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local government in the 21st century

Slough Commissioning Strategy For Older People

2013 - 2018

CONTENTS

1 EXECUTIVE SUMMARY

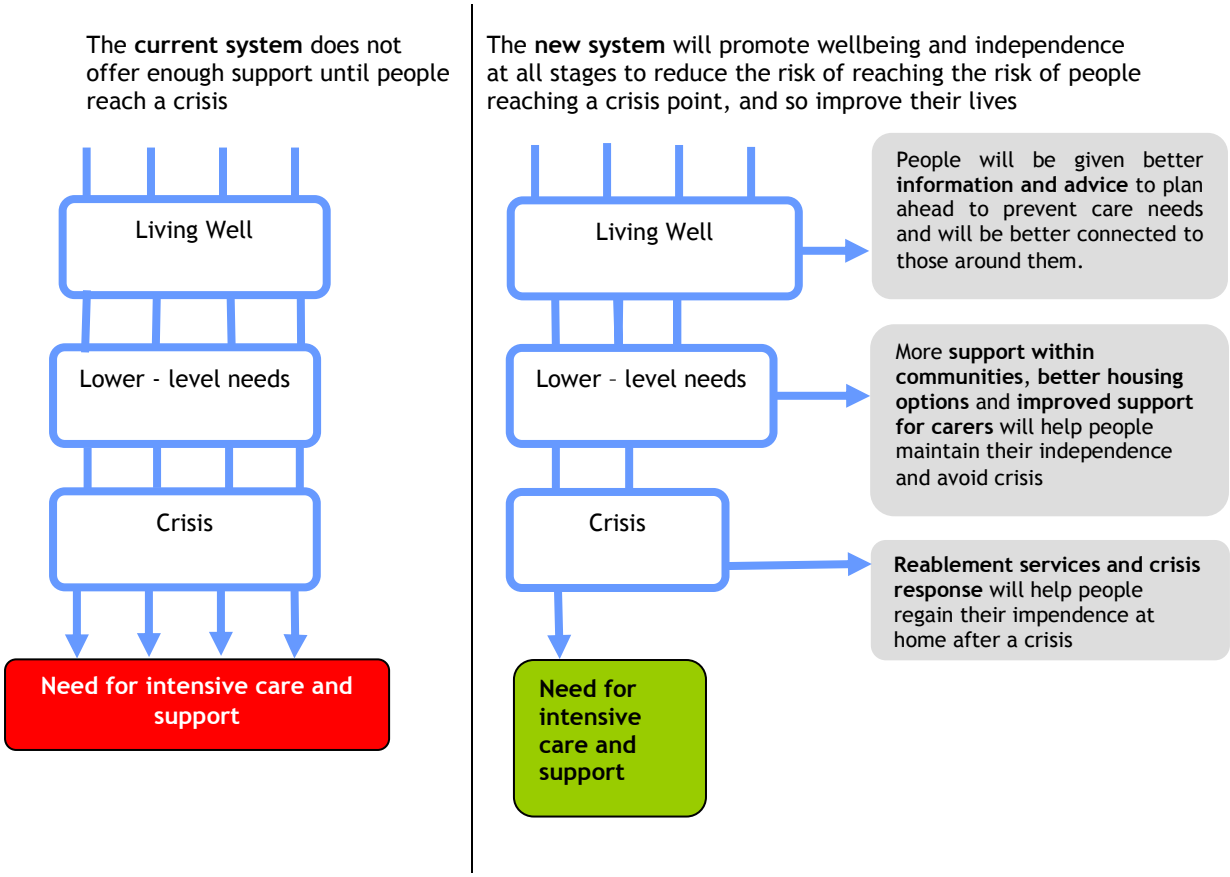
1.1 The strategy

This commissioning strategy for older people focuses on the needs of people requiring support from Slough Borough Council and the resources available to meet those needs. On doing so, it recognises the initiatives that can delay or even prevent older people needing support. It is about how public value can be assured and outcomes improved, particularly for people with eligible needs for support.

This commissioning strategy for older people will explore and detail the community and preventative opportunities for all older people in Slough and will be set within the commissioning for personalisation / transformation programme for social care services.

1.2 Reforming Care and Support

The model below represents the strategic shift in supporting people.



Model 1

DH Caring for our future: reforming care and support - July 2012

Whilst this strategy is about adult social care services in Slough, it recognises the imperative work with a range of partners to deliver whole systems services that meet the needs of local communities.

This strategy needs to be seen in the overall context of how public services respond to an ageing population, in promoting choice and personalisation whilst creating the environment to support community wellbeing. It therefore links with other strategic documents produced jointly by Slough Borough Council and Slough Clinical Commissioning Group (CCG).

1.3 Aims of the strategy

The aims of this strategy are to:

- Stimulate the market to develop flexible services which offer choice and control and can support personalisation and self directed support
- Set up comprehensive commissioning arrangements for preventative services designed to improve the quality of life and maximise independence for older people and also control spend through managing increasing demand
- Specifically improve services for dementia
- Minimise the costs of services provided to ensure we can maximise our ability to help older people in need of support.
- Deliver more cost effective services through more effective utilisation of existing services
- Develop action plans which deliver improvements in patient care, experiences of care and better performance
- Improve mortality and reduction in years of life lost, particularly important for improvements in wellbeing
- Ensure high quality services in health and social care through robust quality monitoring

Whilst we will do as much as we do as much as is possible within the constraints of our budget, we will also take into account the need for a sustainable market. The collation Government has set a challenging agenda with major restructuring within the NHS and significant financial constraints across the public sector.

