HSU

STRATEGIC INNOVATION & PEER LEARNING

In housing, health, care and support

FIRST PHASE INFORMED PLANS

DH Department of Health

Housing LIN

SOUTH WEST REGIONAL IMPROVEMENT & EFFICIENCY PARTNERSHIP

directors of adass adult social services

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Introduction

The Housing Support Unit (HSU).

The Aims of the HSU

The overall aim is to support every Local Authority (LA) area to have an informed plan for achieving better housing options for older and vulnerable people. The HSU will help authorities to develop and implement strategies to:-

- Reduce the use of residential care by developing new Extra Care Housing (ECH) or other specialist housing schemes.
- Remodel and make better use of existing housing, ECH or sheltered stock, or residential homes.
- Develop core and cluster provision.
- Develop new models of housing support e.g. a "Virtual" Extra Care Housing (VECH) model by investment in Telecare and adaptations for people remaining in their own homes.

Outcomes sought:

- Informed strategies for delivering better housing options for older people in the SW.
- Increased choice, independence and wellbeing for older and vulnerable people in the SW.
- Raised awareness of the need to plan strategically for the current and future needs of the ageing population.
- Shared learning and development of best practice in delivering better housing options for older people.

Measured through:

- Number of authorities with status reports and recommendations on the way forward to deliver improved housing options for older, vulnerable people.
- Performance against national indicators measuring achievement of independence and choice in later life.
- Reduced reliance and expenditure on residential care.
- Evaluation of housing strategies across the region.

Project Outputs:

The anticipated outputs expected from the service are:

- For each local authority supported to have in place strategies and business plans for transferring resources from existing residential and nursing provision, and underused warden supported accommodation to new models of extra care and supported housing, Telecare or other identified options.
- For the overall usage of residential and nursing homes to reduce across the South West region, with a commensurate increase in the range and number of appropriate mainstream and specialist housing options and support services to meet the needs and aspirations of the region's older and vulnerable people.
- For local authorities and their strategic partners to identify and take the key steps necessary to, at the very least, develop proposals for future provision of housing and care in their area (this could include the development of an ECH scheme for example).

The HSU work plan.

The HSU steering group identified 7 target authorities to be given the maximum support available and agreed the remainder to be offered a light touch audit.

In November 2010 a team of eight Consultants were commissioned by Wiltshire Council on behalf of the HSU to support its work with local authorities.

To date the HSU has given all target authorities intensive peer support to deliver an informed plan or an alternative area of work they identified by submitting a pro-forma **(appendix C).** The remaining authorities were offered a light touch audit to ascertain where they are, in relation to their peers and where they want to be over the next 5-10 years.

This allowed the authority to undertake a gap analysis and for the HSU to gain a greater understanding of the region as a whole. The summaries of the informed plans (agreed and signed off by the project Boards of the individual LA's) and the audits can be found starting on page 21.

Use of Resources (UoR)

The South West Councils RIEP funded the Association of Directors of Adult Social Services (ADASS) South West to lead on a "Use of Resources (UoR)" project. This project has focused on four work streams:

- Re-ablement
- Voice of the customer
- Financial performance / monitoring model
- Accommodation

The HSU has been a key partner of the UoR project – the work of the HSU has supported Authorities in the South West to implement the outcomes from the UoR project – for example to plan hub and spoke models, making best use of their sheltered housing.

The regional picture

All authorities across the region are struggling to meet the challenges they face. An ageing population coupled with severe budget cuts means that a totally new rethink of how services can be delivered in the future is needed.

There is over provision of traditional residential care homes and an abundance of sheltered housing, most of which was built in the 1960's across the region.

There is under provision of specialised residential care e.g. for dementia sufferers and extra care is under developed.

Traditionally SP contracts are linked to bricks and mortar rather than needs led which has led to the majority of older people who live outside of sheltered housing not being able to access support services to maintain independent living or receive intensive support through a crisis which leads to un-necessary admission to hospital and in some cases entry into residential care.

There is inequality of costs across the region both for residential care and support services. A self-funder can and does find it very difficult to understand why his neighbour who lives in the sheltered scheme (different provider) across the road pays half of what they pay for exactly the same service. Sheltered housing costs across the region vary from £5.00 to £28.00 per week.

The same applies to residential care with even regional/national providers having different rates for each local authority.

However well the region as a whole is responding, there is slow progress towards transformation and personalisation. Long term business planning will be required to completely re-configure housing, care and support services for older people.

In early 2010 three key issues emerged which were;

- The weak relationships between District and county LA's in two tier areas around housing, health and adult care and between strategic partners in Unitary Authorities.

The HSU has developed project Boards in several LA's to bring partners together to agree a project scope to reconfigure housing care and support services. Lack of capacity in some LA's has prevented this from happening but where the project Boards have been formed issues have been identified and addressed through agreeing an integrated informed plan.

This has led to identifying better outcomes from services already commissioned and identifying options to develop new/revised services which are focussed on delivering the targets from the UoR business case for change.

- Ensuring that existing and new ECH actually delivers for Adult care around meeting user's needs/expectations, providing a more affordable option than residential care and delivering on the efficiency agenda.

The HSU has worked with a number of LA's on the contracting and commissioning of EC housing and has produced a financial modelling toolkit to aid LA's to fully understand the costs associated with EC housing.

Private sector models of developing extra care has also been produced suggesting ways in which to develop further extra care with little or no subsidy.

- Developing more options to support and maintain independence to enable people to stay in their own homes and communities for longer.

The HSU has worked across the region supporting LA's to make more effective use of their sheltered stock e.g. the hub and spoke model. Within the toolkits are two models from Cornwall and Bath & North East Somerset both of which have completed pilots of a hub and spoke model.

Through the UoR business cases LA's have predicted the rate of reduction in the use of residential care and are planning with the support of the HSU a range of accommodation options which will see a gradual move from "care land to community land" across the region.

There is a far bigger challenge than anything mentioned so far and that is the cultural change that will be needed to insure the informed plans are fully implemented.

In the summer of this year the HSU hope to hold sub-regional workshops for front line staff and for providers, Member's and commissioners on the cultural challenge aimed at winning hearts and minds.

The HSU hopes to continue to give peer support to local authorities, facilitate collaboration between LA's and work with providers and customers to identify solutions to the challenges they face.

Outputs and toolkits

All of the authorities in the South West now have an informed plan or their local equivalent. The HSU now also has ownership of the high level business case developed under the UoR accommodation work stream (5 of the 7 targeted authorities were also on the UoR accommodation work stream) which enables local authorities to evidence the cost efficiencies' in moving from what's called "care land to community land".

Over the next couple of years each local authority will need to start to implement their "informed plan". Each authority has different issues that they will need to address in order to ensure they can successfully implement their plans – this includes capacity, expertise, two tier working, partnership engagement, understanding the voice of their customers/user experience.

The HSU is a unique project offering a range of bespoke solutions and peer group learning opportunities. Providing capacity, project management, and more importantly a local "champion" to continually drive forward transformation and challenge the decision making process. The HSU also encourages and arranges local authority collaboration both to share learning and gain further efficiency savings. .At the same time, going forward the Housing LIN will maintain its strong regional network in the south West, supported by its newly rebranded and comprehensive on-line resources at www.housinglin.org.uk

During the first phase the HSU has developed a range of practical case studies and toolkits evolving from pilots and bespoke pieces of work across the region, these are;

- The Independent Living Service (ILS) pilot in Cornwall
- The Older Peoples Independent Living Services (OPILS) in Bath and North East Somerset (B&NES)
- An Integrated care & support framework (Devon)
- Pathways into Extra Care (HSU)
- A financial model for Extra Care (HSU)
- Private sector models of developing extra care (HSU)
- A light touch audit template (HSU)
- An assessment template (HSU)
- Extra care allocations and letting protocols
- An Integrated care and support contract
- A Hub and Spoke model

These toolkits are available from the South West Councils website at

http://www.swcouncils.gov.uk/nqcontent.cfm?a_id=6331&tt=swra

Summaries of the informed plans and the light touch audits can be found starting on page 19

Background

In 2007 the Housing LIN was successful in a bid for an Innovation and Good Practice Grant (IGP) from what was then the Housing Corporation.

The funding secured was used for a comprehensive overview of the Regional Housing Market for older people. The Institute of Public Care (IPC) was commissioned and in November of 2008 "Putting Older People First in the South West" (**POPFSW)** was published. The report identified a range of urgent issues facing the region to develop housing options for older vulnerable people over the next 15-20 years.

At the start of this project a 'Leadership Set' was formed to provide a high level strategic steer/guidance with regard to the final report. It was originally intended for this group to meet three times throughout the life of the project. However they continued to support the work of the SW LIN in an advisory capacity.

Context

In recent years, both local and national government has increasingly come to recognize the importance and implications of the growth in the population aged over 65. Current national policy supports two twin themes. Firstly to increase the supply of accommodation available for older people through regulation (in terms of the development of new building to lifetime homes standards); while maximizing the housing options across tenure and property types, to support independent living and access to appropriate services where needed, for example, through support for the development of extra care housing.

The second plank of policy through care (and increasingly through integrating health and social care to transform community services) is to develop the government's personalisation agenda. Supported by an inter-departmental protocol, 'Putting People First', this aims to transform social care in particular, through giving people greater choice and control over services and funding.

In the South West, there are already a higher proportion of older people than in any other English region, and that trend is only likely to continue in coming years. The growth in the oldest population will also be matched by a diminution in the proportion of people in early middle age.

"POPFSW" findings and Recommendations

POPFSW identifies a range of urgent issues facing the region to develop housing options for older, vulnerable people over the next 15-20 years:

- A major growth in the numbers and proportion of older people within the region.
- A corresponding decrease in the proportion of middle-aged people, and potential providers of care, in the population.
- Gaps in service provision for older people and an ageing, in some instances inappropriate, sheltered housing stock.
- Rural isolation and increasing costs of providing services in rural areas.
- A lack of strategic planning (Don't Stop Me Now (Audit Commission, 2008) found that South West local authorities were the least prepared in England for the ageing population).

The key recommendations of the report that are relevant for housing providers and commissioners of care and support are set out below:

- **Better strategic planning**: regional bodies need to work with commissioners, providers and older people's groups to produce a regional housing strategy on housing for an ageing society. An implementation plan is also required to inform future planning as well as advising on inward public and private sector housing capital investment and associated housing, care and support revenue requirements.
- **Enhanced market information**: local housing and social care authorities need to establish the level of need for extra care housing in each area and the appropriate balance between accommodation for rent and for sale.
- **Improved customer engagement**: appropriate mechanisms to engage with a wide variety of housing, care and support stakeholders in the region are required
- **Effective use of resources**: regional bodies need to urgently promote reviews of current sheltered housing stock and facilitate appropriate action to use this valuable asset most effectively.
- **Enabling preventive services**: local authority commissioners need to plan for the expansion of Home Improvement Agencies (HIA), Disabled Facilities Grants (DFG), Telecare and assistive technology, Warm front, information and advice.
- **Maximizing choice**: regional agencies and local housing authorities need to support an expansion of the housing options available to older people and floating support services, including for those with dementia and mental health problems
- **Managing risk and innovation**: create an environment where risks are fully explored and innovation is not stifled.

The POPFSW report has been very successful in raising awareness around planning for the needs and aspirations of an ageing population. To date though, there is a view that despite the available evidence, information and toolkits, South West authorities have not universally adopted a strategic approach to the planning and delivery of housing, care and support for older people.

In July 2009 the group met to discuss how to take forward the implementing of the recommendations of POPFSW. It was generally agreed that the region had not responded positively to the challenges laid out. As a result of this, the group attended an action planning

session on how best to ensure that all South West localities had developed an older person's integrated housing care and support strategy.

The group discussion focused on the following themes:

- Given the amount of evidence, data and reports that exist, setting out the need to develop a coherent strategy for older people's accommodation, care and support; why don't they exist in all South West Authorities?
- What are the potential barriers?
- What could we do to challenge the current situation and support current partnerships?

The group then focussed on data and evidence:

- The evidence base is there with Joint Strategic needs Assessment (JSNA), Project Older People Population Information (POPPI), Projecting Adult Needs and Service Information (PANSI), Housing Needs Analysis, Market Assessments etc.
- The evidence has been drawn into housing strategies, planning policies, sustainable community strategies to a greater or lesser degree in all localities.
- To properly influence planning policy, the Local Development Framework (LDF), providers and other stakeholders, the evidence needs to be drawn together into a strategy for housing care and support, detailing the expected demand for different types of accommodation, care and support, how the existing market will be able to provide these and the short falls/ opportunities arising.
- Additional context is provided by the current economical climate, the need to reduce dependence on residential care, the integration of health and social care and the 'Putting People First' agenda.

The group then looked at barriers, potential barriers were described as:

- Changing priorities locally.
- Relationships locally between key stakeholders.
- Availability of financial resources.
- Strategic capacity.
- Clarity about what the short, medium and longer term issues are and ownership locally.
- Nobody championing the issues and the benefits that could accrue.
- Recognition that this is more difficult in two tier areas.

As a result of the above, the Leadership Set agreed the following way forward

- Every area to have an informed plan.
- Every area to action their plans…
    - To address the efficiency agenda.
    - Innovation/risk-taking.
    - Influence the approach.
- Raise awareness of issues/challenges and promote more effective partnership working.

The Leadership Set decided that their mission statement would be for ***"every local authority area to have an informed plan*** for achieving better housing options for older people". To do this the group felt they needed to benchmark where the LA's were in terms of the above. Therefore, a market survey was commissioned.

The market survey was published in 2009 **(Appendix B)** which gave a picture in terms of the South West region. The analysis showed a disappointing picture. A perceived lack of joining-up across key agencies, no real change emerging and demographic and resource pressures adding a significant additional burden. Capacity locally to stimulate and champion change was also highlighted as a potential barrier.

In response to the above and to deliver on this ambitious vision, the Leadership Set decided that there was a need to provide structured support to local authorities across the region and recommended the formation of a HSU to accommodate this.

A core script **(Appendix A)** explaining the aims of the HSU was developed and funding sought and gained from the DoH, the REIP, JIP, and LIN.

A steering group was established to oversee/steer the work of the HSU, through this group, a Project Initiation Document (PID) was developed **(Appendix D).**

Approach

To date the activity of the Housing LIN has primarily focused around raising awareness of issues and exchanging information, best practice and learning to support change in the delivery of housing, care and support services for older people.

The Housing LIN Leadership Set, supported and jointly funded by a consortium including the Government Office for the South West, South West Councils and the Regional Improvement and Efficiency Partnership (RIEP), have looked to **actively** support the delivery of improved housing, care and support options for older people in the SW, both now and in the future by:

- Developing a Business Plan **(Core Script Appendix A)** incorporating a communications strategy, performance and success measures to ensure that future activity is focused and well understood.
- Carrying out a Market Assessment **(Appendix B)** in the SW to develop an understanding of the current activity and progress to inform;
- Developing the **HSU** - to provide practical support and assistance to authorities in developing an informed plan for achieving better housing options for older, vulnerable people.

Use of Resources Project: Overview

Background/Introduction

ADASS agreed that a key priority for Adult Care in the South West would be a regional collaboration on the Use of Resources agenda. The Joint Improvement Partnership (JIP) supported a UoR collaborative approach for Adult Care.

The project focused on the key areas outlined above.

ADASS agreed to commission external support to develop a benefits realisation model that will:

- Provide a format/proposals for each high impact issue that will highlight the required investment to deliver the proposed efficiency
- Facilitate across Local Authorities with learning and challenge for each high impact issue.
- Develop some evidence based key issues that each Local Authority should consider when developing and implementing their benefits realisation plan for each High Impact issue.

