reliance/raise aspiration/increase opportunity -Increase access to community based options through creative care planning -Reduce reliance on directly funded traditional care services e.g. residential/nursing placements -Pump prime community based initiatives e.g. Innovation Fund -Develop the market to respond to personal budgets	Resilient communities/ personal budgets

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		2.3	I have the opportunity to train, study, work or engage in activities that match my interests, skills and abilities		**Individual Commissioning** **Brokerage** **Supported Employment Services** **Carers Breaks & Training** **SP Services – Accommodation Based:** Older People Learning Disability Mental Health Single People Teenage Parents & Families Ex-Offenders & Former Drug Users **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention **Innovation Fund:** Learning Disabilities	 See 1.4 Info from Rob See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.1	 App 1 App 6 App 1 App 5 App 3	↑ Increase	↓ Decrease	-Encourage self reliance/raise aspiration/increase opportunity -Increase access to community based options through creative care planning -Reduce reliance on directly funded traditional care services e.g. residential/nursing placements -Pump prime community based initiatives e.g. Innovation Fund -Develop the market to respond to personal budgets	Resilient communities/ personal budgets

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		2.4	I feel welcomed and included in my local community		**Supported Employment Services** **EIP Services:** Carers EIP Carers Breaks & Training Mental Health Physical Disabilities Older People Learning Disability Advocacy Services **SP Services – Accommodation Based:** Older People Learning Disability Mental Health Single People Teenage Parents & Families Ex-Offenders & Former Drug Users **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention	 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2	App 6 App 1 App 5	↑ Increase	↓ Decrease	-Encourage self reliance/raise aspiration/increase opportunity -Increase access to community based options through creative care planning -Reduce reliance on directly funded traditional care services e.g. residential/nursing placements -Pump prime community based initiatives e.g. Innovation Fund -Develop the market to respond to personal budgets	Resilient communities/ personal budgets

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
					Innovation Fund: Carers Generic Learning Disability Mental Health Older People Sensory Impairment	 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1	App 3				

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		2.5	I feel valued for the contribution that I can make to my community		**Supported Employment Services** **EIP Services:** Carers EIP Carers Breaks & Training Mental Health Physical Disabilities Older People Learning Disability Advocacy Services **SP Services – Accommodation Based:** Older People Learning Disability Mental Health Single People Teenage Parents & Families Ex-Offenders & Former Drug Users **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention **Innovation Fund:** Carers Generic Learning Disability Mental Health Older People Sensory Impairment	 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1 See 2.1	App 6 App 1 App 5 App 3	↑ Increase	↓ Decrease	-Encourage self reliance/raise aspiration/increase opportunity -Increase access to community based options through creative care planning -Reduce reliance on directly funded traditional care services e.g. residential/nursing placements -Pump prime community based initiatives e.g. Innovation Fund -Develop the market to respond to personal budgets	Resilient communities/ personal budgets

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
3	**Independence - I am supported to live an independent, healthier and more fulfilled life**	3.1	I am supported to develop skills and coping strategies to enable me to live a full and active life		**Individual Commissioning**			↑ Increase	↔ No Change	-Target health inequalities	PH/CCGs/ Place
					Support for Carers:		App 1			-Encourage self reliance/raise aspiration/increase opportunity	
					Assessments	See 2.2					
					EIP	See 2.1					
					Reablement	See 2.2					
					Breaks & Training	See 2.2					
					Information & Advice Services:		App 1			-Increase access to community based options through creative care planning	
					Carers	See 1.1					
					Mental Health	See 1.1					
					Older People	See 1.1					
					Physical Disabilities	See 1.1					
					Brokerage	See 1.1				-Reduce reliance on directly funded traditional care services e.g. residential/nursing placements	
					CAB Universal Service	See 1.1					
					EIP:						
					Mental Health		App 1				
					Physical Disabilities	See 2.1					
					Older People	See 2.1				-Pump prime community based initiatives e.g. Innovation Fund	
					Learning Disability	See 2.1					
					Advocacy Services	See 2.1					
					Innovation Fund:	See 2.1					
					Carers		App 3			-Develop the market to respond to personal budgets	
					Generic	See 2.1					
					Learning Disability	See 2.1					
					Mental Health	See 2.1					
					Older People	See 2.1					
					Sensory Impairment	See 2.1					
						See 2.1					