The advent of Clinical Commissioning Consortia will set a new context for the delivery of effective joint commissioning and coupled with the challenging economic

climate for the foreseeable future, suggests that commissioning in partnership will be critical if we are to deliver quantity and value for money services that people want across the whole system.

The delivery of this strategy will be challenging in a time of unprecedented change and a tough economic climate, however we believe that getting services right for our local older people is critical. The impact of the Health and Social Care Act 2012 presents major restructuring, for healthcare and social care services. This will mean closer working across health and adult social care services resulting in more joined up service delivery. Both health and Social care commissioners must therefore work together to ensure that services are cost-effective, provide value for money and achieve good outcomes for people. We will in turn work with service providers to redesign or decommission ineffective services to ensure value for money and transform the way services are delivered.

This strategy builds on the outcomes of the older people thematic commissioning review which proposed a strategic shift of investment to personalised preventative community services reducing the need for more intensive interventions. See model 1.

1.4 Agreed approach

Slough Borough Council in partnership with Slough Clinical Commissioning Group wants to offer the best opportunities for people as they grow older but these needs to be set within the context of significant financial constraints set by government on public spending and the major restructuring within the NHS. This initiative presents tough challenges but with challenge comes opportunity, and we take this opportunity to do things differently.

1.5 Time period

The strategy centres on the quality of life for those aged 65 and over but also takes account of the needs of those aged 55 and over who may experience long term conditions. It covers a five year period from April 2013 to March 2018, states both health and social care priorities, takes account of the views of local people and links directly with both national and local strategies.

1.6 Investment in resources

Due to the strategic shift towards investment in more preventative services in the community, the following have been the main areas of review and analysis in preparing the Older People Commissioning strategy:

- The demographics of the area and the changes taking place in Slough especially in relation to older people which include a significant ethnic population with diverse needs
- Scarcer resources resulting in services being more targeted and the strategy being more evidenced based rather than repeating current practices
- Recognising that a personalised approach requires providers to be able to offer a range of flexible and innovative services required by the increase in personal choice
- Creating strong working partnerships with all stakeholders including the private and voluntary sector
- Continued consultation with service users
- Re-organising initiatives to reducing hospital admissions
- Maximising opportunities for joint resources by using collective resources differently and more efficiently

In working towards this, some service areas already reviewed included:

- Re-tendering our home based care and support services to include the facility for personal assistants
- Re-tendering our Carers Respite to provide a new way of working which includes joint support planning with outcomes for both the carer and the cared for
- Developing enhanced intermediate care and reablement services to prevent hospital admissions and help people return home safely following a stay in hospital
- Tendering for a Berkshire Community Equipment Service which supports and enables independence
- Tendering a Mental Health Day service provision
- Tendering Floating Support services
- Tendering for a comprehensive Advice, Information and Advocacy service.. Some aspects of the service (advocacy, carer crisis support) are however subject to eligibility criteria.

- Increasing access to psychiatric therapy treatment (IAPT) for emotional wellbeing
- Introducing integrated care teams to provide ‘wrap around care’ which include comprehensive care plans for people with high needs i.e. multiple long term conditions
- Successfully bidding and securing funds through the Dementia Challenge for information services and strategies for early diagnosis
- Providing early supported discharge for stroke patients
- Providing enhanced community rehabilitation in people’s homes

1.7 Shift in resources

Our intentions for shifting resources include:

- Reviewing our nursing and residential provision in line with reductions in predicted demand
- Diverting more care and support services to being provided within the persons own home
- Developing preventative and community based supports that support people to live independently at home and reduce reliance on long term health and social care services.
- Reducing length of stay in hospital beds and getting people back home in the community more quickly and safely

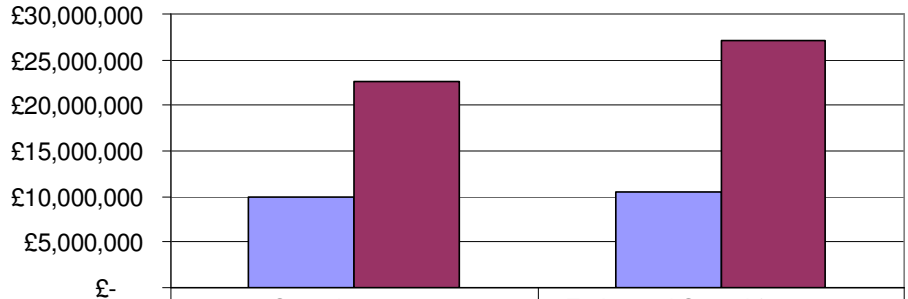
Overall this strategy sets out our vision and principles of care and our commitment to personalisation and local community wellbeing. It also outlines the challenges of responding to and supporting an ageing population and describes our priority commissioning intentions.

2 INTRODUCTION

2.1 Background and Context

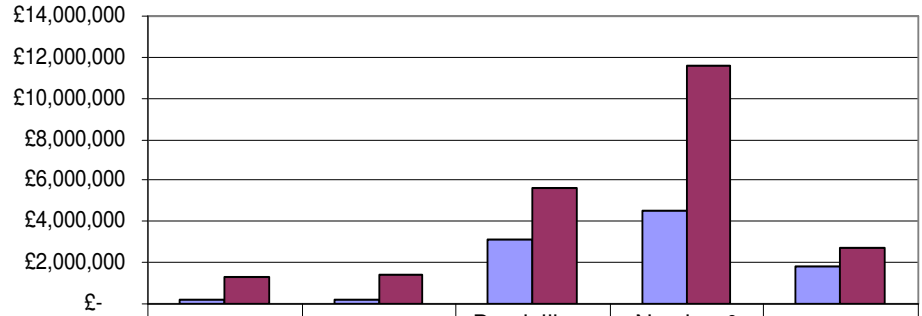
Both Slough Borough Council and Slough Clinical Commissioning Group currently commission a range of services across the borough through different contracting arrangements. Our intention is to maximise the efficiency of our funding streams and re-commission services which are able to meet the personalisation and prevention requirements. Below are details of the councils Adult Social Care spend and older people's spend for 2012/13 and the estimated spend for 2013/14.