Wiltshire Council on behalf of ADASS and Government Office South West (GOSW) commissioned AMTEC-Charteris to support this benefit realisation programme. For each of the 3 High Impact issues, a number of Local Authorities volunteered to work collaboratively to develop a Benefits Realisation Plan (BRP).

UoR Accommodation Business Case – High Impact Issue

The accommodation work stream focussed on one of the three high impact areas identified as part of the region-wide, sector-led, Use of Resources initiative.

The original Use of Resources paper from the Department of Health, produced by John Bolton, identified the shift from 'Care Land' to 'Community Land' as one of the key areas of change needed. It also highlighted the relatively poor performance of local authorities in the South West in this respect. In particular, the South West performed poorly against the standard set of 40% of the budget for care of older people and 30% for people with learning difficulties being spent on institutional models of care.

The Use of Resources paper was a catalyst to scrutinising current practice in the context of challenging budgetary restrictions in the coming period, at the same time as the necessity to improve outcomes and meet rising demand caused by an ageing population, with the consequent rises in levels of illness, disability and dementia, and the rise in the population of people with learning difficulties and complex needs.

The main aim of the work stream is the production of benefits realisation plans for cashable savings and efficiencies in the areas of adult social care related to accommodation and housing-related support, for both older people and people with learning difficulties. This was to be achieved principally through the implementation of a strategic shift from institutional models of care, such as residential care homes, to more flexible and community-based housing support options.

The work focused on:

- *A business case addressing demographic and demand pressures and how to meet them.* **(See appendix F – UoR accommodation business case).**

- Analysing the demographic trends affecting adult social care in the future, quantifying (in both costs and places) the rise in the demand over the next 5-10 years and translating the impacts of the changes needed into specific business cases for change.
- This will result in each local authority having a baseline showing, for example, what a reduction of x% in long term residential care places (or sheltered housing) means in terms of alternative provision, such as increases in extra care housing or floating support.

An Implementation phase

Proposals for continuing the work of the HSU into an implementation phase are currently under active consideration. The proposals include:

- Reviewing what support can be given to Las in relation to similar issues of the high cost of residential placement for people with learning disabilities
- Support for local authorities to action their informed plans
- Engaging with front line staff and members to promote a culture shift
- Commissioning of an Older Peoples Champion for the South West
- Sharing the learning with other regions
- Support for developing partnerships between adult social care, economic regeneration, strategic housing, strategic planning and health.
- Working to educate, promote and integrate the interests and role of private developers
- Integration of the work of the HSU and the Use of Resources project.

HSU regional activity

An introduction to the local authorities

The HSU was introduced to local authorities via an introductory letter from ADASS inviting expressions of interest, involvement and sponsorship of the HSU work in their locality. The letter was followed-up by an interview with James Cawley (ADASS Lead for the HSU). The aim of this was to identify any individual support needed. Notes of these meetings were passed to Pat Palmer (The HSU Lead) for further interrogation.

From this initial work, three key themes very quickly emerged. They were:

- The weak relationship between District and County LA's in two tier areas around housing and adult care and between strategic partners in Unitary Authorities (UA's).
- Ensuring that existing and new ECH actually delivers for Adult Care around meeting user's needs/ expectations, providing a more affordable option than residential care and delivering on the efficiency agenda.
- Developing more options to support and maintain independence to enable people to stay in their own homes and communities longer – this includes issues like:
    - More effective use of sheltered housing e.g. 'hub & spoke' models.
    - Effective telecare coupled with appropriate response service.
    - VECH and individually tailored home care/support etc.
    - Include accessible 'Active Ageing Centres' in the above. Providing in-reach & out-reach services with the aim of implementing the 'Prevention Agenda' objectives.

The market analysis

(The sub-regional workshops)

To further understand the support needed locally and the potential barriers, local authorities were invited to attend a series of workshops across the region. The workshops were designed for senior staff with responsibility for leading and commissioning change, delivering efficiencies and improved outcomes across housing, health, and social care.

Each authority was asked to nominate 2/3 attendees to represent their authority with these agendas in mind. The workshops were designed to deliver positive change, so it was vital that the right people were in attendance e.g. Commissioning Leads, Heads of Strategic Housing and Transformation Leads giving the opportunity to:

- Debate the issues that concerned them
- Identify regional and local issues that need to be addressed
- Identify the barriers to success and the support needed to deliver locally

Five workshops were held during April and May 2010, with 15 authorities attending. During the workshops, each authority was asked to identify 2 or 3 key actions they needed to take forward the transformation agenda. As expected the same key themes emerged as in the introductory meetings to a greater or lesser degree across all authorities.

Key issues/barriers identified are summarised below:

- Lack of capacity/understanding to deliver new services.
- No time to think strategically.
- More resources spent on doing what's urgent than what is important.
- Huge difficulty in top-slicing budgets (generally already overspent) to pump-prime the change needed to implement new services.
- The need to work more strategically with a range of partners to deliver lower level preventative services to stop resources pouring into crisis management.
- Make better use of existing resources i.e. sheltered housing stock.
- Extra care under developed across the region

The workshops also involved collective discussions about the support needed, including both peer and external support. **(See 'South West regional collaborative workshop presentation', Appendix E).**

Armed with a more informed picture, the steering group discussed the tailored support needed to make a significant and positive change across the region.

The seven authorities considered most in need (priority or targeted authorities) were identified and it was decided that the majority of HSU resources be utilised by way of offering intensive support in these areas, this included:

- Interviews to scope the specific support required
- Agree commitment
- Plan the detailed support and funding required

Non-targeted Authorities were also supported by way of a 'Health Check' designed to baseline progress. Some Authorities requested additional support and provided the funding needed to allow this to happen.

Further targeted work from the HSU was identified through the workshop discussions and agreed as being needed by the steering group in order to deliver the following outcomes:

- Reduce expenditure on residential care by developing a range of housing options including the hub and spoke model utilizing fit-for-purpose sheltered housing stock.

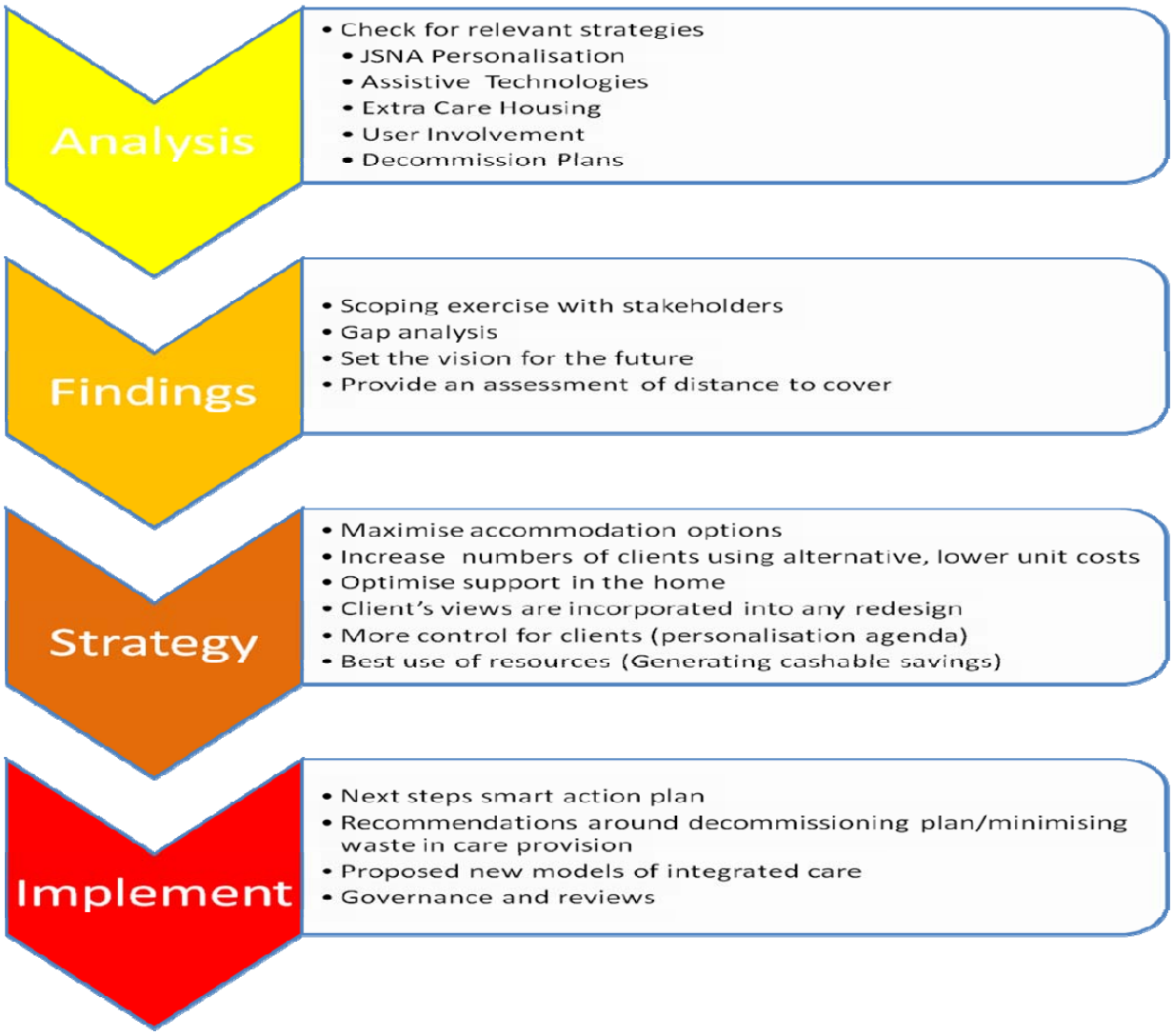
- Develop flexible, person centred contracts delivering preventative services and support during crisis (sure start model for an ageing society).
- Develop clear strategic direction with key strategic partners to strengthen outcome focused, joint commissioning especially in commissioning extra care housing.
- Fundamental work to ensure telecare coupled with a rapid response service is embedded at the heart of all new services.
- Staff and stakeholder events to 'win hearts and minds' and allow a culture change across the region from crisis to prevention.
- To work with planners and the private sector to ensure planned strategic development models that make better use of scarce resources.

In Order for the targeted LA's to tailor the specific support needed, a pro forma was developed which was used to identify and agree a brief, The LA was given options on how the work was to be commissioned and by whom. Key milestones were agreed to ensure the desired outcomes were achieved. **(See pro-forma, Appendix C).**

A moratorium on spend by South West Councils meant that all local targeted work both agreed and planned was put on hold until clarity with regard to funding was agreed. However it was decided that the HSU would continue to be financially supported. It was then decided that in order to maximise the funding available, a team of relevantly qualified experts would be commissioned to take forward the work of the HSU across the region. Each targeted LA was matched with a HSU Lead/Consultant.

The informed plan and summaries

The newly formed HSU team debated on what an informed plan should look like and include, below are the results. The team are using this as a template in each LA



The informed plan summaries – first phase

There were seven targeted authorites, of which six chose to have informed plans. The exception being South Gloucestershire, who chose to have a private sector modeling workshops. Torbay was not a targeted authority but chose to self fund, in order to receive the same support as a targeted authority, thus have an informed plan The remaining authorities received light touch audits and the results are shown in the Light Touch Audit section, along with South Gloucestershire.

HSU

STRATEGIC INNOVATION & PEER LEARNING

In housing, health, care and support

INFORMED PLANS

SUMMARIES

Bournemouth
Cornwall
Devon
Gloucestershire
North Somerset
Somerset
Torbay

DH Department of Health

Housing LIN

SOUTH WEST REGIONAL IMPROVEMENT & EFFICIENCY PARTNERSHIP

directors of adass adult social services

BOURNEMOUTH BOROUGH COUNCIL (BBC)

Development of the informed plan was overseen by a Project Board consisting of a service user/carer, senior council and health staff and voluntary and community sector representatives.

The vision for older people's housing and related services in Bournemouth is:

"Housing and services for older people will link up to provide choice, flexibility and enhanced quality of life, prolonging independence, health and community involvement. Housing and services for older people will meet current and future needs and aspirations".

What already works well in Bournemouth?

- Bournemouth's award winning "Age Friendly Bournemouth" strategy demonstrates a place based, customer focussed approach to older people's services. The Informed Plan builds upon this and is a key output of "Age Friendly Bournemouth".
- Bournemouth Borough Council has a good track record of delivering high quality and innovative services to older people in the borough.
- Bournemouth Borough Council already works well with the neighbouring Borough of Poole on many successful joint commissioning initiatives for effective health and adult social care services.
- Bournemouth Council's Housing Landlord Services provides a good service to tenants. It is the main provider of affordable housing for older people in the borough.

The key issues identified in Bournemouth were:

- There are pressing demographic issues to address, particularly in the under 65s and the over 85s and an ageing population of people with learning difficulties and their carers.
- Public expenditure is under pressure. There is a need to develop cost effective new approaches to meet these challenges to maintain positive outcomes while addressing the significant savings required from the Supporting People budget.
- People want to stay independent in their own homes for as long as possible and services need to be re-designed with this in mind.
- There is an oversupply of basic residential care bed spaces in Bournemouth.
- There is an over supply of basic Category 1 and 2 sheltered schemes in the borough; there is low demand for some of this accommodation, due to it being "non fit for purpose" in terms of location, design or modern standards. Much of this existing

accommodation however could be invested in and used more extensively to gain the most out of its location, to facilitate community outreach and to make it fit for future.

- Despite extensive efforts, older people in Bournemouth are still not aware of the many housing options and other services to enable them to remain independent.
- Bournemouth Council now needs to build upon its successes summarised above to explore how the existing housing stock and Supporting People services for older people are re- configured to be fit for the future and are in line with what older people have said they want.

Current supply of housing and enabling services in Bournemouth

- *Residential and Nursing Care information*

  A strategic review carried out by Bournemouth Council in 2006 indicated that a majority (57%) of residents in residential care were self funders and that the Borough is over supplied with this type of provision – the quality of environment and care being variable , and much of which was not purpose built. There are around 90 registered residential care homes with approximately 2200 bed spaces. Residents are relatively young – 445 being under 84 years.

- *Domiciliary Care going into sheltered schemes in Bournemouth*

  Only 214 tenants of all rented sheltered housing schemes receive a domiciliary care package having been assessed as in need (of course, many tenants may receive informal care from relatives or indeed commission their own care and assistance outside of any formal assessment and pay for this themselves).

- 1371 care hours are delivered to tenants, across 40 schemes (just under 50%). This averages as 6.4 hours per person per week and just 7% of all existing tenants in the borough.

This suggests that the majority of those living in sheltered housing stock in Bournemouth are relatively fit and healthy, and are living in such accommodation by reason of the current operation of the housing register policy, rather than because of any pressing support or care need.

Other current initiatives which can be developed further

- Support for unpaid carers, in particular the newly introduced "Home from Home" pilot scheme in conjunction with East Borough Housing Trust and Borough of Poole. Hosts are paid expenses and a nominal amount to host up to four older people for a day in their own home, usually from 10am – 3pm (but this is flexible and can cover weekends). This gives carers a break and gives those people taking part social stimulus in a non institutionalised setting. Self funders, Income benefit holders and non fairer access to charging eligible people can take part. The hosts are fully vetted and trained.
- SOURCE information website.
- OPAL re ablement hospital discharge service.
- Asset management review already under way by BBC housing landlord services to decommission unsuitable Category 1 sheltered housing.
- Assisted living innovation platform for dementia at soon to be competed BBC housing landlord Extra Care scheme in Draper Road.
- Development of single entry Hub to supported housing.
- Supporting People (SP) Pilot of a menu of support options for older people at John Pounds House Fawley Green by Sanctuary Shaftesbury.
- Choice based lettings initiatives to ensure best use of stock to those in most relevant need.
- Points based priority system for DFG applicants across all housing tenures.