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
					SP Services – Accommodation Based:		App 4				
					Older People	See 2.2					
					Learning Disability	See 2.2					
					Mental Health	See 2.2					
					Single People	See 2.2					
					Teenage Parents & Families	See 2.2					
					Ex-Offenders & Former Drug Users	See 2.2					
					SP Services – Non Accommodation Based:						
					Physical Disability/ Sensory/Generic	See 2.2					
					Ex-Offenders	See 2.2					
					Drug & Alcohol	See 2.2					
					Mental Health	See 2.2					
					Resettlement & Homeless Prevention	See 2.2					
		3.2	I have access to my own home		**SP Care & Repair** **Equipment Services** **Telecare Services**	£363,340 £405,812 £220,208	App 4 App 7 App 8	↑ Increase	↑ Increase	-Influence housing strategy / planning -Influence allocations policies -Ensure timely adaptations to properties	Housing/ PH/ CCGs/Ambulance Service

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		3.3	I am supported to maintain a stable home environment		**Individual Commissioning** **Domiciliary Care** **Equipment Services** **Telecare** **SP Services – Accommodation Based:** Older People Learning Disability Mental Health Single People Teenage Parents & Families Ex-Offenders & Former Drug Users **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention	 See 2.2 See 3.2 See 3.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2	 App 4 App 7 App 8 App 5	↑ Increase	↑ Increase	-Target vulnerable groups e.g. falls prevention, winter warmth -Maximise/target tenancy support -Maximise care and repair services -Deliver effective equipment services -Deliver effective AT/Telecare services	PH Housing Housing/PH Consortium PH/CCGs
		3.4	I am supported in my role as a parent to be able to provide a safe and stable family life for my children		**SP Services – Teenage Parents & Families**	See 2.2	App 5	↑ Increase	↑ Increase		Childrens / PH/ CCGs
		3.5	I am supported in my role as a carer and have a life outside of caring		**Individual Commissioning** **Information & Advice** **Assessments** **EIP** **Reablement** **Breaks & Training** **Innovation Fund**	 See 1.1 See 2.2 See 2.1 See 2.2 See 2.1 See 2.1	 App 1 App 3	↑ Increase	↑ Increase	-Maximise impact of carer support to enable carers to continue in their caring role (far cheaper than direct provision).	PH/CCGs/ Resilient Communities

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		3.6	I am supported to plan ahead and makes choices and decisions about my future		**Individual Commissioning Information & Advice Services:**		App 1	↑ Increase	↑ Increase	-Target health inequalities/vulnerable groups	
					Carers	See 1.1				-Encourage self reliance/raise aspiration/increase opportunity	
					Mental Health	See 1.1					
					Older People	See 1.1				-Increase access to community based options through creative care planning	
					Physical Disabilities	See 1.1					
					CAB Universal Service					-Reduce reliance on directly funded traditional care services e.g. residential/nursing placements	
					IMCA						
					IMHA	See 1.4				-Pump prime community based initiatives e.g. Innovation Fund	
					Brokerage	See 1.4					
					Advocacy Services	See 1.4				-Develop the market to respond to personal budgets	
					SP Services – Accommodation Based:	See 1.4	App 5				
					Older People						
					Learning Disability	See 2.2					
					Mental Health	See 2.2					
					Single People	See 2.2					
					Teenage Parents & Families	See 2.2					
					Ex-Offenders & Former Drug Users	See 2.2					
					SP Services – Non Accommodation Based:						
					Physical Disability/ Sensory/Generic	See 2.2					
					Ex-Offenders						
					Drug & Alcohol	See 2.2					
					Mental Health	See 2.2					
					Resettlement & Homeless Prevention	See 2.2					
					Hospital Discharge Services	£142,826	N/A	↔ No Change	↑ Increase	-Develop alternative services which are community based and avoid residential placements	Hospital Trusts/CCGs