Summary of Adult Social Care Spend



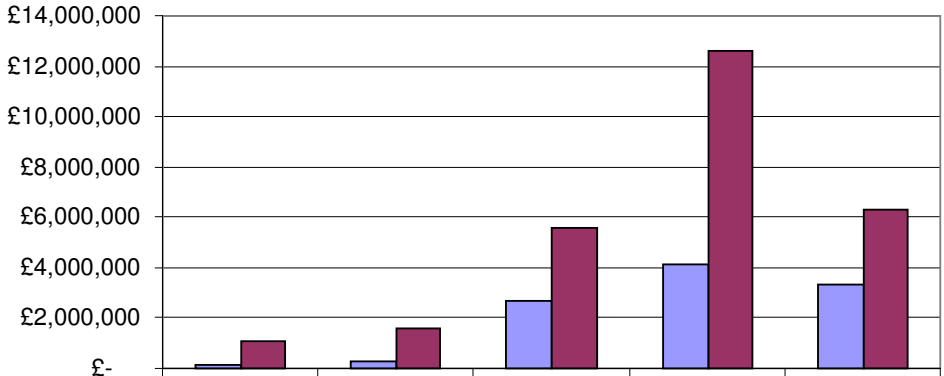
	Spend 2012-13	Estimated Spend for 2013-14
Older People Services	£9,904,058	£10,496,000
Adult Social Care Services (all care groups)	£22,643,624	£27,186,100

Summary of Spend by Service Type 2012-13



	Respite Care	Day Care	Domiciliary Care	Nursing & Residential	Other
Older People Services	£231,000	£217,000	£3,138,000	£4,505,000	£1,815,000
ASC Services (all care groups)	£1,296,000	£1,427,000	£5,657,000	£11,549,000	£2,717,000

Summary of Estimated Spend by Service Type 2013-14

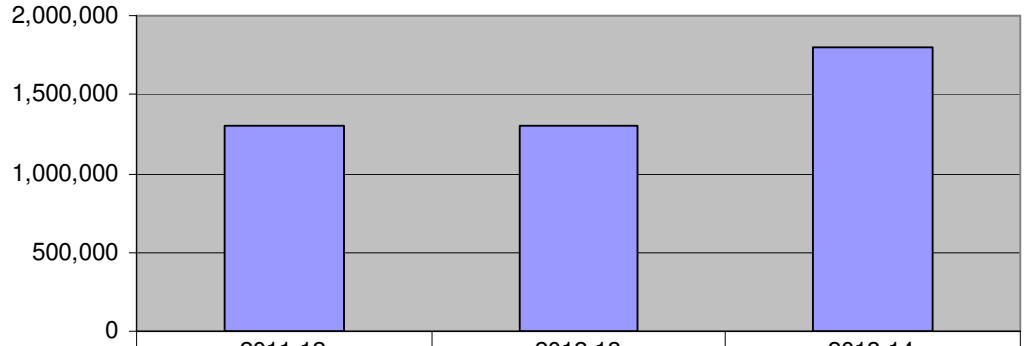


	Respite Care	Day Care	Domiciliary Care	Nursing & Residential	Other
Older People Services	£119,800	£255,800	£2,660,100	£4,152,300	£3,308,000
ASC Services (all care groups)	£1,070,100	£1,599,200	£5,583,600	£12,632,300	£6,300,900

The department of health has identified funding to be transferred to local authorities through the NHS Commissioning Boards (formerly PCT) for investment in social care services which will have a health benefit. Slough Borough Council has put forward proposals to Slough Collaborative Commissioning Board for projects to be funded which will achieve the outcomes in both the NHS and the Adult Social Care Outcomes Frameworks. These projects include:

- Enhanced Intermediate Care and End of Life Care
- Reablement
- Equipment and Assistive technology
- Project management and Support

Health Investment in Social Care



	2011-12	2012-13	2013-14
£	1,300,700	1,300,100	1,800,400

2.2 The Purpose of Commissioning

"Commissioning" describes the activities undertaken to plan and secure the delivery of services in response to assessed and prioritised needs within the resources available. The purpose of this Older People's Commissioning Strategy is to state how Slough Borough Council in partnership with Health / Slough Clinical Commissioning Group (CCG) will deliver quality care and support across the care pathway for older people in the Borough within the constraints of our budget.

- It is based on strategic commissioning principles and best practice
- It provides a framework for the provision of health and wellbeing services
- It proposes specific actions to transform services for older people that provide a greater range of choice
- It sets out the priorities for the Council and Health in the planning and delivery of services which will also include key partners in the voluntary and private sector organisations

2.3 Shared values and visions

The shared values and visions of Slough Borough Council, Health and Slough Clinical Commissioning Group are:

- To maximise independence, promote health and wellbeing and keep people safe
- Increase community engagement, bringing services closer to people's home
- For GP's, other health professionals and patients to work together within the NHS to continually improve the health of Slough
- To ensure healthcare services are making the best use of taxpayers money
- For service delivery to be reliable, trustworthy, transparent and accountable
- To encourage service innovation using best practices that are efficient, effective and evidenced based
- To ensure good quality service provision