Research and consultation carried out to develop the informed plan

An extensive consultation strategy was approved by the Project Board. In addition to this, two questionnaires were devised and sent out early in 2011. One was distributed via the council's established generic E-Forum, the other distributed across tenures, to carers, providers and the voluntary and community centre and during the consultation events.

Key Findings

Key findings from both surveys were very similar and are summarised below:

- Significant numbers were receiving considerable care and support packages to assist them to live independently.
- There were no discernible patterns in the areas where help was most needed,

suggesting that assistance to live independently needs to be truly flexible and personal centred to be successful.

- There seems to be a markedly lower level of independence at home after age 65.
- The vast majority of people wanted to stay where they were and to receive the appropriate and tailored support, services and advice to enable them to do so.
- Those in larger properties that are perhaps more difficult to manage show a desire to move to more suitable ordinary housing.
- Convenient access to facilities and property that is well located is important.
- Those with a disability are more likely to live alone in smaller properties.
- Some found that privately rented or owned purpose build accommodation find the costs – particularly service charges – expensive and these units can be difficult to sell for executors.
- Paradoxically, those who did foresee a change in their living arrangements were most receptive to more suitable ordinary housing or a flat in a private sheltered housing scheme to own. **(e-forum only).**
- Ensuring information and advice is easily accessible giving clear details of housing options is important and many responses indicated that they did not feel they had enough information to answer the question (***this question was added deliberately to measure this particular issue).***
- Amongst respondents there was a general lack of understanding about the options available for their future accommodation or a lack of desire to change their accommodation in the future.
- There would appear to be a small but clear "niche" market for affordable shared ownership / leasehold extra care – particularly coupled with the identified need to have clear information about all available housing options to enable informed choice;
    - 20% of respondents would consider a shared ownership scheme. (e forum).
    - 10% of respondents would consider a shared ownership scheme (questionnaire).
- 29% and 35% respectively did not feel they knew enough about the options to answer this question.
- Residential care is not the first choice of most older people with care and support needs

Over-arching strategic themes

The overarching strategic themes for the informed plan were identified as follows:

The need to develop a "whole systems" and person centred approach to housing support and care services for older people in Bournemouth by;

- *Making better use of what we already have.*
- *Improving access to information, accommodation and services for all older people.*
- *Culture change and learning.*
- *Innovation.*
- *Ensuring value for money.*

Developing effective solutions

- Older people should be viewed as a considerable resource. Their skills, experience and expertise can be harnessed in a voluntary capacity to create peer led and multi generational initiatives which will add considerable value. Using this "social capital" will improve and inform any actions as well as ensuring the voice of the customer is heard and acted upon.
- Any investment or changes to existing designated housing or models of housing related support services to enable a more targeted service in line with what older people have said they want will not take place without extensive customer and provider consultation and involvement.
- It is important not to lose the momentum and impact of the "Age Friendly Bournemouth" strategy and the recommendations in the report will assist in doing this.
- A Transformation Plan must be developed to modernise and transform existing housing and services. This will require dedicated project management resources and strong leadership to support staff and providers through the culture change needed to meet the challenges that are faced.

Specific Recommendations

- A Transformation Plan should be drawn up to start the journey to make the changes required to fulfil the vision for older people's housing and services in Bournemouth. This will build upon current initiatives such as the single entry "Hub" for supported housing services, the floating support service for memory loss and the pilot of a "menu" based approach to providing support, not just in sheltered housing but the wider community.

The plan will address culture change and should also include:

- A strategic action plan to make better use of existing specialist housing for older people in the borough should be agreed. This will include the current decommissioning programme converting low demand Category 1,2 and bedsit accommodation for use as general needs or other specialist use (as per the needs identified by Strategic Housing Services). This will also mean consulting and liaising with existing tenants to draw up plans to invest in some existing sheltered / Independent Social Landlord properties to upgrade or facilitate use for community activities for older people within the wider neighbourhood alongside existing tenants where this is appropriate, and ensure the design and facilities in the building are fit for the future;
- Access to and eligibility for the Housing Register waiting list should be reviewed to ensure those with the greatest need are prioritised to make better use of existing sheltered housing / Independent Senior Living stock and general needs properties with major adaptations;
- Policies on under occupation incentives and advantageous transfer applicants and vacancy chains should be reviewed;
- "Crisis" admissions to residential care need to be reduced by ensuring other intensive re-ablement, support and housing solutions are in place;
- The Extra Care Model needs to be introduced in both new and existing extra care schemes in the borough as soon as possible and evaluated after 12 months. It should provide a clear alternative for residential care and a corresponding reduction in placements should be identifiable;
- The proposed culturally specific (but not exclusive) affordable mixed tenure Jewish Extra care scheme should be supported;
- Bournemouth Borough Council should review its affordable housing development partners framework and should consider any registered provider that could develop such a scheme without grant – potentially on a "co-housing" basis;
- There does appear to be a small but definite market for affordable mixed tenure/shared ownership Extra Care in the borough;
- There is potential to explore further the idea of shared services and carry out more sub regional working to produce cost effective outcomes, such as further joint commissioning for specialist provision; for example, the needs of ageing ex-offenders - and operation of telecare and assisted living services;

- Telecare and Assistive Technology should be main-streamed and used more extensively and strategically to meet health and social care needs and benefit more, older people and their carers. This does not always mean the use of central control call centres. Staff across all disciplines needs to be supported to learn more about its application. Likewise a programme of awareness raising and confidence building needs to be put in place so both customers and staff understand its potential benefits;
- Whilst there is an over supply of basic residential care bed spaces in Bournemouth, there does appear to be a need for additional specialised dementia provision and Elderly Mentally Infirm (EMI) residential and nursing care provision;
- Bournemouth should also support, adopt and develop small scale but innovative schemes to address older people's housing and support needs which align to the “Big Society” concept that will harness the resources of the voluntary and community sector, neighbourhoods and older people themselves to add value;
- When developing new services the needs of all older people (including those who commission and purchase their own services to help them remain independent) and the wider community should be taken into account;
- Any new support services developed must also address the need to make savings across Supporting People services;
- A communication and information strategy is required to ensure older people are aware of services and choices available.

CORNWALL COUNTY COUNCIL

Cornwall is a relatively new unitary council and is still in the process of developing its structures, policies and strategies.

Cornwall's Sustainable Community Strategy *(Future Cornwall)* has been refreshed and, while *Future Cornwall* sets out the 2030 vision and long term objectives, it also highlights immediate priorities for the next five years:

Demographic information evidences that the population of Cornwall is not only gradually increasing but also changing demographically. In line with national trends Cornwall's population is getting older as average life expectancy continues to rise. By 2031 over one in four people will be over 65.

Average life expectancy in Cornwall continues to be generally higher than the national average, although again there are significant geographical variations; linked to deprivation and inequality. The variance for men in Cornwall is 5.4 year difference and for women it is 4.5 years.

The challenge of catering for an ageing population is recognised in various documents and plans in Cornwall. There is acknowledgement that there is a need to maintain people in their own homes and for the development of smarter housing solutions to do so. Much of the existing Sheltered Housing provision no longer meets the needs and wants of older people and needs to be reviewed.

There is acknowledgement that, with significant Supporting People budget reduction, housing related support needs to change from buildings based support to tenure neutral and focus on outcomes.

There is a move to integrated hubs for Adult Care and Support and Health to ensure coordination and improved outcomes for people in Cornwall. This needs to be further extended to incorporate housing support to deliver the preventative model.

The challenge for Cornwall is in developing a whole systems approach across statutory and voluntary sector which focuses on prevention and avoids duplication.

There is a need to work positively with partners, statutory and voluntary, to develop innovative alternative care support and accommodation solutions, reducing the need for residential care and maximising choices for older people.

Partners are engaged and keen to drive forward this agenda. It is recognised that there are difficult discussions that need to take place around funding and diversion. There is also acknowledgement, however, that integrated leadership is the key to implementation and delivering better outcomes for older people.

DEVON COUNTY COUNCIL (DCC)

DCC has been actively developing a strategic approach to housing care and support for older people, including an extra care housing commissioning strategy. A captial programme for extra care housing is being tendered jointly with Wiltshire Council.

The main task has been to build on the existing informed plans and develop a strategic approach to the integration of housing support, enabling and personal care services, with the aim of providing choice, quality and cost efficiencies. As a result DCC has adopted a generic approach to the integration of care and support services that encompasses all vulnerable client groups, including older people.

The agreed approach involves using a framework agreement to procure integrated care and support services. A considerable level of detailed work has been carried out on how the framework agreement for care and support services will work in practice.

Following agreement to the strategic approach a project plan has been developed for the implementation of the framework agreement. This plan sets out the key milestones for implementation, as well as the procurement timetable. This plan is currently being taken forward.

GLOUCESTERSHIRE COUNTY COUNCIL (GCC)

The Use of Resources business case for Gloucestershire has been developed and refined in recent months and GCC now consider that there is a clear need and direction for making significant changes to the delivery of care and support services for older people. Furthermore, reductions in the number of residential care accommodation units by 12% per year and nursing care units by 2% per year have been set as objectives.

The first task for the HSU team (set in November 2010) has been to develop a combined framework for delivering care and support services to older people based on a hub and spoke model. This work also contributes to the Council's 'Meeting the Challenge' agenda and the HSU team have participated in monthly Programme Board meetings that have been held since January 2011.

To ensure that the proposed model continues to play its part in the Council's 'Meeting the Challenge' agenda, avoids duplication of effort and minimises misunderstandings during the implementation phase the HSU team is linking with other programmes within the Council. Of particular significance here are: the revised SP strategy which works towards separating accommodation from support, the review of re-ablement, the customer journey work stream and the current boundary revisions and restructuring of health and social care teams.

An integrated model for delivering care and support based on a 'hub and spoke' service delivery framework

A number of models have been considered and tested against the GCC context and related priorities and the outcomes from this activity has led to the adoption of a 'lead provider' model as outlined below.

The service delivery model works on the premise that delivering services to older people involves:

- Responsibility falling to a significantly reduced number of lead providers (who deliver services, either directly or via specialist sub-contractors)
- The lead providers being commissioned and monitored by the Council while they in turn commission and monitor their sub-contractors.

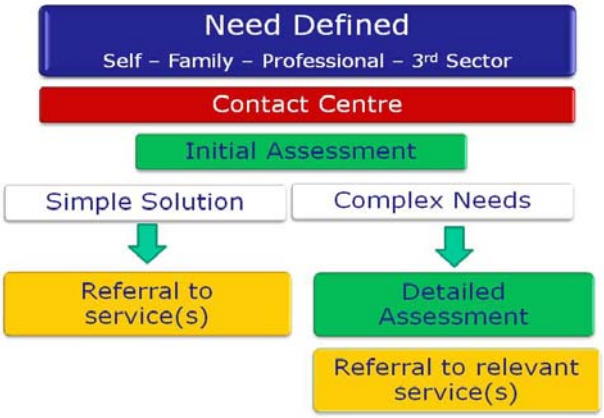
This approach offers the potential to contribute to the wider efficiency savings identified within the Council.

Safeguarding outcomes for the customer is essential and, in addition to robust monitoring and feedback loops introduced by the lead providers, a process would be put in place to ensure that customers can gain redress from the Council if they not satisfied with the outcomes from lead providers' complaints procedures.

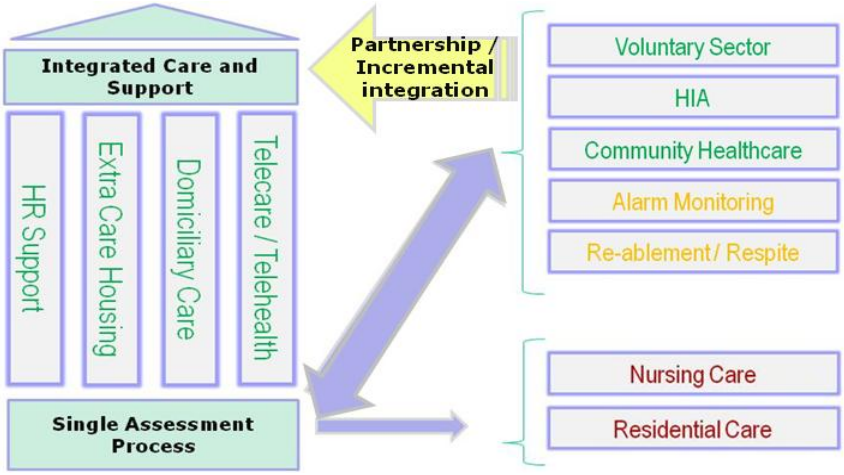
The lead providers will establish a single gateway for service provision so that the potential customer or their representative can engage effectively with the service and receive a seamless assessment or referral. This approach will:

- Fast track individuals (or their representative) requiring a simple solution (e.g. installation of a ramp, referral to a befriending service) to the appropriate agency.
- Involve the contact centre agent owning the enquiry until the agency has confirmed contact with the client.
- Ensure that those identified with more complex needs at the initial contact stage of the enquiry will be dealt with via a telephone assessment.
    - This will be followed within a defined timescale by a face to face assessment by a Trusted Assessor

Assessment and Referrals



A decision about which services are to be included within the model framework was agreed by Gloucestershire in February and an incremental approach for implementing the service was chosen, as illustrated in the diagram below.



The incremental approach allows for greater flexibility for partnerships to develop around a 'core' over time whilst the comprehensive change approach which was also tabled set a more challenging agenda for all concerned, including both the Council and lead providers. Following consideration by the members of the Programme Board it was agreed that the incremental model was most appropriate for Gloucestershire in the first instance.

Discussions around the inclusion of other services included:

- Whether re-ablement should be included in the first phase as it is a key factor in achieving cost efficiencies in respect of reducing placements in residential care provision.

- The in-house service is currently under a review process which is due to be completed in the summer of 2012, therefore it was concluded that a decision concerning this service at a later date would be more appropriate

- The potential of tendering a countywide alarm monitoring contract to ensure that service is cost efficient and the centre chosen is capable of monitoring and responding to Telecare and, potentially, Telehealth provision.
  - It was agreed that this would be challenging within a two tier authority and maybe a step too far for stakeholders at this stage. In addition it is understood that NHS in Gloucestershire is discussing a strategic partnership with Tunstall to deliver Telehealth and this could affect the ultimate decision on the direction taken.
- A further consideration for the future will be the opportunities that could be gained through including Continuing Health Care services within the model.

The Tender

In relation to tendering the integrated service, to allow fair competition, it has been agreed that the prospective lead providers, together with their associate sub-contractors, will be able to bid for:

- The County as a whole.
- One defined area.
- More than one defined area; or
- The County as whole plus any of the individual defined areas.

Discussion on the specific areas to be tendered will be finalised over the next three to four months as the choice could be affected by other work packages within the Council.

The Evidence Base – why change?

Demographic challenges

The current population in Gloucestershire aged over 65 is estimated to be approximately 111,400, which equates to 18.8% of the district's total population (593,500). There is significant projected growth in the older population to 2020 and, for example, the 85 plus population is set to grow to 22,000 by from its current estimated level of 17,000. Taking into account this growth in population (and not allowing for inflation) ***service costs are likely to increase by almost 30% by 2020*** unless action is taken.

Further issues that support this growth in the care market include the fact that:

- Older people are likely to suffer increased periods of poor health and planned/unplanned admissions to hospital and there are predicted increases in a range of health conditions up to 2020.
- Projections indicate significant growth in the number of people who are likely to be unable to manage at least one 'day to day' activity or have self care limitations which could challenge their ability maintain independence.

The above draws attention to:

- The need to deliver services in a more effective and efficient manner and address the level of care and support services required if people are to remain living in the community for longer, so delaying or avoiding a move into higher forms of care.
- The requirement for joined up care and support services, underpinned by robust assessment to avoid duplication of service provision.