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		3.7	I receive care and support in my own home		**Individual Commissioning** **Domiciliary Care** **SP Services – Accommodation Based:** Older People Learning Disability Mental Health **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention	 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2	 App 4 App 5	↑ Increase	↑ Increase	-Maximise the delivery of care and support in the home. -Minimise residential/nursing placements. -Ensure effective monitoring/quality assurance /safeguarding	CCGs
		3.8	I live in a residential or nursing care home and have a positive experience of care and I am treated with dignity and respect		**Individual Commissioning** **Safeguarding** **Res/Nursing Home** **Healthwatch**	 £41,861,092 Jill	 App 9 App 2	↓ Decrease	↓ Decrease	-Development of personalised care plans -Effective contract compliance/monitoring -Providers sign up to the dignity challenge -Individuals are effectively safeguarded	

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
4	**Control - I can access services and control the services that I receive**	4.1	I can speak to people who know something about what I need and can make things happen		**Individual Commissioning Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Responsive service providers -Develop the market to respond to personal budgets	CCGs/PH/ Community Resilience
		4.2	I have help to make informed choices if I need and want it		**Individual Commissioning Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Responsive service providers -Develop the market to respond to personal budgets	CCGs/PH/ Community Resilience Finance CCGs/PH/ Community Resilience

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		4.3	I am in control of my care and support		**Individual Commissioning Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Responsive service providers -Develop the market to respond to personal budgets	CCGs/PH/ Community Resilience Finance CCGs CCGs
		4.4	I have care and support that is directed by me and responsive to my needs		**Individual Commissioning Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Responsive service providers -Develop the market to respond to personal budgets	CCGs/PH/ Community Resilience Finance CCGs CCGs

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		4.5	My support is coordinated, co-operative and works well together and I know who to contact to get things changed		**Individual Commissioning Safeguarding Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Responsive service providers -Develop the market to respond to personal budgets	CCGs/PH/ Community Resilience Finance CCGs CCGs
		4.6	I can decide the kind of services I need and when, where and how to receive it		**Individual Commissioning Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Responsive service providers -Develop the market to respond to personal budgets	CCGs/PH/ Community Resilience Finance CCGs CCGs

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		4.7	I know the amount of money available to me for care and support needs and I can determine how this is used (whether it is my own money, direct payment or council managed personal budget)		**Individual Commissioning Brokerage Advocacy Services**	See 1.1 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Responsive service providers -Develop the market to respond to personal budgets	CCGs/PH/ Community Resilience Finance CCGs CCGs
		4.8	I can get access to money quickly without having to go through over-complicated procedures		**Individual Commissioning Brokerage Advocacy Services**	See 1.1 See 1.4	App 1	↑ Increase	↑ Increase	- Improved financial process	Finance
5	**Public Protection & Safeguarding. Risk enablement - I feel in control and safe.**	5.1	I have considerate support delivered by competent people		**Individual Commissioning Safeguarding CQC Healthwatch**	Jill	App 10	↑ Increase	↑ Increase	-Person centred care management Separation of commissioning from contracts. Improved contract compliance. Development of an effective quality assurance/ safeguarding function Workforce development/training	PH/CCG PH/CCG PH/CCG

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		5.2	I can plan ahead and keep control of my life, even in a crisis.		**Individual Commissioning Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management	CCGs/PH/ Community Resilience Finance PH/CCG
		5.3	I feel safe. I can live the life I want and I am enabled to manage risks.		**Individual Commissioning Information & Advice Services:** Carers Mental Health Older People Physical Disabilities CAB Universal Service **IMCA** **IMHA** **Brokerage** **Advocacy Services**	 See 1.1 See 1.1 See 1.1 See 1.1 See 1.1 See 1.4 See 1.4 See 1.4 See 1.4	App 1	↑ Increase	↑ Increase	-Improved access to information and advice - Development of a RAS -Person centred care management - Personal budgets -Separation of commissioning from contracts. Improved contract compliance. -Development of an effective quality assurance/ safeguarding function -Workforce development/training	CCGs/PH/ Community Resilience Finance CCGs CCGs PH/CCGs/ Childrens PH/CCGs/ Childrens/ Safeguarding

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		5.4	I am protected from harm when I am unable to protect myself		**Individual Commissioning** **Safeguarding** **CQC** **Healthwatch** **SP Services – Accommodation Based:** Older People Learning Disability Mental Health Single People Teenage Parents & Families Ex-Offenders & Former Drug Users **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention	 Jill See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2	 App 10 App 2 App 5	↑ Increase	↑ Increase	-Improved access to information and advice -Person centred care management -Separation of commissioning from contracts. Improved contract compliance. -Development of an effective quality assurance/ safeguarding function -Workforce development/training -Effective advocacy services	CCGs/PH/ Community Resilience/ICT CCGs PH/CCGs/ Childrens PH/CCGs/ Childrens/ Safeguarding HR PH/CCGs/ CWP