2.4 Principles

We are committed to improving our patients' / services users' experiences of health and social care services. With GP's and clinicians working together to deliver high quality services consistently in the community we aim to ensure a comprehensive range of services based on best practices. Our shared vision promotes and is supported by the following rights and principles in that older people:

- be given equal respect, both as individuals and as members of their families and chosen communities
- are enabled to make contributions as citizens, and are not just recipients of services
- have the right to decide how and where they live and die, and to make informed choices about services that affect them, enabling them to maintain their independence and putting them in control
- are provided with good information in ways and places they find useful and which enables informed choice
- have the right to expect high quality, proactive services
- have the right to be protected from harm
- have the right to privacy and dignity and to be treated with respect
- are entitled to an assessment, services and support in their own right

2.5 Outcomes

To best meet the needs of those requiring care and support, we need to move from focussing on ill health to that of promoting good health and wellbeing and more active lifestyles. Our outcomes are in line the principles of *'A Vision for Adult Social Care: Capable Communities and Active Citizens'* (2010).

- **Prevention** – Empowering people and communities to work together to maintain independence
- **Personalisation** – Individuals taking control of their care and wellbeing
- **People** – A workforce given the freedom to provide care and support with skill and innovation
- **Plurality** – People's needs matched by diverse service provision through high quality providers
- **Protection** – Safeguards against the risk of abuse or neglect
- **Partnership** – Partnership working between individuals, communities, the voluntary and private sectors and housing.
- **Productivity** – Greater local accountability which drives improvements to deliver higher productivity and high quality care and support services

The Slough Clinical Commissioning Group outcomes indicators include:

- Reduction in potential 'years of life lost'
- Improved health related quality of life for people with long term conditions
- Increase in proportion of people feeling supported to manage their condition
- Reductions in emergency admissions for acute conditions that could be managed in the community
- with appropriate care and support
- Reduction in emergency readmissions within 30 days of discharge from hospital
- Improvements in patient experience of GP services
- Improvements in patient experience of GP out of hours services
- Improvements in patient experience of NHS dental services
- Reductions in incidences of healthcare associated infections

2.6 Strategy development

This strategy has been developed using a variety of different methods including:

- Extensive consultation with older people and key stakeholders
- An older people steering group providing the lead which enabled us to strategically consult with as many older people as possible. The group contributed to the design of a questionnaire for wider consultation and were kept regularly informed throughout the process
- Engagement with the voluntary sector in arranging a consultation event
- A feedback event to share the results of the consultation. The consultation provided significant but important information which helped inform this commissioning strategy
- Reviews of current service provision providing valuable information regarding services throughout the Borough
- Partnership working with key stakeholders to identify priorities for future commissioning

3 NATIONAL CONTEXT

3.1 Key drivers for change

The Government's vision for adult social care heralds a new direction and sets out how the Government wishes to see services delivered. The new Health and Social Care Act 2012 describes major restructures such as the development of Clinical Commissioning Groups, local Healthwatch and Health and Wellbeing Boards. The Act also initiates the move of Public Health services into local authorities giving them greater responsibility for local health and wellbeing and strengthens the drive for partnership working by supporting the development of new innovative services with all providers.

3.2 Major policy issues nationally

Other national policies which have influenced this Commissioning strategy include:

- Putting People First – (2007)
- National Dementia Strategy – (2009)
- Valuing People Now (new) – For people with Learning Disabilities – (2009)
- National Carers Strategy (2010)
- A Vision for Adult Social Care: Capable Communities and Active Citizens (2010)
- The Quality, Innovation, Productivity and Prevention (QIPP) - 2010
- Think Local, Act Personal: Next steps for Transforming Adult Social Care (2011)
- Caring For Our Future: reforming care and support – (2012)
- Adult Social Care Outcomes Framework (ASCOF) – (2013/14)
- NHS Outcomes Framework – (2013/14)
- Integrated Care and Support: Our Shared Commitment – (2013)

3.3 Priorities

Our priority is to continue to improve the ways in which we support people, with a focus on improving the experience of people who use the services of Slough. With limited resources, the challenge is to utilise our services more efficiently and effectively through building and improving our current provision. Both Slough's Joint Strategic Needs Assessment and service user consultation identified the following overarching priorities:

- *Personalised care and support* – working with GPs and community nurses, private and voluntary sector to provide joined up services for people with the most complex needs
- *Providing of high quality information* – to increase informed choice and control
- *Promoting active engagement in the community* – reducing isolation
- *Avoiding unnecessary hospital admissions* – working with hospitals and community health services to increase the numbers of people who get rehabilitation and other services to prevent hospital and care home admission
- *Making a positive contribution* – where whole systems approaches include services users and patients
- *Freedom from discrimination* – promoting dignity and respect and further develop the ways in which we keep people safe
- *Promoting and maintaining independence* – enabling people to remain longer in their own homes and communities

Other significant local priorities and key areas of work include:

- *Stroke* – providing enhanced early intervention services
- *Dementia* – working in partnership to embed the National Dementia Strategy in Slough
- *Supporting carers* – allowing them to continue to care