The challenges in meeting the diversion rates and the required financial efficiencies

Diversion rates / financial efficiencies from ***higher forms of accommodation-based services*** are unlikely to be met unless:

- The number of providers of Nursing and Residential care is reduced significantly as currently these services are being purchased from 417 different providers.
- Savings are achieved through reduced commissioning, on-going monitoring and management of services as these elements will be substantially undertaken by the lead provider.
- Detailed research is undertaken to understand the care needs of those living in residential care and identify residents who would wish to move to ECH and are capable of doing so with the appropriate care and support.

In relation to ***Domiciliary Care Services*** currently there are 83 agencies providing domiciliary care to 3,822 clients living in their own homes across the County. Therefore, as with accommodation based services, to achieve savings the number of providers will need to be reduced significantly and commissioning, on-going monitoring and management of services will need to be substantially undertaken by the lead provider. In addition:

- Research is required to understand the current commissioning profile of domiciliary care services so that any cultural challenges can be identified and addressed as part of an

intensive training programme for social care staff.

- Research needs to be undertaken to understand the breakdown of the tasks across the current provision to assess where changes in working practices are required.
- Training and support will need to be provided for social care staff to assist them in making the cultural change necessary in implementing the new service model, including:
  - Adopting new ways of assessing customers by ensuring that a full range of options are considered before recommending residential care, e.g. Telecare, re-ablement services, HIA services, Third sector services, ECH – so ensuring that residential care becomes the final choice for social care staff.
  - Moving from an annual assessment of customers to regular reassessment of an outcome based care and support plan.
- Further efficiencies (frontline and back office), achieved through the integration of care and support services.

Work will be undertaken to ensure that ***low level support and well-being services*** which address the ***'prevention agenda'*** are delivered to older and vulnerable people in the community irrespective of where they live. This work will be undertaken to:

- Ensure that working practices meet the requirement to delay / avoid the requirement for Fairer Access to Charging (FAC) eligible accommodation and non-accommodation based services.
- Provide advice so that customers are able to access to services provided by other agencies, e.g. the Third Sector.

Extra Care Housing is a key component in the provision of accommodation as one third of the diversion rate is set to be achieved through ECH. Currently there are approximately 10.9 units of ECH per 1,000 of the 75 plus population in Gloucestershire and with no change in provision this would fall to 8.4 units per 1,000 by 2020. The DoH recommended number of units for the 75 plus population is 25 per 1,000 and to achieve this Gloucestershire would need 1,355 units currently and 1,753 by 2020.

To address this shortfall in provision, and as part of the implementation plan, work will be undertaken to identify the models and location of ECH provision required to increase supply within the County and so meet the diversion agenda. Activities will include:

- Positive action to ensure that the current ECH provision is used effectively by, for example, undertaking research to determine how the provision is currently used and developing a strategy for increasing its effectiveness.
- Working with landlords and contractor/developer partners to identify sites for building new ECH provision with little or no public funding.
    - Such developments will need to include substantial provision for outright sale / shared ownership as well as social rent as data indicates that such 'for sale' provision will be necessary for homeowners who wish remain in the same tenure as they age and require care and support services (currently there are only 88 units for sale / market rent).
- Work will be undertaken to encourage landlords to undertake detailed option appraisals of their sheltered stock (if they have not done so already) to identify 'fit for purpose' schemes which could provide suitable 'hubs' for 'virtual' ECH provision with a small amount of capital input.

Note: There are 7,315 units of designated housing for older people in the County (source HGO consultancy) and the needs data suggests that this represents ***an overprovision of 2,634 units of accommodation.***

Delivering effective ***Telecare services*** to provide a platform to underpin an integrated 'hub and spoke' service model in partnership with a market leader in the Telecare equipment field is essential as currently there are significant areas of duplication within the County's Telecare services. The issues here are:

- Services are in the main concentrated on people who are FACs eligible, therefore the ability to provide a service that prevents / delays FACs eligible services being required is missed.
- A key plank in the new service will be to ensure that older people receive the service they require at an early stage, so preventing them presenting at a later date with FACs eligible needs.
    - The emphasis here is to ensure that the customer receives the service they need at 'first point of access' and so does not 'slip through the net'.
- It should also be borne in mind that the majority of these people will pay for the service and the ancillary services offered such as welfare benefits advice will help ensure that they can do so.

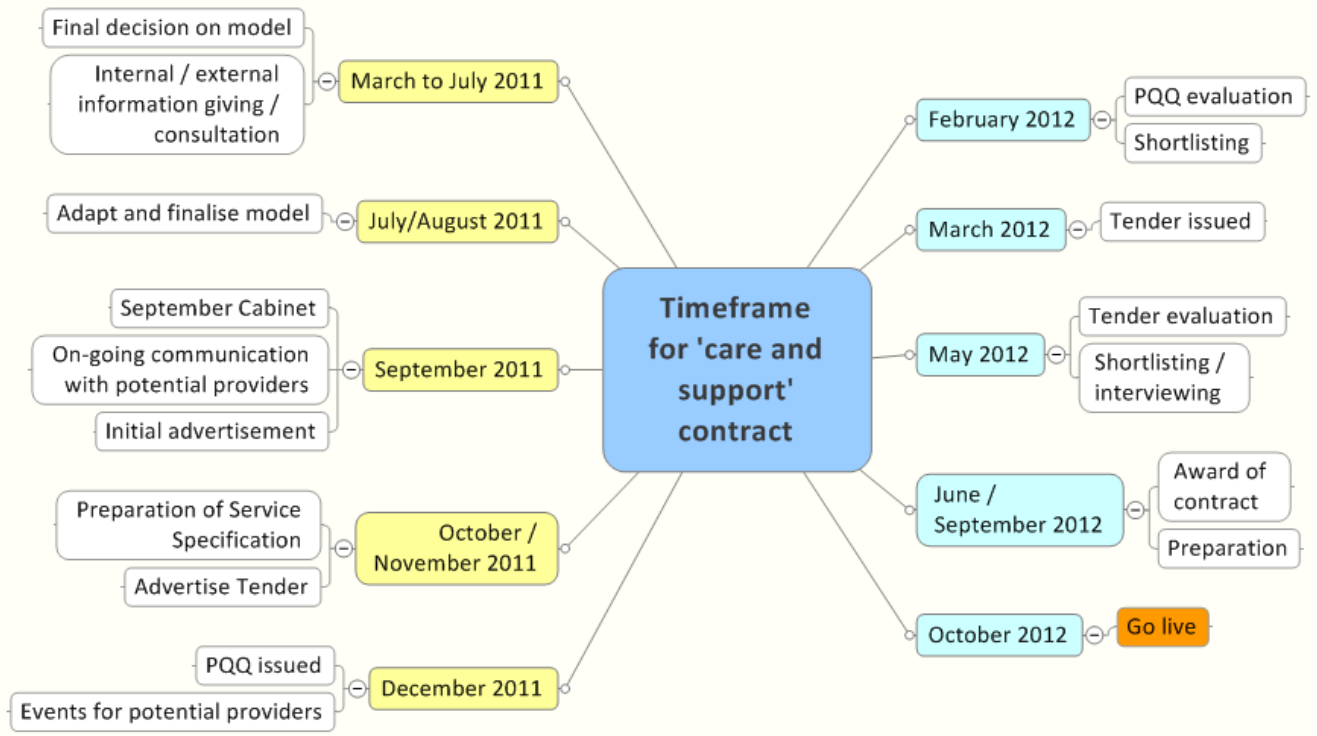
Ancillary services

These are services that will not, in the first instance, be included in the integrated care and support model of service delivery but are vital components to its success. These include:

- ***HIA:*** The provision of HIA services is vital if the planned diversion from higher forms of care is to be successful as these services contribute significantly to the prevention agenda. Gloucestershire has recently tendered a countywide HIA service which has been let to the Mears Group
    - Clear lines of engagement (similar to a Service Level Agreement) will need to be put in place to ensure that the Lead Providers and the Mears Group establish a robust partnership working agenda.
- ***Re-ablement / respite:*** These are in-house services and are currently being reviewed therefore this service will sit also outside the integrated model of care and support. However:
    - If diversion rates are to be achieved extensive work will need to be undertaken to understand how these services should link with those inside the integrated model and so avoid duplication
    - Work will also be required to identify and put in place a framework for re-ablement 'pathway' flats within sheltered and ECH provision.
- ***The Voluntary Sector:*** Gloucestershire has a well established voluntary sector and any integrated care and support model will need to encourage close partnership working with this sector. It will be important to ensure the sector is fully engaged with the implementation phase of the project.

Time frames for implementation

A time frame for achieving an integrated care and support contract based on a 'hub and spoke' delivery model is shown overleaf.


Timeframe for 'care and support' contract
March to July 2011
Final decision on model
Internal / external information giving / consultation
July/August 2011
Adapt and finalise model
September 2011
September Cabinet
On-going communication with potential providers
Initial advertisement
October / November 2011
Preparation of Service Specification
Advertise Tender
December 2011
PQQ issued
Events for potential providers
February 2012
PQQ evaluation
Shortlisting
March 2012
Tender issued
May 2012
Tender evaluation
Shortlisting / interviewing
June / September 2012
Award of contract
Preparation
October 2012
Go live

NORTH SOMERSET COUNCIL

North Somerset Council, in conjunction with the HSU agreed a project brief and established a project board to develop an "informed plan" aligned to the Council's existing vision and requirement for the Development of a Strategy for Older People in North Somerset.

The project steering group agreed a project scope which was based around the requirement to produce an ***"Informed Plan by 31 March 2011 for the reconfiguration of housing, care and support services to older people in North Somerset."***

The plan is intended to enable the vision for the future delivery of housing, care and support services in North Somerset Council, provide an assessment of the current effectiveness of services and an associated gap analysis to meet this vision and create a series of strategic themes and a related set of delivery objectives that become the basis of a strategy and an Implementation Plan to be delivered over the period 2011-13.

The primary source of data and evidence was to be existing research included in the Council's strategies and plans as well as reports previously commissioned by the Council.

Key aspects to include how better outcomes from services that are already provided/commissioned can be delivered and what are the options to develop new/revised services focussed on delivering the targets from the UoR business case for change.

An overview of the research findings was presented in March 2011 which concluded:

There are a number of "visions" for older people in North Somerset which are, by the nature of the source document that they are derived from, different but are also complimentary.

The project steering group determined that overall:

North Somerset Council defines "Supported Living" as the range of services that enable older people to live independently in a variety of types of accommodation, including their own homes.

Our Vision *is to ensure that older people in North Somerset have access to housing and support and care options that respond to their preferences and needs and avoid an over reliance on residential care provision. In delivering our vision, we aim to ensure that:*

- *Older people have a choice about the services they wish to use to meet their needs.*
- *Services promote independent living.*
- *Services are affordable for older people, the Council and the Primary Care Trust (PCT).*
- *Services provided in specialist housing schemes are also available to older people living in the wider community to meet their needs.*
- *There are defined and agreed standards for housing, care and support and the services are co-ordinated.*
- *Recognise the need to meet the financial challenges of demographic growth and economic circumstance.*

Strategic Themes

The strategies and associated action plans have, as expected, recurring themes and strategic aims and objectives which can be broadly summarised as:

"Ensuring that service users, carers, families and citizens are central to service developments and are fully engaged in planning and delivery of those services."

It was also noted that there were a number of work streams where it may be helpful to develop "stand alone" strategies if the full potential is to be realised. These were

- Assistive Technologies/Telecare.
- Decommissioning Strategy – Nursing, Residential and Sheltered Housing.
- Extra Care Housing.

The desk top study/research also included an overview of:

- Service Map for North Somerset.
- Existing Accommodation Provision (supply) in North Somerset.
- Estimated Appropriate Rates of Provision.
- The Accommodation Aspirations of Older People.
- Key issues of Current Stock.
- A series of stakeholder soundings taking a view of service aspects that work and aspects

which need to be improved.

- A potential system or model of older peoples housing for North Somerset.

The challenges and areas for further investigation

The study findings informed the process of identifying issues that need to be addressed through the informed plan in order to achieve better housing options for older people and work towards delivering a Strategy for Supported Living for Older People in North Somerset.

The main challenges which emerged can be summarised as:

- Dealing with the financial issues resulting from the increased service demands caused by demographic change and efficiency requirements.
- Improve the notion that older people are not able to access the support to live in their homes for as long as they want to.
- Can extra care housing work in North Somerset and what is the appropriate model?
- What is the role of Sheltered Housing?
- Improving supporting people services.
- Develop a common understanding of extra care, sheltered Housing and virtual Extra Care housing along with property and service standards that are clear for people to understand.
- How to reduce the use of residential and nursing care homes in North Somerset including the stresses on the system caused by inward migration.
- How to ensure that older people are fully aware of the options that are available as alternatives to care facilities and particularly in rural areas, that housing and other services are fully accessible.
- What is the most appropriate commissioning model for care and support?
- Test the assessment and placement process to ensure that they are effective in considering options to residential and nursing care placements and consider how choice based letting fits with the agenda.
- How to further reduce waste in domiciliary care packages.
- Further develop assistive technology and telecare solutions.

Progress to an Informed Plan and Implementation Phase

The project steering group further refined the outcome and outputs at a meeting in March 2011

to focus closely on the explicit action that reflect the Use of Resources Accommodation work stream topic **Accommodation Mixture Optimisation** targets.

The view within North Somerset is that substantial progress has been made regarding the topic area of **Reducing Care Package Waste** and that further evidence is emerging regarding the case for a move towards **Integrated Contracting Care and Support** contracts. There are however ongoing actions and work which will ensure that these topics are reviewed and revisited as appropriate.

Implementation Actions

The specific implementation actions that North Somerset Council have agreed are detailed below and, due to the approach taken in the project to date, some of these implementation actions are being developed and undertaken as part of the initial support package.

- Identify the specific actions required to develop the additional extra care capacity and conversions of existing sheltered capacity as outlined in the use of resources accommodation conversion model for North Somerset.
- To undertake an analysis of the potential for integrating the existing community patch working with the hub and spoke and VECH model to include a review of the potential of an existing scheme to become a “hub”.
- To review a sample of cases of older people going into care, to identify establish extent/profile of target group for diversion to Extra Care, Sheltered housing or hub and spoke based services.
- Consider demand from self funders with a view to identifying potential target group for sheltered/extra care housing.
- Establish, with partner providers, what potential exists in their stock for sheltered housing to accommodate older people diverted in future from residential care and what changes to buildings would be needed.
- To consider and develop a County wide ‘standard’ for sheltered stock and to identify any implications for such a standard.
- To review how the provision of advice and information about housing options needs to be developed.

SOMERSET COUNTY COUNCIL

A wide range of stakeholders in Somerset have recognised the need to acknowledge the national agenda of austerity measures in responding to the demographic challenges of meeting the housing, health, care and support needs of their ageing population.

With the support of the HSU they agreed to work across a broad partnership of service users, commissioners, providers, local communities and carers on a broad strategy for both the range and volume of services needed and the processes of change to achieve any revised pattern of services. Reaching this agreement was recognised as being hard in the face of conflicting priorities and the different world views of the various stakeholder groups.

The first step in developing the plan was to get a common understanding among the various stakeholders of the current situation and the context of any change, the challenges faced the level of need, the constraints to change, and the resources available.