	Council Outcomes			Priority Level	Current Services Commissioned	Annual cost of Service	Activity Levels	Projected Demand	Projected Spend	New / Alternate commissioning options	Potential for CCG/P/H Funding
		5.5	I feel that my community is a safe place to live and local people look out for me and each other.		**SP Services – Accommodation Based:** Older People Learning Disability Mental Health Single People Teenage Parents & Families Ex-Offenders & Former Drug Users **SP Services – Non Accommodation Based:** Physical Disability/ Sensory/Generic Ex-Offenders Drug & Alcohol Mental Health Resettlement & Homeless Prevention **Telecare**	 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 2.2 See 3.2	App 5 App 8	↑ Increase	↑ Increase		All statutory and community based agencies/ all residents of Cheshire East

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Appendix 11

Glossary of terms

Advocacy	The provision of independent support, helping people to speak up for themselves and ensuring their views are heard, understood and taken into account.
Clinical commissioning groups (CCG)	The bodies which will carry out local commissioning of NHS services. They are public bodies holding their meetings in public. Their members will be primary and secondary care doctors, nurse specialists, lay people and others.
Commissioner	A management role in social care or the NHS who oversees the day-to-day process of commissioning services.
Commissioning	The process of ensuring that care and health services are provided so that they meet the needs of the population.
Community Care Assessment Process	A process for assessing an individual's social care needs.
Community support groups	Organisations providing active help to help vital community organisations to develop their services to the community.
Direct payment	Budgets paid directly to people in need of social care services.
Domiciliary care	is the range of care and support services provided in peoples own home to enable them to remain independent. These services can range from a short call to assist with medication up to 24 hour live-in care.
Health and Wellbeing Board (HWB)	Statutory committees of local authorities, which lead and advise on work to improve health and reduce health inequalities among the local population. They have a performance monitoring role in relation to NHS clinical commissioning groups, public health and social care.
Healthwatch	Public and patient engagement bodes which have replaced local involvement networks (LINks); they are supported by Healthwatch England, which is part of the Care Quality Commission.
Integration	Bringing together the work of partners so that their efforts can be combined. Most commonly applied to the NHS, public health, housing and social care. However, all sectors could potentially have a role in working with people in need of care and support. Integration can avoid the disadvantages of working in silos and offers a joined-up experience to people in need of support services, such as assessment.

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Joint strategic needs assessment (JSNA)	The process and documents through which councils, the NHS, people in need of support services, communities and the voluntary sector reach and agree a comprehensive local picture of health and wellbeing needs. Development of JSNAs is the responsibility of health and wellbeing boards. Clinical commissioning groups (CCG) and the NHS national commissioning board will be required to have regard to Joint strategic needs assessment (JSNA) when developing their commissioning plans.
Pooled budgets	One of a range of options to support the integration of social care and health. While partners such as local government and the NHS can delegate some functions to each other, they may also commit a single or "pooled" budget which is separate from other budgets and is for a specific purpose, thus helping to avoid funding disputes and creating greater flexibility in the use of budgets.
Providers	Organisations which are commissioned to provide services direct to people who need them, including hospitals, mental health services, GP surgeries, social care services, etc.
Public health	"The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society." (UK Faculty of Public Health, 2010). Public health is generally thought of as being concerned with the health of the entire population, rather than the health of individuals – and therefore requiring a collective effort – and as being about prevention rather than cure.
Reablement	A range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.
Social determinants of health	The social and economic conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which themselves are influenced by policy choices.
Strategic intelligence	All the information that collectively enables judgements to be made at a strategic level. This might involve data which is processed and presented so as to become information, evidence, best practice or forecasting.
Universal services	Universal services are made available to everybody, including those who need social care and support. For example, people who are not eligible for free social services (those who are "self-funders" can access

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	advice and information on where they can find services, such as home care or residential care, for which they will pay themselves.
Wellbeing	“Feeling good and functioning” (New Economics Foundation, 2008). Creating wellbeing requires mobilisation of the widest assets to ensure community cohesion and safety.

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