3.4 Health and social care 'Must Do's'

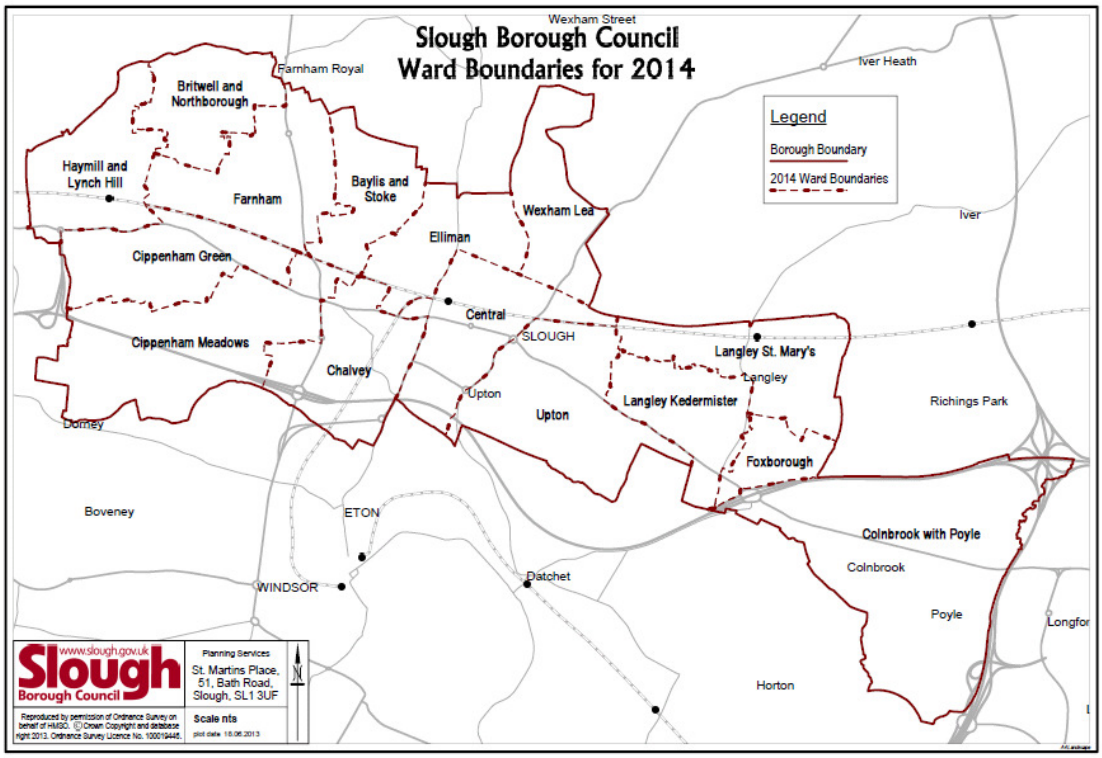
Within the context of national guidance are some 'must do's' which health and social care are required to ensure adherence and implementation. These include:

- *Personalisation* – people being provided with a personal budget as part of their care planning process
- *Managing the market* – stimulating and developing the provider market
- *Investment in preventative services* – prevention and early intervention being central to any care and support
- *Accountability* – establishment of Local Healthwatch and Health and Wellbeing Boards
- *Quality Assurance* – robust monitoring of services and having clear arrangements in place to manage poor quality
- *Partnership Working* – on all levels including families and communities
- *Dementia Services* – raising awareness, encouraging earlier diagnosis and improving living conditions for those with dementia

- *Zero tolerance of healthcare acquired infections* – everyone working together and playing their part to tackle and help stop the spread of healthcare acquired infections by taking a range of actions
- Improved access to Psychological therapies – an NHS programme offering interventions for treating people with depression and anxiety disorders.

4 LOCAL CONTEXT

4.1 Overview of Slough



Slough is an urban area situated 25 miles to the west of Central London. It is a densely populated area, only 7 miles long and 3 miles wide and has a population of around 140,700 (Office of National Statistics – ONS 2011). It is the most ethnically diverse local authority area, outside London and is home to a diverse community from over 80 different countries who live and work together harmoniously.

Slough is a multicultural town and the results of the 2011 Census show that the borough is now ranked as having the most diverse population outside of London.

- 50% percent of its adult residents (aged 18 or older), and 31.4% percent of its older people (aged 65 or older) are from a black or minority ethnic background
- It has the highest percentage of Sikh residents in the UK making up 10.6% percent of Slough's population

- It has the seventh highest percentage of Muslim residents (23.3%) and at (6.2%) the tenth highest proportion of Hindu residents across England and Wales

Slough thrives as an exciting and diverse town with people from all around the world who choose to live and work here and whilst we can all be proud of the success the town achieves we are also right to be concerned about the social and economic challenges this diversity brings including the provision of appropriately culturally sensitive services.

4.2 Health Profile of Slough

In terms of future planning of health and social care services, the following key themes are identified in the Joint Strategic Needs Assessment (JSNA) 2012.

- The general health of many local people is poor and many people in Slough experience more years of ill health and disability than average
- There are high rates new cases of coronary heart disease and pulmonary disease (chest and lungs)
- Cardio-Vascular disease is the single most common cause of all premature death
- Diabetes rates are above the national average
- There are a higher than average number of people who are HIV positive or have AIDS and there has been a rise in the rate of TB
- There are high numbers of people with mental health problems with rising numbers of people with problems of misuse and addiction to drugs or alcohol
- There are high rates of childhood obesity and people who smoke and these factors will impact on health and disability

Many of the above factors will affect people under 65 and continue to impact into old age. This will present significant challenges to improve on the number of people being supported to manage their conditions and will require considerable service planning and partnership working. In relation to this, Slough has a number of key local strategies / policy documents which include:

- Slough's Sustainable Community strategy – Proud to be Slough
- Slough Joint Strategic Needs Assessment 2012
- Berkshire East Dementia Strategy
- Slough Joint Commissioning Strategy

- Berkshire Multi-Agency Safeguarding Adults Policy and Procedures
- Local Account 2012
- Slough Supported Accommodation Strategy
- Sloughs Public Health Strategy (2013-2016)

It is essential that older people are at the core of everything we do and are involved as key stakeholders in the re-designing and development of services. One of the Government's aims in the new Health and Social Care Act 2012 is for there to be a *"no decision about me, without me"* culture. This means the involvement of patients / service users taking place at the very beginning of any service planning and delivery. We are therefore committed to reviewing and strengthening our partnership groups where service users are key contributors.