A Steering Group was established drawing in membership from the wide range of partners engaged, and this group determined and monitored the HSU work-plan. The objectives of the stakeholder group and the plan were:

- Enabling older people to remain independent in their own homes and in the communities they choose.
- To remain healthy and active citizens and contribute to their communities.
- To achieve a high quality of life.
- To see specialist housing (sheltered, extra care, residential, nursing or whatever other model we devise) as *part of our community of provision, and not set apart.*

In order to try and determine the current position in Somerset, the HSU delivered a “Foundation Document”. The aim of this document was to help the partnership assess the initial conditions for change in Somerset by pulling together a raft of available data and information from a range of disparate sources. It provided an overview of the work that has been undertaken and is ongoing within the County to shape services for older people. The document also includes the UoR data that is designed to help authorities consider the accommodation cost/needs mix.

The document is intended as a source of information to assist in decision-making about the shape of future services. It begins to try and make some of the connections between available data on demographics and need and the different policy initiatives that are happening in response. In so doing it seeks to reduce any duplication in work between the different stakeholder groups and deliver some synergy between them. It has already been acknowledge this will be an important document in the JSNA refresh that is happening this year.

It was clear during the process of data collection that the way in which data is collected was not consistent; it was collected at different times, and for different purposes. The Foundation Document was not intended as a definitive source document. It is however meant to be dynamic: that is capable of being updated as new information becomes available.

This document was then tested amongst a wider stakeholder group to determine the strategic themes for the Plan. A 'Stakeholder Event' was held on 31st January 2011 and attended by around 50 local stakeholders, including a small number of service user representatives. These stakeholders, through HSU facilitated sessions were directly involved in developing the strategic themes around the future Plan and the opportunity was also given to provide feedback on the "Foundation Document". Following this event, and review by the Steering Group the strategic themes were agreed as:

Strategic Themes:

- Within the available resources we will make the best use of all types of housing and ensure there are resources available to meet the aspirations of older people wherever they live.
- We will give a high profile to preventative services to promote health and well-being and to reduce the impact on high cost health and social care services.
- We will promote the mix of housing and related services as one system so that each part links together to meet the aspirations of older people as customers.
- We will agree new measures that show we are improving outcomes that promote the seamless services that older people seek.
- We will create workforce stability whilst recognising the increasing value of the voluntary sector in working to achieve more joined up services.
- We will use the available information more effectively.

- We will change the way we work across traditional agency boundaries to create the right partnerships for seamless service delivery.

The Steering Group then wanted to test these themes more widely with service users to see whether they reflected a broad consensus. As a result a series of 6 meetings were held across Somerset in a range of settings from Active Living Centre's, a sheltered housing complex, Somerset Older Citizens' Alliance, and a meeting of sheltered housing residents at the offices of a local housing provider. In total, around 160 older people participated in the process.

The findings from these meetings held with older people were then fed back to a second 'Stakeholder Event' held on 21st March 2011. The Steering Group were keen to maintain the momentum gained in engaging the wider stakeholder base in the development of the Plan. This event was held to begin the process of creating the delivery objectives that flowed from the agreed strategic themes. On this occasion 15 older people representing a range of older people interests across the county attended, forming 25% of the whole audience.

Again, a series of HSU facilitated sessions were held and attendees were invited to begin thinking about how the strategic themes would translate into very practical changes to improve housing, health, care and support services for older people in Somerset. This process led to a total of 38 delivery themes being identified by the stakeholder group.

At the time of writing the Steering Group is in the process of finalizing these themes and taking them through the formal approval processes. These themes will then contribute to a wide range of existing work streams and planning processes for housing, health, care and support in Somerset at both County and District level. The Steering Group is also considering how best to deal with the future governance of these strategic themes and delivery themes in order to hold the whole Plan together and monitor progress.

TORBAY BOROUGH COUNCIL

SUMMARY

Central government policy and funding for the future are designed to encourage major change in local authority provision of care for older people.

The care will need to be much more person centric and much better integrated

There is also projected growth of approximately 23% in the population of older people in the Torbay area over the next 10 years. However, it is also clear that current levels of funding are unlikely to increase with reductions in funding being more likely.

At first glance it may seem that these factors present an insurmountable challenge but this is not necessarily the case.

In practice there are a number of positive factors that could be combined to make the desired changes a reality. Changing care models, moving provision away from expensive residential units into the community, further integrating services, commissioning care from alternative providers, improving access to preventative services and adopting new technology can all combine to help the authority produce an implementable plan.

There is also potential within the current housing stock for carrying out relatively minor changes which would improve that stock sufficiently to meet the changing needs without the need to develop entirely new facilities.

However, although some early integration work is already in place there is further work to do. The new models will require much wider integration with housing, leisure, policing, the voluntary sector and others. There is still the need for a large amount of change and those changes are long term ones that need to be underway very quickly if they are to have the desired effect within the needed timescale.

There are also a number of short term, simple changes (such as changing case review patterns) that can be made immediately to reduce significant waste of resources within the current model of care.

There is a real opportunity to improve provision for users alongside achieving better value for money but it is essential that the senior people from all the services involved reach agreement quickly and enthusiastically promote change within their own organisations if the project is to succeed.

INTRODUCTION

Torbay has successfully undertaken the significant challenge of integrating its health and social care functions to create Torbay Care Trust. This is an important step in the realisation of efficiencies in care and support functions for older people and vulnerable adults.

However, it is clear on both a national and local level that in order to achieve an integrated service for the population of Torbay, joint working should go further and there is a drive to work collaboratively in order to deliver real whole system change to improve outcomes for individuals and realise best value for organisations.

The HSU is working with Councils to assist in the implementation of the UoR programme for Adult Social Care (October 2009). The UoR sets out the challenge to Local Authorities of self assessing effective use of their Adult Social Care resources. It recognises that some of "the interventions which will lead to transformational reform for adult social care will take a minimum of five years to deliver" and presents a series of key questions to commence this process. It refers to local authorities falling into two groups 'Care-land' and 'Community-land' – the highest and lowest share of spending on residential and nursing care respectively. It suggests that an "excellent" authority should have a balance of services available with not more than 40% of its overall adult social care budget is spent on residential care.

As a member of the Use of Resources accommodation work stream Torbay has commissioned this informed plan from the HSU in order to highlight where improvements and strategies can be delivered in partnership in order to maximise person centric and economic benefits.

It will do this by appraising the current provision of housing, health and social services and make recommendations for how to realise these benefits. The opportunity is available to consider a whole systems approach and the recent modelling work done combined with an overlay of the associated costs will enable and drive the payment for services at early, preventative and cost effective points in the system.

PLANNING FOR THE FUTURE

Summary

It is clear that if the current model is not changed then it will neither meet the requirements of users nor be financially sustainable.

The change needed is one that has been described as a journey over time from “Care-land” to “Community-land”. In essence, care is provided in the community by a network of provision rather than being provided is specialist institutions such as residential or nursing homes.

Moving Forward

In order to develop a way forward which encompasses health, housing and care as an integrated systems change, consideration should be given to the emerging environment in which we are set to deliver these challenges.

However, there are already initiatives in progress and a number of useful ideas under consideration.

General Practitioner (GP) Commissioning

Torbay Care Trust is currently working with the Torbay GP Commissioning Consortium to ensure that opportunities for streamlined and integrated working are on the agenda through this period of transition.

Developing Co-production

Co-production turns consumers into producers, demand into supply. Most care is offered between ordinary people with few professionals involved and no money, specifications or contracts. A coproduction is a service offered, produced or provided, by the service users themselves. For people to get involved to this extent they have to see the value of the service and have been involved in its design and development. This means more than consultation. This requires enabling mechanisms to be in place that will support growth in this area.

Person Centred Care

At its core, the approach to Health, Housing, and Care Services needs to be person centred. A number of initiatives and work-streams would help to realise some of the improvements and

savings opportunities highlighted within the HSU evaluation, and as demonstrated in the summaries of local and national evidence provided within this report:

- Create a central information point. It is essential that staff have access to information about preventative services not only through health and social care but also through other providers. This to be complete within 3 months.
- Create a new team by combining staff currently located in different zones and the local authority. This team would then screen requests and provide a "Single Point of Access" to Telecare, prevention, "supporting people" and personal budget services. This to be created within 6 months.
- Creation of a screening team to undertake reviews of home care packages on a regular basis – shifting from annual reviews and long term care packages to time limited care packages. Again a single team for the whole Torbay area will bring efficiency savings and a more consistent approach. This to be created within 6 months.
- Central Evaluation panel to challenge recommendations – the creation of a high level dynamic panel to run for 12 months whilst new practices are being embedded. This needs to be done immediately.
- A clear strategy of purpose for extra care services in Torbay and specifically in the new facility Dunboyne. This should include greater attention and investment in chosen and targeted sheltered schemes Hub and spoke model across zones (these virtual models of extra care can provide support by delivering falls clinics, basic foot care, reminiscence therapy, health and wellbeing/active aging services for residents of schemes and the wider population). This to be created within 6 months.
- A review of existing sheltered schemes with a view to identifying those schemes that could be developed to the required standard of provision.
- Expansion and greater adoption of Telecare services and technological solutions.

HSU

STRATEGIC INNOVATION & PEER LEARNING

In housing, health, care and support

LIGHT TOUCH AUDITS

South Gloucestershire

Isles of Scilly

Bath and North East Somerset

Swindon

Bristol

Plymouth

Dorset

Poole

Wiltshire

DH Department of Health

Housing LIN

SOUTH WEST REGIONAL IMPROVEMENT & EFFICIENCY PARTNERSHIP

directors of adass adult social services

SOUTH GLOUCESTERSHIRE COUNCIL

Driver	Please describe how you are responding to this 'driver'?	What are the local influences (strengths and weaknesses, opportunities and threats) affecting this response?	Can you evidence the active use or review of the following?	Can you describe examples of innovative or good practice in meeting these pressures?
Demographic Pressures of dealing with an increasing older person population	• OP are one of 6 key strategic priorities for the council • Current strategic priorities within "Better Services for Older People" were widely consulted upon with the community • JSNA completed and informed strategic plan • Benefits of working with other LA partners as part of West of England Partnership to plan and co-ordinate responses sub-regionally • Planning to break mould of tying accommodation and	• JSNA Completed early • Promotion of re-ablement in assessment and service delivery (further review due 2011) • Willing provider partners to work in partnership to meet strategic objectives • Challenges associated with high level of owner occupation by older	✓ JSNA ✓ Assistive Technologies ✓ Extra Care Housing ✓ Sheltered Housing ✓ User involvement ✓ Consultations with stakeholders ✓ An integrated vision ✓ An integrated route map ✓ Integrated commissioning	• Have been successful in obtaining funding to support carers in the community which will add a further dimension to the service • Priority given to lettings to "bed blockers" through Home choice scheme • Implementation of targeted re-ablement at

	support together	people living in council area • Not yet offering support services to those older people living in the community	✓ Integrated provision/new models of delivery ✓ Revised 'mix' of housing options ✓ Cashable savings ✓ Preventative strategies ✓ Optimise support at home ✓ Active Re-ablement ✓ Personalisation	hospital discharge and use of short-term res care beds to facilitate early return to patient's own home
Financial Constraints imposed by the cuts to public expenditure	• Programmed closure of Residential care and re-provision through targeted new development of replacement residential care, ECH and support services • Early delivery (2009) of Hub and Spoke model of service delivery in Sheltered housing • Better utilisation of ECH and sheltered housing as Hubs for services • Re-tendering of HIA to link with other care and support services • Linking current single	• Early recognition that too many people were going into residential care and impact on cost to LA • Early planning of closures of residential care (LA Owned) and re-provision through ECH and lower number of residential care beds • Had to re-tender HIA because current		• Commissioning the Voluntary Sector to deliver some elements of homecare that are not within current remit of home care providers e.g. taking the Service User shopping • Provision of new ECH developments ahead of target • Currently working

	assessment processes to Community Health Care Assessments and develop closer working with Health. • Have been able to grow ASC budget (marginally) but have had to find savings from other budgets	provider pulled out and impact yet unknown • SP within ASC but have retained SP eligibility criteria as seen as essential to future models of service delivery • Extensive public consultation undertaken on strategic plan. 70% of respondents supported BSOP approach		with Providers to try and change tenure mix within existing ECH • Priority letting of ECH to existing users of homecare services has led to cashable savings • Leader in evolving private sector models of ECH delivery in the region • WoE Partnership enabling sub-regional liaison and strategic planning on strategically important sites e.g. Frenchay and

				Thornbury Hospital sites
Central Government Directives that dictate how are meant to deal with these related pressures e.g. localism, reform to the health service, changes to rent setting regime etc.	• Positively promoting re-ablement to minimise use of residential care and target hospital discharges • Single assessment process takes a broad approach to assessing needs and is driven by re-ablement • Personal budgets being promoted as a way in which to offer service users more choice and control over the services they receive • See GP commissioning as opportunity to develop closer links with help and address current concerns where services may not be working	• Assistive Technology not yet mainstreamed • Personal Budgets not yet mainstreamed • Not yet really integrating delivery of care and support services		

ISLES OF SCILLY COUNCIL

Introduction

This report provides a review of the current care model on the Isles of Scilly. It highlights the types of services and facilities currently available, and aims to identify where enhancing services in order to meet the changing needs of the population of the islands can ensure that people have access to holistic support packages in the future.

The report makes recommendations for providing alternative models of care to enable older people to continue to live as independently as possible within their own communities, and more generally, to continue to support the needs of islanders requiring health, care or housing services.

Redesigning services fit for the future

Health and social care policy increasingly seeks to support people to remain more independent and to have greater control over their lives. Nationally it is recognised that we need to explore and exploit the advantages of the preventative aspects of a variety of accommodation options with integrated health and care services. Promoting and working towards the well-being and wellbeing agenda by adopting a joined up approach will achieve greater improvements and efficiencies in local health and care economies. This will be essential if society is going to meet the needs, maintain and improve the quality of lives of the increasing older population, particularly as this population are more likely to have complex long term conditions that may mean that they need to access a variety of services in order to maintain their conditions.

Locally there is a need to think differently about how we support the growing needs of an ageing population. It is essential that agencies work collaboratively in order to develop better and more integrated health, social care and accommodation strategies.

Health and social care services can achieve better outcomes for people when facilities that are designed to ensure that people with sensory impairments; physical disabilities; learning disabilities and dementia, and other long term conditions. When people can remain as independent as possible, living alongside their partners if they have them, and enjoying the rest of their lives in a supportive, safe and fulfilling community, it is shown to have significant financial benefits to the health and social care community. Adopting a service model that uses innovative, responsive, and flexible levels of support can ensure that individuals remain in their own homes without the need for traditional care settings.

Background

Why the need for change?

The financial challenges that all public sector bodies are facing across the country mean that health and social care have to be creative about how it delivers services. As funding streams reduce, or become static, health and social care still has to contend with a growing ageing population with increasingly complex needs.

The census data (2001) shows the Isles of Scilly to have a population in the region of 2,153. Whilst this has not changed significantly over the last decade, the most challenging aspects come from the unique and remote formation of the Isles of Scilly. This means that in order for the needs of the islanders to be met, there needs to be flexibility within health and care, and that the local authority must have a key role in shaping and developing services with the NHS so that services innovatively meet the needs of the islands population.

Personalisation agenda

Personalisation, including a strategic shift towards early intervention and prevention, are becoming the cornerstone of public services. This means that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings. It means that people are able to live their own lives as they wish; confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity.

The work on direct payments and individual budgets, alongside that of In Control, are crucial to delivering greater personalisation, choice and improved quality. They are not separate initiatives or fleeting experiments, but fundamental components of a future social care system.

This holistic approach is set out in 'Putting people first: a shared vision and commitment to the transformation of adult social care', the ministerial concordat launched on 10 December 2007.

