DRAFT Adult Social Care Commissioning Strategy

Commissioning to meet social care needs

April 2014

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.

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

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
- 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

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. (Appendix 1 - Think Local Act Personal (TLAP) report)

- 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 excludes 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. (Appendix 1 - 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.

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. (see Appendix ? 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 coherence 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 (see Appendix 2 - Dementia 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.

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.

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.

  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.

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.

  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.

Commissioning Strategy

Introduction

Background and Aims

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

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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

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 in that new context will be the beginning of a journey of 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.

Quality informal support is needed that meets the objectives of:

encouraging the prevention of ill-health or dependency

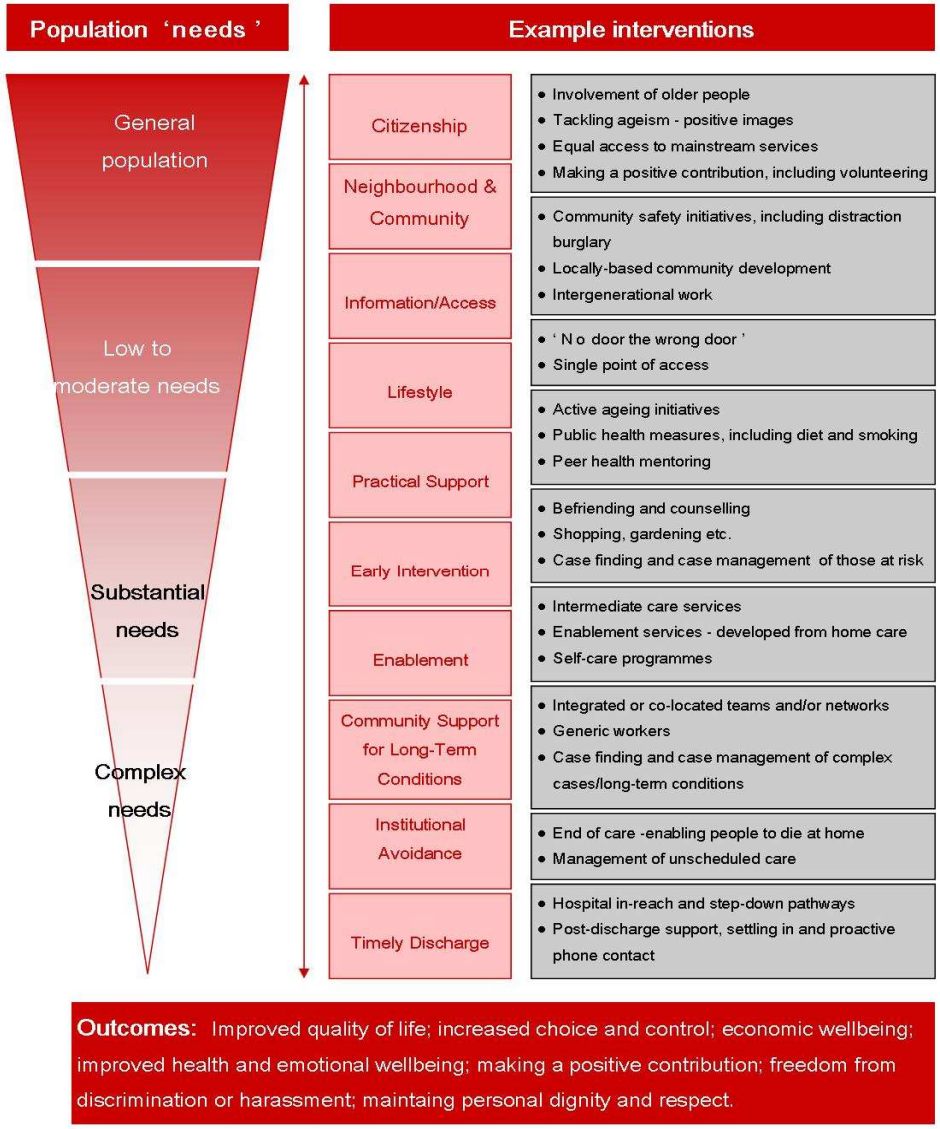
accessing early help and advice to maintain or regain health and independence

promoting self-reliance and community inclusion to increase well-being

personalisation and promoting open choice

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.



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...? Social Care Legislation and Policy 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.

Current Market Analysis and What Is Needed in Future

This section of the strategy provides a summary of the current market analysis 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....? ('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. Adult Social Care has commissioned a number of services from the independent sector that provide information and advice; these will be in place from 1st April 2014.

It is not yet easy for customers to know how to access these services. 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.

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. This is providing for a better market fit with the direction of travel and increased coherence of support.

Adult Social Care has recently commissioned a number of services from the independent sector that provide prevention and early intervention; these will be in place from 1st April 2014. These services include for example:

- 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.

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. (Appendix .... 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.

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.

What we will do in 2014/15

Closely monitor the impact of the adult social care newly commissioned services from 1st April 2014.

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

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

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. 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. The Council has already removed the domiciliary care block contract arrangements to widen the available supply. The uptake of domiciliary care has increased through the current 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:

- 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.

What we will do in 2014/15

Procure a new framework for providers of this care to widen the choice of supply and provide for developments of the range of support
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
consider the potential impact on this market's development of a need for 7 day care responses across the health and social care system
promote personalised care including flexibility, choice and control for customers

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. (Appendix 1 - 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.

What we will do in 2014/15

map the current opportunities in the community for social/recreational activities
publish a Resource Directory of all opportunities so that people can choose their preferences
stimulate informal support, working with the Council's Head of Communities and other partners

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. 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. 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. We believe the success of telecare and reablement has contributed to the reduced demand for lower level home care services.

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.

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.

The commissioning intentions driving developments are:

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

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 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 in is provided through a range of providers. 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.

The commissioning intentions driving this area are:

- 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.

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.

The commissioning intentions driving this area are:

- 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

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.

The commissioning intentions driving this area:

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

What we will do in 2014/15

create a new quality assurance service to monitor all regulated care provision
monitor 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
ensure personalised care is available within residential and nursing home settings

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:

- 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

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
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- People with Mental Health Problems
- People with Physical and Sensory Disabilities
- Carers of people with social care needs

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
- 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 coherence 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:

- 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 wrap-around 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 community wrap around and 7 day working in future.

Develop specifications for rapid response services to avoid health deterioration and possible admissions to hospital.

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

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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.

The commissioning intentions driving this area are:

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

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.

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 for social/recreational activities

publish a Resource Directory of all 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.

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.

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 social/recreational activities

publish a Resource Directory of all opportunities so that people can choose their preferences

stimulate informal support, working with the Council's Head of Communities and other partners

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.

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

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 (Appendix ? 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 (Appendix? 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.

The commissioning intentions driving this area are:

- 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.

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