Our aim is that by developing stronger local links and partnerships with the private, voluntary and community sector we can create more community based environments which are innovative and person centred. We will use partnership engagement through our Local Healthwatch, Health and Wellbeing Boards and Clinical Commissioning Groups whose key role is bringing together local commissioners to agree integrated ways of improving local health and well-being.

4.3 Good practice that has informed the strategy

- *Enhanced intermediate care and reablement* – Intermediate care services in Slough have had significant, positive impact on promoting and maintaining independence for people using services. The national indicator is for people over the age of 65 years who are still at home 91 days after receiving the service. Slough has consistently hit a 100% target throughout the year.
- *Integrated care teams* - providing co-ordinated care for patients and carers in the community has helped in achieving improved patient experience and clinical outcomes.
- *Wellbeing services including community groups* – day activities and opportunities play a vital role towards the preventative agenda, providing social links and reducing isolation
- *Shared Decision Making* – multi-disciplinary teams working together to provide co-ordinated care and support. Pathways of care and support have led to improved outcomes.

5 FUTURE DEMAND

5.1 Older people in Slough

We know that older people are living longer, that life expectancy has been steadily growing and is set to set to continue to increase. In 2010 it was estimated that there were approximately 12,640 centenarians nationally and this figure is expected to rise.

The 2012 Census results indicated that whilst the national average of older people is increasing, Slough's population of those aged 50 and over has reduced. This still however presents challenges as our health profile indicates that Slough has a high unwell younger population.

The figures from the last census show there are around 14,400 older people living in Slough, however any future commissioning plans need to take account of the Borough's younger / older people (those aged 55 to 65) and in particular those who may be affected by long term conditions.

The demand for care and support services arising from specific groups will place a significant challenge for Slough in the coming years. Part of that challenge will be to provide access to sufficient preventative services to enable people to maintain their independence and to self care for as long as possible. There will also be challenges around providing sufficient quantities of good quality care with skills, competency and knowledge to appropriately support those with chronic acute illnesses which require both health and social care services. Some key areas of concern are:

5.2 Physical Disability / Sensory Impairment

Physical disability and or sensory impairment will be different in each individual. Conditions may be present from birth or acquired later in life, temporary or longer term, stable or fluctuating. People with the same condition will also have very different needs depending on the severity of the condition and other circumstances. Each person's impairment is unique and so too will be their personal experience of disability.

Although there is service provision to support those with a physical disability, in relation to sensory impairment, based on national statistics, a far greater number than those currently registered in Slough on the voluntary deaf, hard of hearing and

visual impairment/blind registers are likely to have a sensory need. Although it is difficult to predict future service needs, the development of an integrated sensory needs resource is nevertheless essential.

5.3 Learning Disability and Autism

People with learning disabilities are living longer and generally having more complex health needs and this will present a number of future challenges for Slough. GP's are now to have responsibility for carrying out annual health checks to identify any conditions earlier.

The challenge in relation to Autism is in raising awareness of the condition which is often overlooked or misunderstood by professionals and by society. Adults with autism and their families face many barriers in their everyday lives and in accessing the services and support they need to live independently within the community.

5.4 Dementia

Nearly 1000 people in Slough have dementia – and this number is expected to increase rapidly in the next thirty years. Slough Clinical Commissioning Group (CCG) is committed to improving the care and experience of people with dementia and their carers by transforming dementia services to achieve better awareness, early diagnosis and high quality treatment at every stage and in every setting, with a greater focus on local delivery of quality outcomes and local accountability for achieving them.

5.5 Limiting Long term conditions

It is estimated that by 2030 around 50% of the population over 65 in Slough will have a limiting long term condition. Long term conditions include a number of illnesses including diabetes, asthma, neurological conditions and conditions caused by a stroke. People with long-term conditions are the most frequent users of health and social care services and our challenge is to ensure earlier diagnosis and improved support which helps people to manage their conditions.

5.6 Stroke

Stroke is one of the major causes of premature deaths and disability in the country and is the third highest cause of death in Slough with 26 deaths in males and 27 in females in 2010 (Source Annual District Deaths 2010). Further in Slough CCG area,

approximately 227 patients suffered a stroke in 2011/12 and were admitted to hospital.

There has been considerable focus on improving stroke services, both nationally through the National Stroke Strategy (2007) and locally over the last 5 years. Significant improvements have been made to local services as they have developed in line with the National Stroke strategy including the development of a hyper acute stroke unit (HASU) at Wycombe hospital which offers intensive care, rehabilitation and therapy for three days following a stroke which is vital in ensuring positive outcomes. This and the work of local clinicians in implementing an agreed pathway of care for stroke has led to improvements in outcomes as measured by the number of people who return home following admission to hospital for a stroke.

During 2013/14 further developments are planned with the introduction of the Early Supported Discharge team which will enable appropriate stroke survivors to leave hospital 'early' through the provision of intense rehabilitation in the community which corresponds to a similar level of care provided in hospital. This reduces the risk of re-admission into hospital for stroke related problems and increasing independence and quality of life.

5.7 Mental Health

There is evidence of proven links between social disadvantage and deprivation with levels of mental health illness. Given Slough's continued levels of deprivation, it will require continual reshaping and reviewing of mental health services. There will be continued expansion of Memory Clinics in Older people's Mental Health services, plus funding to cover dementia medication costs in Memory Clinics and primary care. There will also be investment to ensure delivery of national priorities for an expanding caseload focussing on early intervention as far as possible.