At the same time as many councils have been seeking to manage their resources by tightening eligibility criteria, a programme for the significant transformation of social care services has been put into place. This reform programme is described in the cross-sector agreement Putting People First: a shared vision and commitment to the transformation of Adult Social Care. Putting People First sets out a shared ambition for radical reform of public services, promoting personalised support through the ability to exercise choice and control against a backdrop of strong and supportive local communities. To broaden their focus beyond those with the highest needs, councils are required to ensure that the application of eligibility criteria is firmly situated within this wider context of personalisation, including a strong emphasis on prevention, early intervention and support for carers. In practice, this suggests that councils may need to make adjustments to ensure a seamless approach between their personalisation programmes and the determination of eligibility for social care.

Putting People First makes it clear that personalisation will only flourish where investment is made in all aspects of support for individuals and their carers including:

- Universal services – the general support available to everyone within their community including transport, leisure, education, employment, health, housing, community safety and information and advice.
- Early intervention and prevention – helping people live at home independently, preventing them from needing social care support for as long as possible and potentially creating future cost efficiencies.
- Choice and control – giving people a clear understanding of how much is to be spent on their care and support and allowing them to choose how they would like this funding to be used to suit their needs and preferences.
- Social capital – fostering strong and supportive communities that value the contribution that each of their citizens can make

At a time when resources are tight, it is recognised that it will not be possible for councils to invest large amounts in prevention and early intervention schemes. Rather it is hoped that that councils and those applying this eligibility guidance are prompted to think about prevention and early intervention beyond just adult social services. Suitably adapted housing smart technology and equipment, improved health care and joint working, greater benefits take-up and community support can all help to delay or avoid the need for care completely.

All of this supports the need for clear pathways of care. However, whilst the unique formation of the islands does present challenges to delivering these expectations, the island already benefits from strong communities which if harnessed, will ensure a fully integrated model of enablement, care and support can be achieved. By combining health, care and housing services and facilities the island can secure the appropriate level of resources that will maximise benefits for patients and service users that wish to have their needs met locally.

Requirement Going Forward

Health and Needs Analysis of Population

There are currently 2,153 people living on the Isles of Scilly. It is well documented that there is nationally an increasing ageing population; this is no different for the Isle of Scilly. Projections for the islands predict that by 2013, a third of the population on the

islands will be over 65 years of age, and one in five of people over 80 will be suffering from dementia. Current research has already shown that 90% of those offered care on the islands are over 65 and the majority of patients admitted to St. Mary's hospital were over 60. A recent assessment of the needs of the people residing in the islands care home found that many of the residents would have been able to remain living at home if they had access to an integrated housing, health and social care support package.
To gain a greater understanding of the needs and aspirations of this demographic, an in-depth consultation and a questionnaire took place at the end of 2010.

The questionnaire received a positive response rate of 19% of all the islanders over the age of 55's. From the results certain needs and aspirations can identified. When asked about potential future issues the main responses were:

- cost of heating home
- accessing enough support to remain in the own home
- becoming trickier to get out and about

The main priorities identified by people who currently felt the need help were:

- foot care
- minor repairs to house

In addition to this, the majority of respondents confirmed that the person who lives with them, in most cases a spouse/partner or family member generally provided the support they were in receipt of.

When asked, 'Can you imagine being interested in living in an extra care scheme in the future?'

- 81% of respondents said yes

Compare this to when they answered, 'Can you imagine living in residential facilities in the future?'

- 52% of respondents answered yes

This directly correlates to the national findings that show that:

- Older people are increasingly key to the housing market and increasingly want to continue to be owner occupiers;
- Older people's aspirations in relation to accommodation are the same as people of any age. Older people want space for their treasured possessions. They want to retain opportunities for recreation, activities, dining together and for welcoming visitors.
- There is a growing community of people who want to reject what for many older people is the isolation of living alone. Loneliness in old age is not synonymous with living alone; rather it is linked to the depletion of relationships as a result of loss of functional abilities, chronic illness and bereavement. Loneliness is a risk factor for emotional and physical health problems. Social support and engagement in social activities has an impact not only on survival but also on preserving functional ability and mental health, conversely a lack of social support is associated with increased mortality and poor health. Social participation and engagement in social activities is linked with well-being through, for example, opportunities for enjoying life and having something meaningful to do. Important in maintaining life quality from the perspective of older people themselves is the existence of networks where support flows not only toward older people but from them as well;
- Major threats to life quality of older people relate to the maintenance of a positive sense of self, engagement in meaningful activities and participation as valued members of social networks and communities.

Current Provision

Residential Care – Park House

The local authority manages the running of Park House residential home. The 1970's building is old and would require significant refurbishment in order for it to be fit for purpose and meet the increasingly complex needs of an aging population. At present Park House is a ten-bed care home with shared washing and bathing facilities. These communal facilities contravene the current shift in

government policy, which promotes the physical, social, emotional and financial advantages of enabling people to retain their independence and dignity for as long as possible in later life.

Whilst the building will continue to fall short of the standards required, the staff that run and care for the residents at Park House demonstrate a true commitment to providing the highest level of care and support to residents. The resilience and community spirit of the islanders is clearly visible within the care home and this ethos should not be underestimated when looking at alterative models of care and support.

Hospital

The local Community Hospital, St. Mary's also has ten beds. It is reported that these beds generally have excess capacity, and therefore is currently a cost pressure. There is also a limited range of services that are currently provided by the hospital, and the islands rely heavily on the mainland for meeting many of the populations healthcare needs. This is not efficient in terms of cost, or care planning, and in most cases, patients are disadvantaged with basic preventative and maintenance care.

It is common practice for a patient to travel to the mainland for an outpatient appointment, which may only take a short amount of time. This appears to an inefficient use of resources and does not put the patient at the centre of the care planning.

It is clearly not realistic for the islands to be completely self sufficient in terms of health care provision, however much can be achieved by analysing where the demands are in the local healthcare provision, and developing hub and spoke services to best cater for these needs. This includes looking at technology such as Telehealth and telecare; using mainland and community hospital, and housing facilities and services to in reach and outreach into the community.

Potential Future Shortfall

The current health and social care systems on the Isles of Scilly are working. The strength of the island is in the resilience and proactive nature of the local communities. However, the islands will find it increasingly difficult to provide the quality of care and support that remains in line with islander's expectations, and with the government direction for self-directed care. These challenges will increase as the ageing population needs are becoming progressively more complex. To mitigate this, more advanced and preventative care planning and delivery is required. In essence, if nothing changes, the existing service model will cause an ever-growing gap between requirement and provision.

The inefficiencies in the current model need to be addressed. The level of service that is required and the increasing pressure on health and care budgets are not going to disappear quickly. There are many changes imminent in the way that health and care is to be directed, specifically the shift of Public Health functions to local government, and the transfer of responsibility to GP consortia led commissioning. This will push the decision making much closer to patients and local communities. There is a need to ensure that the right services are planned for now, during the early stage of this change cycle, so that the islands are able to have a real choice in determining their future provision. (Liberating the NHS: local democratic legitimacy in health, (July, 2010))

One of the greatest challenges will be the growing numbers of people with dementia and their accommodation needs, at present they and their partners have very few options when considering their residential requirements. In most cases locally, the primary option people are faced with is being separated from their loved ones to go into a care home setting.

The Current System Upgraded

As indicated, the current care home facilities would be difficult to renovate or refurbish to cater for an enabling model of support. Whilst the care standards are good, the shift towards en-suite bathroom facilities, the lack of flexibility of the build to ensure that people can enjoy full mobility of the home, such as no lift or stair lift are real barriers for the future of Park House.

St Marys Hospital has some potential to reconfigure the building to better meet the needs of the community. Greater flexibility in the space that is currently available, the potential to remodel and reduce the number of beds would give the hospital an opportunity to develop enhanced assessment and treatment, outpatients or therapy space opening up the possibilities for more localised services.

A New Option to Consider

A Different Approach

Specialised accommodation with health and care support offers certain advantages over private housing, particularly for those who need a physical environment designed for those with impairments, better access to help and care, company and a sense of safety. Extra Care Housing for people on the islands would also particularly help address the integration between various services.

An example of integrated working with housing can be seen in the development of Marina Court Extra Care Scheme in Tewkesbury. The scheme opened in January 2008, adopting a collaborative approach to partnership working. Residents and the local Tewkesbury community are at the heart of the innovative and preventative approach to wellbeing and independence at Marina Court.

A unique development of 75 one and two bedroom flats and bungalows for people aged 55 and over, it offers 24/7 onsite care and support to residents.

The success of working across sector boundaries was celebrated in April 2009 when the scheme was nominated and shortlisted for the regional Health and Social Care Partnership Award.

The partnership developed preventative services that maximise the independence of older people, including the development of a health and wellbeing suite and ethos within the building. Health and Social Care appointed a Therapy and Wellbeing Coordinator to coordinate and/or deliver holistic programme of activities.

These activities range include:

- boxercise
- active balance
- Nintendo wii exercise circuits
- art classes
- hopi ear candle waxing
- hand and foot massage

The remit of this post is focused on testing and tailoring activities that stimulate people's minds and bodies with a strong focus on preventing a decline in health or emotional wellbeing of residents of the Extra Care Sheltered Housing Scheme, and the wider community.

Architect site appraisal

Site option and recommendations

In October 2010 the Council of the Isles of Scilly appointed St Ives based architects PBWC Ltd to advise on the potential of sites on St Mary's to support Extra Care housing and associated community facilities. Eight sites were put forward for scrutiny based on suggestions developed via community consultation. The sites identified were A - Park House, B - Holgates Green, C - The former primary school site at Carn Thomas, D - The existing secondary school site at Carn Thomas, E - Land Adjacent to the Health Centre, F - Land behind Buzza Tower, G - Porthloo boat store, H, Land at Telegraph.

PBWC considered the suitability of all sites against a robust set of criteria and a model brief. The model brief was developed to test each site for size and suitability. The brief included the provision of a community hub with day care facilities and drop in services, a number of self-contained 1 and 2 bedroom 'Extra Care' apartments, live-in staff accommodation, residential care facilities and outdoor space to serve the whole facility. The report concluded that an Extra Care project located on the site of the existing secondary school site at Carn Thomas offered the most potential. The report concluded that Extra Care housing on the site of the existing secondary school linked to re-structured community facilities on the site of the former primary school at Carn Thomas opposite could provide a vibrant and accessible addition to housing and welfare provision serving the needs of Scilly.

Next Steps

To further define the development potential of the existing secondary school site and former primary school site PBWC architects advise that the Council commission a measured building survey and topographical survey of both sites. An instruction to proceed in March 2011 would allow the relevant surveys to be undertaken during the Easter 2011 school holidays. Documentation of the existing building stock and topography will allow a robust design assessment of both sites to be developed against the type of development identified by the business case. The design assessment will also identify how the sites could be used to provide a mixed-use scheme to assist to the funding of the Extra Care proposals.

What Next?

The Isles of Scilly are special and distinctive. With the communities passion for the island and clear desire for self-sufficiency there is now an opportunity to capitalise on its uniqueness. By delivering a model of care and support that has the potential to make a huge difference to people's lives living on the islands. What is proposed is an exciting development of housing with built in care and support systems. These would meet a series of current national and local policy objectives, and would contribute to meeting the associated targets, in addition to enhancing socially inclusive and personalised services which promote independence and well-being.

Recommendations

The committee are asked to consider and agree to:

- The development of specialized accommodation (approximately twenty units) with health and care support for people 55 years and over.
- Access to flexible 24 hour on-site health and social care services both in people's own accommodation and in a care home, supported by a range of assistive technologies
- Short-term step-up and step-down care, rehabilitation, specialist respite and palliative care
- Day services and a health and well-being centre to provide falls prevention services; stroke rehabilitation, memory assessment clinics; physiotherapy; podiatry; GP services; long term conditions management and promotion of self-care; expert patients programme, cognitive stimulation, pulmonary and cardiac rehabilitation programmes. These services could also be made available to the wider community.
- Provision for people with special and complex health needs to take short breaks with or without their carer so that respite care feels more like a holiday for the individual as well as the carer
- A physical design and service model which will ensure that people with a range of abilities and disabilities are able to live as independently as possible, with their partners if they have them
- A hub for the provision of outreach services to the local community
- Apart from specialist hospital care the services should be able to provide the complete range of older people's health and care services from initial assessment through to end of life care. It represents a truly integrated and holistic approach to care, reducing the number of assessments and ensuring consistent staff through an individual's care journey.

If the committee agree to the above the next stage will be to:

- Identify funding streams and partners
- Agree site recommendations
- Agree number of units through consultation

- Create an integrated private and public sector project team

BATH & NORTH EAST SOMERSET COUNCIL

Driver	Please describe how you are responding to this 'driver'?	What are the local influences (strengths and weaknesses, opportunities and threats) affecting this response?	Can you describe examples of innovative or good practice in meeting these pressures?
Demographic Pressures of dealing with an increasing older person population	• Where ever possible health, housing, care and support services are integrated. (See example of good practice, far right column.) • The remodelling of sheltered housing," (the majority provided by Somer Community Housing Trust.) Over 50% of the units are now occupied by older people 84-plus • A new tenure-blind floating support service to promote	The drive for joint strategy and commissioning goes back to 2008 when the initial JSNA was done (refreshed 2009). A report *"Key to Independence"* produced a series of recommendations that have all been implemented. BANES is operating specific placed-based strategies to	The (BANES ASC) home care intake team and the (Royal United Hospital Trust) Intermediate Care Team in reablement have been brought together to provide a joint assessment service post discharge, which enables older people to access grants for support (using the central

	independent living (delivered by Somer) with a banded-approach of differing levels of service to maximise choice and flexibility, and minimise costs. This includes a community alarm service. • 3 community resource centres (within the extra care schemes) which act as a hub-and-spoke model, and is the geographical base for Somer's Sheltered Housing Officers. • Improvements to carer support (See *Give us a Break* project, next column). A new carer's centre will be commissioned with aim of providing a more co-ordinated, strategic service in future. - Having focused on reconfiguring support services over the last 3 years the Authority will next shift attention to accommodation, re-developing the last of the unpopular sheltered housing sites:	achieve more balanced spatial communities so some units of sheltered housing have been de-classified - Some of the smaller RSLs are still continuing with their live-in warden services. - The *Give us a Break* project generated improvement in local services, but will end this month as a result of central government grant cut. It enabled carers to take up leisure activities either on taster/one-off basis or across a number of sessions. The aim has been to improve quality of life and give respite from caring duties. The hope is that the links the carers have made will endure.	government reablement money) and adaptations (using housing money) - The Chandler Close 'project' in Weston. Here local residents in the sheltered bungalows have come forward asking to run their own independent living service in the locality, some of whom may not be Somer Housing tenants, and which could be accessible to self-funders as well as those in normally in receipt of support services. (This project is currently in the early stages, and has echoes of personalisation.)

	often the 60s buildings, in small schemes, many in rural locations. It will also review needs and services to older people in the BME communities. A specific consultation has been arranged for June.		
Financial Constraints imposed by the cuts to public expenditure	• Joint commissioning is the norm to maximise use of public funds. In OP services the Director of Service Improvement (Health and Wellbeing Partnership) and the Manager of the Non-Acute and Social Care Commissioning Team, jointly chair the Older Peoples Strategic Partnership Group. • RSLs (in particular Somer Community Housing Trust) consultation with older tenants resulted in the creation of the *Smooth Moves* initiative (see far right column) to enable tenants gain confidence to move from larger properties they no longer	• The contractual arrangements for all sheltered services for 2011/12 include a cap of £4 per unit per week. • No specific initiatives under the heading of 'seeking cashable savings' although the growing emphasis of joint commissioning has sought to reduced duplication e.g. the consolidation of the social exclusion services. There is not the same rigor yet around domiciliary care and residential care commissioning e.g. block	• *Smooth Moves* undertakes the liaison with utility suppliers or organises removals, providing a more personalised service that has taken the fear out of moving. The service has been funded by shifting the budget from 'cash enticement' to 'officer-led support', and is now linked to the Independent Living Service so it can be extended to private sector residents.

	need into more appropriate accommodation	contracts, too much plurality of providers. However, BANES to date had actively endorsed a policy of diversity/plurality of providers (while actively rooting out duplication). They are not comfortable with a contractor/sub-contractor model from the choice and cost-shunting angle as a matter of policy.	
Central Government Directives that dictate how authorities are meant to deal with these related pressures e.g. localism, reform to the health service, changes to rent setting	While BANES is not currently pursing place-based strategies, they are familiar with the CSIP paper "*More Choice, Greater Voice"* which advocates geographical strategies in providing accommodation with care for older people. They aim to look at property type/values by ward, and thus better understand the propensity to pay for care, to maintain their properties and, if	• BANES want to better understand numbers and forecast across the whole sub-population over the next 20 years. (*It is this visioning, in the context of place-based connections, understanding hidden poverty, and best use of resources – perhaps changing the available 'mix' -*	Somer Housing is looking at increasing the use of volunteers to provide aspects of the floating support service, such as shopping. This will promote community integration and so add value to the contract.

regime etc.	appropriate and out of choice, move to something more suitable.	*that BANES would like some project support with if HSU implementation monies became available.*)	

SWINDON BOROUGH COUNCIL

Driver	Please describe how you are responding to this 'driver'?	What are the local influences (strengths and weaknesses, opportunities and threats) affecting this response?	Can you describe examples of innovative or good practice in meeting these pressures?
Demographic Pressures of dealing with an increasing older person population	• The JSNA is used as the starting point in understanding community needs. (See note column 3) • 5 ECH schemes, 1 managed by the Council, 4 by RSLs. Although struggling to fill these (see note column 3) ECH is more popular than residential care, so the future 'solution' is seen as better utilization/diversion strategy from more expensive options.	• It is acknowledged that the process of assessment still feels "disjointed", but will be enhanced when public health is transferred to the Council in October. • Currently struggling to fill ECH beds, but the view is that this is due to very high quality,	• There is a long tradition of user involvement in housing schemes in Swindon. There is at least one trained and active representative for each sheltered scheme who is part of a body called TASH. This group

	• The Council owns and manages 33 sheltered housing schemes comprising about 1,500 units, with about the same number again owned and managed by RSLs. There are wardens at each scheme *"because they are very much valued"*. (See note column 3) • There is some oversupply of sheltered housing, but this represents schemes/units not fit for purpose, and which will be decommissioned and converted to general needs housing (a waiting list of 13,000). • Swindon's Housing Strategy commits to ECH, effective use of adaptations linked to keeping people in their homes for as long as possible (in common with ASC and health strategies), and to Lifetime Homes standards (to ensure the sustainability of property). • There is one popular Care & Repair scheme in the Borough, managed by an RSL. • Optimising care services at home is	effective home care services that prevents demand for more expensive options. • There will be pressure to review the sheltered housing service as the housing-related support element comes under closer scrutiny with the reductions in public expenditure. • However, emerging local intelligence data suggests there may be a potential future demand, possibly from self-funders who don't want to pay for residential care. • Swindon has an Engagement Team who targets different hard-to-reach B&ME community groups, working in non-traditional ways e.g. attending their cultural events and festivals as the "places of engagement" rather than	generates their own activities. The Borough's leisure services offer training to residents in a range of well-being activities. • There is an inter-generational project between a sheltered housing scheme and a school. By focusing on 'exercises' that can span cultures e.g. stories of the Second World War, this has broken down barriers and promoted inclusion in many inspiring ways e.g. reducing the fear of older people to come out of their front doors. • Swindon is working on an innovative project with the social enterprise Turning Point to develop

	based around 3 operational hubs: one for 24/7 urgent care (that will soon have a mental health component), another providing 'virtual wards' for those who "bounce in-and-out of hospital", and a third that specifically supports people with dementia and their carers by creating the 'ward at home' to avoid the disorientation that comes from admission to hospital. • GPs understand the system and support the focus on care at home. • Swindon's Assistive Technology strategy joins up Telecare (the Council service) and Telehealth (the PCT service) in a programme managed through housing. This provides a 24/7 single point of access.	calling specific meetings. • There are 'Health Ambassadors' who provide support across the whole community on issues such as smoking, obesity, substance misuse, alcohol, diabetes etc.	'connected care' in 3 deprived areas of the Borough. It starts by training local residents to be community researchers who identify needs (and in the process help develop skill sets).
Financial Constraints imposed by the cuts to public	• There is a strong partnership with planners to deal with new applications for residential care homes. A recent application was turned down, as it did not fit 'strategy'. (See note column 3.)	• Swindon feel they are currently oversupplied with private residential care homes. The key question asked by all	• Swindon is a demonstration site for improving strategies of engagement with carers,

expenditure	▪ Swindon has 4 in-house residential care homes, shortly be reduced to 2 that will have a specialist role, and only for those with significant mental health issues. The aim is to better utilise ECH (see above) and continue its strategy of home care wherever possible. ▪ To fund the preventative agenda and future strategy for older people ASC are 'rebalancing' the social care system by moving resources from the learning disability sector (where spend is disproportionately skewed to this client group compared to other areas in the South West). ▪ Swindon is continuing the process of service integration by now linking mental and physical health services wherever possible as a way of reducing duplication and thus delivering cost efficiencies so that more expensive services e.g. residential care will *"wither on the vine*". ▪ Other cost prevention measures include boosting the interdisciplinary	partners in the planning process is: "What's Right for Swindon?" ▪ Market testing also revealed that in-house provision for ECH services is cheaper than buying in from the external market. ▪ Overarching so much of the activity is the *"One Swindon Strategy"* that replaces the LSP, and through which all the agencies agree, through feedback, what the underpinning strategic themes should be for service delivery. ▪ Efficiencies in housing are seen as arising through the better use of the sheltered housing estate (see above), together with the regeneration of 'hot spot areas' such as 1960s bungalows and flats-above-shops. Regeneration is not seen simply as the bricks-and-	assessing the savings that can be made on care costs. ▪ The '360 project' is about engaging with excluded people in new ways to reduce dependency on public service, *"people who cost us a whole lot of money"*.

	Reablement Team in supporting people out of hospital or their 'virtual ward'. Swindon are studying the lessons about the use of resources from across the South West, in particular the savings that can accrue by better skill mix and better engagement with volunteers.	mortar, but as the whole fabric of people and buildings.	
Central Government Directives that dictate how authorities are meant to deal with these related pressures e.g. localism, reform to the health service, changes to rent setting regime etc.	Commissioning is focused around the needs of each individual. PPF and transforming social care is one joined-up programme of work in Swindon focused on the whole person (i.e. Clara!) The analogy used is the tube map: the circle line represents the core support, but all the 'arms' indicate the chance to get off and do things for themselves. A driving force in shaping services and spend in Swindon is the emphasis on prevention which all partners believe *"is starting to have an impact"*: a mix of pragmatism based on recognising opportunity and using an incremental approach to change predicated on some	Consultation processes benefit in Swindon by the integration of housing, health and ASC, with inter-disciplinary teams often in the same building, *"something we often take for granted"*. There is an acknowledgement that more progress could have been made on the use of personal budgets as this will support so many other objectives *"but we've been working on so many other things"*. (Swindon is also a pilot site for the use of Personal	In policy terms, this person is called 'Clara'.

	key principles, rather than a 'Grand Plan'. Every job has an element of prevention. - The preventative agenda in housing leads to building 2-bed properties (rather than 1-bed), so people can have visitors to stay, it feels like home. - This links more widely to their building communities agenda, aimed at those places that "don't work". The concept of building outward from a community hub is important, although what constitutes a community hub can be different in different areas.	Health Budgets in stroke cases.) - Swindon are re-thinking the use of libraries as information points and meeting places; and developing the idea that a community hub can be part of a school or a supermarket.	

BRISTOL CITY COUNCIL

Driver	Please describe how you are responding to this 'driver'?	What are the local influences (strengths and weaknesses, opportunities and threats) affecting this response?	Can you evidence the active use or review of the following?	Can you describe examples of innovative or good practice in meeting these pressures?
Demographic Pressures of dealing with an increasing older person population	• JSNA completed early and has informed strategic planning. Currently under review again to refresh and under management of Project Board and Project Manager • Pressure of ageing population different in Bristol to many other LA's in SW.	• JSNA Completed early • Promotion of re-ablement in assessment and service delivery • Early review of role of sheltered housing in delivery of preventative services	✓ JSNA ✓ Assistive Technologies ✓ Extra Care Housing ✓ Sheltered Housing ✓ User involvement ✓ Consultations with stakeholders	• VSH Programme and associated strategic planning • Project Boards • "Slithers of time" model • HIA Service review (practice yet to be tested)

	Face high numbers of 85+ age group but lower numbers of 65+ group compared with other LA's • Broke mold of binding support to accommodation in early years of SP • Planned early on delivery of VSH Programme in Bristol over 10 years • Undertook early review of sheltered housing and rationalised stock and focussed provision on need for support (further review due in 2011) • About to go out to consultation on re-ablement strategic plan • HIA provision currently under review and have engaged customer journey mapping to inform revised process to be implemented in 2011	and focussed on need for support • Delivery of VSH programme close to agreed timescale • Reconfiguration of HIA and customers influencing how HIA service is delivered and services offered • Older People represented in strategic reviews and influencing service delivery through thematic Boards (Chaired by Director of ASC) • Not yet fully explored integration of Care and Support Services as models of service delivery • Review of residential	✓ An integrated vision ✓ An integrated route map ✓ Integrated commissioning ✓ Integrated provision/new models of delivery ✓ Revised 'mix' of housing options ✓ Cashable savings ✓ Preventative strategies ✓ Optimise support at home ✓ Active Reablement ✓ Personalisation	• Sheltered Housing Review • BCC Dementia Kite Mark for care homes that are dementia friendly

		care provision now underway with move towards specialist care provision only (Dementia focussed)		
Financial Constraints imposed by the cuts to public expenditure	• Current review of ASC Spend and focus on delivery of more cost effective methods of working and commissioning within ASC Teams (prior to current government cuts) has delivered savings for the ASC team in a time of financial pressure. • Focus on operating models and service delivery of efficiencies has meant cuts not as severe as some other LA's in SW • Have employed external support to undertake some key cost modelling and	• Early recognition that current operating methods needed review to be more customer focussed and more efficient • Early planning of VSH programme to meet need and divert from residential care • Now recognise that still too many people were going into residential care and cost implications of this and planning to review placements		• Review of service delivery models in ASC to deliver savings and support staff to deliver more efficient models of operational delivery • Employing external support to undertaken cost comparisons and drive savings • Exploring

	renegotiate with providers to make some savings (also linked to some external benchmarking to achieve cost-comparators)	and promote re-ablement model further • Recognised need to mainstream Assistive technology into the assessment process. • VSH needs further review to ensure that it is meeting objective of diverting people away from residential care and providing a positive alternative to residential care. • Need within BCC to further explore modelling of cost of services to identify where further savings can be made		alternative models of VSH with private sector as part of WoE Partnership

Central Government Directives that dictate how are meant to deal with these related pressures e.g. localism, reform to the health service, changes to rent setting regime etc.	• Bristol City Housing Partnership currently exploring how to generate a more customer focussed service and range of products and services for customers • See GP commissioning and integration of Health as opportunity to develop closer links with help and address current concerns where services may not be working	• Assistive Technology not yet mainstreamed • Personal Budgets not yet mainstreamed • Not yet really integrating delivery of care and support services • Some localised pilots for promoting VSH as resource may be scrapped due to cuts • Customer journey within service delivery needs better mapping and shaping of services around this experience to improve quality of customer service		

PLYMOUTH CITY COUNCIL

Driver	Please describe how you are responding to this 'driver'?	What are the local influences (strengths and weaknesses, opportunities and threats) affecting this response?	Can you evidence the active use or review of the following?	Can you describe examples of innovative or good practice in meeting these pressures?
Demographic Pressures of dealing with an increasing older person population	• JSNA informs commissioning plans • Older peoples strategy in place "All our Futures" • Joint Dementia Strategy in place • Leading on Dementia Quality Mark pilot for South	• Social Care enabling team in place to "right size" care packages before moving to independent sector. • Increasing availability of universal services – low level prevention	✓JSNA ✓Assistive Technologies ✓Extra Care Housing ✓Sheltered Housing ✓User involvement ✓Consultations with stakeholders ✓An integrated vision ✓An integrated route map	We have a "fair price for care project" – £400k FYE efficiencies in LD We have established category management in adult social care in order to manage expenditure and make strategic links to wider

	West – improving quality in the market place • Extra Care Housing Strategy with focus on increased Care & Support options for older people • Winter pressures funding to review and improve community services to prevent admission – money to support increase in low level prevention, advice and overnight domiciliary care provision.	services in place. • Developing outreach pilots for sheltered housing to make better use of resource. • Tendering 2011/12 domiciliary care in extra care housing to ensure we get Best Value • Increased social care re ablement • step down flats "Pathways into Independence " from residential care and hospital in extra care housing to 9 – the flats also accept older people who are at risk of homelessness through carer	✓Integrated commissioning ✓Integrated provision/new models of delivery ✓Revised 'mix' of housing options ✓Cashable savings ✓Preventative strategies ✓Optimise support at home ✓Active Reablement ✓Personalisation	council initiatives PCC secured SWREIP capital funding to build an extension to a LD residential short break service. Enabled PCC to decommission the council run service – efficiencies £400k estimate FYE We fast track older people into sheltered housing and extra care housing from Pathways project .We have a fast track policy with housing so that people who have been admitted into the project can be guaranteed a housing offer within 6 weeks .This prevents the units

		breakdown		from being blocked in appropriately . ECH in Plymouth is not part of CBL which means ASC Care Management Teams able to access 200 units of housing thereby reducing dependency on residential care – priority to extra care is given to people with a care package in place or at risk of entering care Opened the LD extra care scheme 2010. The 6th scheme for older people opened in March 2011 – both new schemes are running a personal budget pilot. If successful we will be offering personal

				budgets to all in extra care housing – core and flexible contract has been developed. We secured 18 new build flats for people with a LD in 2010/11 under market recovery scheme through HCA and section 106 affordable housing funds .All flats have telecare enabled and are linked through staff team – moved people out of care to be there . All offered personal budgets. Reablement focuses on "right sizing "care packages before people get long term support –

				this includes hospital discharge. **PCC have asked all LD and PD homes to reduce their fee levels by 5%. 44 responses with most very positive. PCC have revised their contract values in partnership rather than cutting costs across the board without any dialogue with the sector**
Financial Constraints imposed by the cuts to public expenditure	• Revenue funding for new extra care units an issue • Better use of extra care housing and sheltered as hubs	• Increase in extra care is dependent on access to HCA funding and residential care revenue budgets		

	• Successful in modernising "in-house" residential care units from 5 to 3 - we only have 1 unit for long stay dementia – modernisation plans to decommission these over next 2-3 years subject to cabinet decision.	• We have SP/ASC tender programme – floating support and day care • Rolling out personalisation • Charteris have worked with us on care management systems and we are in the pilot stage of a "proof of concept " team which will deliver efficiencies and roll out of PBs •		
Central Government Directives that dictate how are meant to deal with these related	• Working on social care reablement strategy • Developed a Joint	• Assistive technology not well developed in Plymouth • We have integrated		

pressures e.g. localism, reform to the health service, changes to rent setting regime etc.	Commissioning Executive (JCE) where commissioners from PCT and ASC meet to agree commissioning priorities across the community. • Considering GP consortia as an opportunity to extend role of ASC commissioning into Citizens and Communities commissioning board to take on work streams.	social care and SP budgets in relation to the LD framework for supported housing – efficiencies £200k FYE		