5.8 Diabetes

Diabetes is a significant health issue in Berkshire East. The high prevalence in Slough is likely to be attributable to Slough's higher rates of deprivation and larger number of patients from at-risk population groups (particularly South Asian population). These health needs are being addressed through a diabetes strategy which includes an integrated diabetes service which is clinically led and where

specialist and primary care services work collaboratively to improve health outcomes for those people with diabetes across East Berkshire.

5.9 Carers

It is recognised that carers play a vital role in contributing towards health and social care and many of those affected by the above conditions will be cared for by others. Both national and local profiles of carers show a projected overall increase in the numbers of those caring, carers themselves getting older and in those carers with physical and mental health needs Slough has commissioned several carers organisations to provide respite and support services. There is a need for GP's to both recognise and have a register of carers.

5.10 Housing

Many people who use social care services also have health and housing needs and there are high numbers of houses of multiple occupation. In Slough we therefore need a range of housing including Extra Care and other specialist housing able to meet the growing number of people with specialist needs.

5.11 Overall assessment of demand and the implications of this data

Through various data sources Slough is aware of both current needs and future service demands. The commissioning action plan in Appendix A provides more detailed information in relation to gaps in services, actions required to remedy this and the intended outcomes. Transformational change has also been identified with the Clinical Commissioning Group where planned care, preventing crisis, supporting people, joint commissioning and staying healthy are key elements of their commissioning plan

The outcomes of any finances spent must demonstrate benefits to both health and social care services, and encourage greater integration between health and social care at the local level as this investment will result in better outcomes for people needing support or treatment and at a lower cost of provision overall.

Annual reviews of our commissioning plan will help us address and reduce any risks associated with potential pressures in future government funding of care and support.

6 MARKET ANALYSIS

6.1 Current commissioned services

Our externally commissioned services operate across the Borough

- *Information and advice* – Voluntary sector
- *Home Support including Personal Assistants* – framework of 15 external providers. No volume work is guaranteed allowing greater flexibility for council and service users
- *Carers Services* – framework of 16 external providers
- *Residential and Nursing* – external providers
- *Berkshire Community Equipment Service* – external provider / Berkshire wide service
- *Community Meals* – external private provider
- Day Care / Day Opportunities – Mix of voluntary sector providers
- *Handyperson Service* – Voluntary sector
- *Berkshire County Blind* – Voluntary sector
- *Dementia Respite Services* – Voluntary sector
- *Extra Care* Housing – external provider
- *Floating Support* – external provider
- *Mental Health Day Activities and Opportunities* – external provider

Action plans for future provision of these services is included in Appendix A.

6.2 Service performance

Through our consultation process older people gave their views on service provision in the Borough and fed back what improvements they would like to see:

- Improved health services and facilities cross the borough in particular for people with long tem conditions including those with dementia, autism, physical and sensory needs
- More weekend facilities including day centres and lunch clubs
- Wider variety of activities including BME specific services and those which help maintain independence and promote healthy and active lifestyles
- Improved partnership working between Social services, health, housing and voluntary and community groups in service development, planning and delivery
- Increased monitoring of service provision and more joint responsibility

- More opportunities for older people to be consulted and involved in local issues which directly affect them
- Improved and innovative ways of providing older people with advice and information.
- Increased access to domiciliary care type services

6.3 Service quantity

National projections inform us that older people are living longer and health and social care providers need to be more strategic in planning how services are to be provided. Locally, we are aware of gaps in some service areas and our aim is to address these through future commissioning. These include:

- Specialist accommodation – particularly extra care housing. Research indicates that extra care housing can delay or prevent need for more intensive forms of support
- Sensory needs services – There is an under provision of service in the Borough
- Care homes for elderly mental health and enhanced nursing care – A wider range of provision is needed

6.4 Developing the Market

The role of commissioners is to work effectively with providers, service users, carers and communities to ensure that the right services are available, in the right place, at the right time. We need to understand need based on evidence and how people and communities want to live their lives.

Slough is a multicultural town with a diverse social care market. It is only through understanding the local market that will help us to decide when and how to commission services which enable self help and community resilience. We recognise that the voluntary and community sector make a unique contribution to the needs of service users. Their responsiveness, flexibility, independence and capacity for innovation are valued qualities. They are also able to reach and provide support to individuals, in particularly our growing ethnic community, whom may be overlooked or do not meet an eligibility criteria.

Providers are very realistic, understand the challenges that we all face over the coming years, and accept the need for change even though these may be difficult.

However, Slough is keen to develop closer relationships with providers both large and small to make the best use of joint intelligence, knowledge and skills in developing our social care market.

7 THE SHAPE OF FUTURE SERVICE PROVISION

7.1 Prevention

There is widespread acknowledgment of the requirement to shift the balance of services from acute care to promoting health and wellbeing thereby reducing the demand for acute services. It is essential that prevention activity is targeted where it can be of most benefit. This can include a range of social care measures from:

- Supporting social inclusion
- Reducing isolation and preventing depression
- Provision of recovery, rehabilitation and reablement services
- Further development of community based services

Health and Slough Clinical Commissioning Group's transformational plans include:

- Implementing pathways that support an integral whole system urgent care service locally
- Integration of out of hours into urgent care centres
- To further embed and expand patient navigation at the front door of the hospital
- To expand capacity in community alternatives to admission
- Improve provision of primary care services during peak demand
- Increase availability of direct access diagnostics in urgent care settings
- To increase opportunities and encourage people to stay healthy

These objectives can only be successfully achieved by closer partnership working and utilising existing resources. The voluntary and community sector are central to prevention services as they are well placed to reach those who are socially isolated and to support them through befriending and other services. Through the promotion and development of preventative services, our aim is to help support people to maintain independence through the ability to use mainstream community based services.