DORSET COUNTY COUNCIL

Driver	Please describe how you are responding to this 'driver'?	What are the local influences (strengths and weaknesses, opportunities and threats) affecting this response?	Can you evidence the active use or review of the following?	• Can you describe examples of innovative or good practice in meeting these pressures?
Demographic Pressures of dealing with an increasing older person population Dorset has a significantly higher population of older people than UK average, the highest %	• There is an "Ageing Well in Dorset" strategy (2009) and action plan with 8 locally agreed outcomes • County staff are currently updating the OP strategy (the last Extra	• JSNA not widely used / publicised • "postcode lottery" of housing related support services, depending on provider (for example West Dorset LSVT customers and	JSNA Assistive Technologies Extra Care Housing Sheltered Housing User involvement Consultations with stakeholders An integrated vision An integrated route map Integrated	• Extensive customer consultation mechanisms exist via the Seniors' forum and POPPs • A wide scoping consultation event was held in September 2010 with providers and

over retirement age in the UK (28.6% and this is set to rise to 37% by 2025, the largest increase set to be in the 85+ age group. The amount of people with a diagnosis of dementia is set to rise by 44% by 2020	Care housing strategy was written in 2004 and needs updating) and reviewing all OP SP funded sheltered housing and extra care contracts. As current SP contracts and extra care domiciliary care provision come to an end in 2012 the timing is right to do this and this should achieve better outcomes in a more cost effective manner • Dorset was part of the Total Place	East Boro Housing Trust customers can access a rapid response out of hours service not available in other parts of the county) and crisis support is good but not available or standardised across county • Opportunities to further develop services such as floating support and handyperson etc to the high number of self funders in the county and older people report that there would be	commissioning Integrated provision/new models of delivery Revised 'mix' of housing options Cashable savings Preventative strategies Optimise support at home Active Re-ablement Personalisation	issues identified are being incorporated into the new strategy • A small project group has been set up with service user, strategic housing (district council) and adult social care representation to oversee progress on new strategy • some good examples of multi agency working and involvement of OP's voluntary groups

	pilot in 2009 covering Dorset, Poole and Bournemouth • Several strategic groups are co-ordinated on a county level such as Home Improvement Agency, LSVT, Extra care and sheltered housing • September 2009 – a comprehensive review of future accommodation and domiciliary care needs was carried out • REIP funding in place to review Equipment and	demand for this • Some existing models have had operational problems which have been time consuming to resolve and hindered scheme success - these would appear to be strongly linked to a lack of clarity at the start to incoming tenants as to what was being offered and failure to have a clear vision and set of outcomes for the scheme which all stakeholders		

	Adaptations service • Vision agreed (in January 2011) that “Housing and associated services will promote independence and are suitable for each older person's individual needs” • Existing extra care schemes in Weymouth and Portland, (including some for affordable leasehold purchase) Christchurch and	originally signed up to. The two schemes in Verwood and Ferndown have all the facilities required for an extra care scheme but no on site care and are run as ordinary sheltered housing and let via choice based lettings		

	East Dorset			
Financial Constraints imposed by the cuts to public expenditure	• Newly built Extra care scheme in North Dorset (partly funded via DOH grant) should create an opportunity to reduce residential care placements in this locality • Opportunity to develop further mixed tenure extra care scheme in West Dorset • The required SP funding cuts for 2001/12 have been met following	• This scheme will be subject to a thorough research and evaluation report led by Dorset County Council in 2012, which will test the chosen model of delivery and impact on residential care • Addressing the additional budget cuts required for 2012/13 and 13/14 will		• Dorset already operates a menu of support options for LSVT SP contracts which can be tailored to the individual's needs • new Terms of Reference for SP partnership groups have been agreed to take forward service remodelling agenda

	discussion with providers. • Adult social care	require a more strategic approach than simply “salami slicing” across the board. • There are opportunities to reduce the number of providers and contracts (over 20 separate contracts for non LSVTs)to meet efficiency savings on client and contractor sides – this can be achieved whilst simultaneously protect the diversity of the		

	and NHS teams now working together as 6 locality based teams with further plans for more co-location and integration	market and smaller support providers via consortia bids • Currently there is no floating support service available for older people and self funders – the LSVT providers have flexible hours based contracts but have not been successful in community outreach • Integration of care and support contracts can produce further efficiencies and		

		cashable savings		
Central Government Directives that dictate how are meant to deal with these related pressures e.g. localism, reform to the health service, changes to rent setting regime etc.	• Positively promoting re-ablement to minimise use of residential care and target hospital discharges • Personal budgets being promoted as a way in which to offer service users more choice and control over the services they receive			• Strong link within the county to Use of Resources work on re-ablement

POOLE BOROUGH COUNCIL

Driver	Please describe how you are responding to this 'driver'?	What are the local influences (strengths and weaknesses, opportunities and threats) affecting this response?	Can you evidence the active use or review of the following?	Can you describe examples of innovative or good practice in meeting these pressures?

Demographic Pressures of dealing with an increasing older person population The Borough of Poole has an ageing population. 80% of the older population of Poole are owner occupiers. Research indicates that the majority wish to stay in their own homes (75% of over 70's) Only 0.5% of over 65s are non-white as identified in the last census in 2001.	• JSNA completed in 2008 • In December 2010 a 5 year joint commissioning strategy for older people "Improving outcomes for older people" Bournemouth and Poole councils and B and P NHS identifies top 10 priorities for transforming services • Recently completed new Extra Care affordable rent scheme with local registered provider • Borough of Poole was part of a "Total Place" pilot in 2009 covering Bournemouth Dorset and Poole	• Recently withdrew a floating support service for older people with memory loss, despite a clear need identified by the 2007 – 12 SP strategy to offer services to the majority of older people who do not live in purpose built housing • Poole has the lowest level of care home expenditure in the region • The Borough has transformed its Adult Social Care services following a CQC inspection in 2009 – the latest CQC report in 2010 now rates the council overall as delivering outcomes well	JSNA Assistive Technologies Extra Care Housing Sheltered Housing User involvement Consultations with stakeholders An integrated vision An integrated route map Integrated commissioning Integrated provision/new models of delivery Revised 'mix' of housing options Cashable savings Preventative strategies Optimise support at home Active Re-ablement Personalisation	• Handy person scheme run by local provider is very popular • New "Home form Home " support for carers scheme • "carers in crisis" scheme • Evidence of effective "supra local" joint commissioning of services with Bournemouth • Integrated locality teams with single line management being developed

Financial Constraints imposed by the cuts to public expenditure	• Anticipated reduction of residential care placements through new development of ECH • SOURCE website • A full review of sheltered housing and a comprehensive evaluation of the extra care provision and chosen service delivery model had been scheduled and agreed to take place in the forthcoming fi nancial year (20011/12) • Provision with regard to staff and financial resourcing for this review had been made • In October 2010, following consultation	• Opportunity to use telecare services more strategically and to expand service, particularly within the care pathway following discharge form acute hospital • Need to review current model of extra care provision to ensure outcomes are being achieved • Need to work closely with Poole Housing Partnership (ALMO) on a strategic asset management review of sheltered housing in the borough to develop new delivery mechanisms		• Poole spends proportionately less than either Bournemouth or Dorset on care home placements (with and without nursing).

	which supported this, FACs eligibility criteria was raised to Critical and Substantial	such as “virtual “extra care / community hubs etc and consider alternative use of less popular schemes		
Central Government Directives that dictate how are meant to deal with these related pressures e.g. localism, reform to the health service, changes to rent setting regime etc.	• Positively promoting re-ablement to minimise use of residential care and target hospital discharges • Personal budgets being promoted as a way in which to offer service users more choice and control over the services they receive	• Further opportunity to integrate care and support services for greater efficiencies • Need to consider role of strategic housing representation in forthcoming health and wellbeing boards • Opportunity to review access to housing register and thus sheltered housing and extra care via localism bill • Opportunities for more joint		• Early adopter of personalisation agenda

		commissioning of services		

WILTSHIRE COUNTY COUNCIL

Introduction & background

Wiltshire Council's Older People's Accommodation Strategy recognises the challenges as identified in various reports and papers including "Putting Older People First in the South West (2008)" and "Use of Resources in Adult Social Care (2009)" in terms of the need to respond to demographic change, promoting independence, choice, and better preventative services in order to keep people in their own homes or within specialist services, reducing the reliance on traditional residential settings and the efficiency agenda.

In January 2010, Wiltshire Council agreed the following overarching strategic outcomes as the means of responding to those challenges:-

- Increased number of nursing and specialist dementia care homes
- Reduced number of residential homes – aspirational aim to not commission any general residential beds by 2015
- Re-commissioning of care & support services
- Creation of 3 locality centres of excellence for rehabilitative step down and specialist dementia services
- Support more people to remain in their own homes by providing greater emphasis on preventative services, including re-ablement, telecare and crisis response

- Substantial development of extra care housing
- Management of future revenue and capital funding requirements

Use of Resources Project

Based on the Use of Resources Accommodation work stream business case, Wiltshire Council has made progress in respect of each of the topics:

Accommodation Mixture Optimisation.

The Accommodation Mixture Optimisation model explores the effect of demographic increases in the older people population on the cost of delivering accommodation based services. The model assumes that clients can be diverted away from residential / nursing care and will be allocated to an alternative form of accommodation based support, either domiciliary care, sheltered housing or extra care housing.

Wiltshire Council has in place an Older People's Accommodation Development Strategy which, building on the older Persons Accommodation Strategy, gives a delivery plan for the quantified number of new extra care units that are required. Wiltshire also has a fully costed 25 year financial projection model which demonstrates that the development of new ways of delivering services through new facilities will result in reduced expenditure. The model depicts that by undertaking the proposed development plan and service remodelling, the Council would realise a cost avoidance of approximately £600m over the next 25 years. This cost avoidance will help to offset the challenges of the forecast demographic change around older people and is achieved through a diversion of people from residential care to community support or specialist nursing or dementia care, which achieves an on average saving per person of £44 per week.

The initiatives which have already commenced include:

Extra Care Housing

Working jointly with Devon County Council, Wiltshire Council is currently procuring Preferred Development Partners to join a framework to develop and manage the programme of new extra care facilities over the next 10 years. The Council has recognised that the programme cannot be delivered through traditional funding methods and is seeking innovation from partners in funding, design, construction and service provision. The Invitation to Tender is due for return in May this year.

Sheltered Housing

The Council is currently undertaking a review of sheltered housing across the County, working with the main provider partners to ensure that the stock is fit for purpose, meeting current and projected needs and expectations.

The review will identify a standard or model of sheltered housing, identify schemes which are not fit for purpose or cannot meet the standard adopted and will consider the options for schemes which require intervention. The options may include remodelling as extra care or community extra care housing but will ensure that the stock contributes fully to the older people's housing system in Wiltshire. The review will be completed in the summer of this year.

Integrated Contracting Care and Support & Reducing Care Package Waste

Wiltshire Council estimates that the combined efficiencies of implementing the UoR Integrated Contracting Care and Support and Reducing Care Package Waste model are in the region of £1.6m each year. The Reducing Care Package Waste model is based on the notion that person centred care packages based on re-ablement and prevention will result in reducing needs. Close monitoring and regular review will then reflect changing needs, resulting in reduced care package costs.

The Integrated Contracting Care and Support model is based on the aggregation of the provider base as well as internal efficiencies through reduced number of contracts and shared case management with providers. Implementing this model is not without its challenges however not least of which is communication with all stakeholders.

Help to Live at Home Programme

The Council has embarked on an innovative and extensive programme to help people to remain in their own homes. The services included within this review are domiciliary care, housing related support, out of hours response services, equipment and telecare and live in care.

The vision for this programme includes:

- Enrich people's lives: The Council will make it easier for people to access the help and support they require to enable them to remain in their own homes with the lifestyle they want
- Deliver what people want: The Council will work with other organisations to help people achieve what they want, and by doing so will help people gain control of their lives
- Provide greater choice: The Council will ensure that people have choice in where and how they can get what they need and do what they want
- Enable empowerment: The Council will promote an approach from our partners that treats people as equals
- Improve our collaboration with partners: Working with partners such as the PCT to deliver a "joined up" service to our customers that meet their needs
- Improve efficiency: The Council will work with other organisations to ensure services are provided in a cost effective and accessible manner and will continually monitor these services to ensure quality standards are maintained.

This will ensure that all people are assisted to remain at home where possible and the review will incorporate all types of services required to enhance quality of life, promote independence and reduce social isolation whilst ensuring that their care needs are met in the most appropriate manner.

The goals of the helping people to remain at home programme include:

- Better outcomes for people through the commissioning of generic services able to meet a wide range of customer's needs
- Efficiency savings from rationalisation of services and reduction in travel times and overheads
- An increase in early intervention and preventative services to decrease the number of people needing acute care
- Better access to the right information.

The Council is currently undertaking the procurement exercise to re-commission care and support services through an independent living service tender. This will improve the quality of support by working with the best, most forward thinking providers strategically in delivering an outcome focused person centred services and delivering savings through improved economies of scales achieved through a rationalisation in the number of providers. The Council is also commissioning a range of outcome based preventative services through the tender which will include falls prevention, continence management, counselling, support for Carers, and information and advice.

2011/12 Implementation Plan Priorities – HSU Support

- Undertake internal cultural change programme to ensure full benefits of programmes are realised
- Appoint preferred extra care development partners and commence development projects
- Complete sheltered housing review
- Undertake needs assessment & develop accommodation strategy for people with Learning Difficulties, mental health issues and dementia

- Review allocations procedure for extra care housing

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Glossary of abbreviations

ADASS	Association of the Directors of Adult Social Services	IPC	Institute of Public Care
ASC	Adult Social Care	JIP	Joint Investment Partnership
B&NES	Bath and North East Somerset	JSNA	Joint Strategic Needs Assessment
BBC	Bournemouth Borough Council	LA	Local Authority
BRP	Benefit Realisation Plan	LDF	Local Development Framework
DCC	Devon County Council	LIN	Learning Improvement Network
DFG	Disabled Facility Grant	OPILS	Older Peoples Independent Living Service
DoH	Department of Health	PANSI	Projecting Adults Needs and Service Information
ECH	Extra Care Housing	PCT	Primary Care Trust
EMI	Elderly Mentally Infirm	PID	Project Initiation Document
FACs	Fairer Access to Charging	POPFSW	Putting Older People First in the South West
GCC	Gloucestershire City Council	POPPI	Projecting Older Peoples Population Information
GOSW	Government Office South West	RIEP	Regional Improvement and Efficiency Partnership
GP	General Practitioner	SP	Supporting People
HCA	Homes and Communities Agency	SW	South West

HIA	Home Improvement Agency	UA's	Unitary Authorities
HSU	Housing Support Unit	UoR	Use of Resources
IGP	Innovation and Good Practice	VEC	Virtual Extra Care
ILS	Independent Living Services	VECH	Virtual Extra Care Housing

Appendices

The Core Script	Appendix A
A Market Assessment	Appendix B
The pro-forma for support	Appendix C
The Project Initiation Document (PID)	Appendix D
The sub-regional workshop presentations	Appendix E
UoR accommodation business case	Appendix F

Toolkits

Models of 'Hub & Spoke' a) Hub & Spoke an introduction b) Older People's Independent Living Services (OPILS). Bath & N East Somerset model c) The Independent Living Service (ILS) evaluation, Cornwall model
Extra Care – Pathways and Allocations a) Pathways into Extra Care b) Extra Care allocations and lettings protocols c) Allocations and lettings. The Blandford model d) Allocations and lettings. The Wiltshire model e) Extra Care process flowchart f) Care pathways chart
Extra Care – The financial benefits
Extra Care – Private sector models of developing with little or no subsidy
Extra Care – A model integrated care and support contract (Extra Care)
An assessment task list
An integrated framework
A light touch audit tool