7.2 Partnerships and integrated working

Delivering high quality outcomes and experiences for individuals can be challenging but the government is determined that collaborative working which improves both people's health and the delivery of integrated care and support will become the standard for everyone with health and care needs.

Fragmented care and support services can negatively impact individuals, therefore creating a culture of co-ordination and co-operation between health, social care and the voluntary and community sector is essential in providing quality care and support as better integration can help drive positive change.

Slough has had previous successes of working with and jointly commissioning services with our health and housing colleagues and neighbouring authorities. These include:

- Floating Support services – a joint social care and housing commissioned service
- Berkshire Equipment services – jointly commissioned with 6 neighbouring local authorities
- Mental Health Day services – a joint health and social care commissioned service

Our aim is to continue joint working and commissioning by:

- Implementing integrated care teams
- Commissioning and providing integrated health and social care services to ensure rapid responses aimed at optimising the patients' condition
- Pursuing opportunities for further integration of services across the health and social care economy
- Providing enhanced joint support for carers
- Exploring options for joint commissioning with other neighbouring authorities

8 COMMISSIONING INTENTIONS

Our Joint Strategic Needs Assessment is used as an indicator for health and wellbeing needs and will help inform our decisions on future commissioning. Adult social care is highly resource intensive and our growing and ageing population is set to increase.

8.1 Our intentions

Our intention is to focus on shifting the way in which we commission services traditionally, to build on, improve and utilise resources more effectively to continue to meet the health demands of the local population. No new money will be available so it is important that what funding and services are provided can deliver on key strategic objectives and are targeted towards priority places with the greatest level of need. This will include:

- The de-commissioning any unnecessary duplication of services
- Greater coverage of cancer, HIV screening programmes and health checks
- Expansion of health promotion and prevention schemes to support self-management

Our joint health and social care service objectives have been placed under the following themes in our action plan *(Appendix A)* which gives a more detailed outline of our strategic programme.

Theme ❶ Promoting and sustaining health and wellbeing for older people including prevention

Theme ❷ Increased support to enable independence in the community and improving quality of life

Theme ❸ Managing long-term conditions

Theme ❹ Supporting people at the end of their lives

8.2 Safeguarding

Safeguarding sits at the forefront of all our priorities and is at the core of everything we do. Measures need to be in place locally to protect those least able to protect themselves. The Government believes that safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse. Safeguards against poor practice harm and abuse need to be an integral part

of care and support. Slough has successfully implemented a range of methods to improve adult safeguarding in the Borough including developing a Safeguarding Board and creating stronger links with all stakeholders, implementing new governance arrangements and tools to escalate concerns.

8.3 Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards apply to adults in a care home or hospital setting who lack capacity to consent to their stay in the care home or hospital in order to receive support or treatment, and whose care regime is such that it amounts to a deprivation of their liberty. The DoLs code of practice assists staff and institutions in considering whether or not the steps they are taking, or proposing to take, amount to a depriving a person of their liberty.

The Safeguards give a 'best interest assessor' (BIA) the authority to make recommendations about proposed deprivations of liberty, and supervisory bodies (the local authority) the power to give authorisations to deprive people of their liberty. It is the role of the best interest assessor (BIA) to undertake six assessments, with an appropriately trained doctor, for the purpose of determining whether the person is being, or needs to be, deprived of their liberty and the role of the supervisory body to ensure this happens and that the code of practice is complied with.

Slough jointly commissions with other neighbouring Berkshire authorities an Independent Mental Capacity Advocacy (IMCA) service to deliver this provision. In addition Slough arranges and delivers annual DoLs workshops for registered care home providers and NHS hospital staff together with advice, guidance and bespoke training for internal and external staff. Slough has also produced a DoLs guidance booklet for care homes.

8.4 Workforce Development

Workforce Development supports improvements in the quality of practice by developing the skills and knowledge of the workforce to be able to provide high quality, personalised care and support.

The importance of a skilled workforce cannot be underestimated as better skills and training are an important part of raising standards overall.

It will be an expectation of any future commissioning that providers are able to identify and demonstrate the appropriate proportion of available resources to support training and development and Slough is committed to extending joint training and development across sectors and employers and providing targeted training to partners.

Our aim is to ensure

- Workforce are appropriately trained
- Staff are supported through effective management
- Adult Social Care will have a competent and settled workforce
- Awareness raising
- Encouragement of 'Champions' for service areas
- The Council's policies and procedures are implemented and monitored

9 COMMISSIONING THE VOLUNTARY SECTOR

9.1 Voluntary sector

The voluntary and community sector make enormous contributions to the wellbeing of residents within Slough. Slough has a large and diverse range of voluntary and community services within the borough and it is our aim to continue to support and develop further activities which will include:

- Supporting hard to reach communities and individuals
- Providing solutions to local problems, by working in partnership
- Providing opportunities for local people to get involved
- Contributing towards the local economy and help create volunteering opportunities

9.2 Funding arrangements

There are a number of voluntary sector groups in the borough who have been able to source alternative funding arrangements to that of the council and have been successfully providing valuable services for several years.

Those who are funded from Slough's current budget of £1.2m are managed through either contracts or service level agreements. Funding streams are currently split under the headings of 'Prevention' or 'Adult Social Care'. Some services are categorised as for older people, although a number are intergenerational. We aim to combine the current funding arrangements and formalise new commissioning arrangements.

9.3 Areas for Improvement

A review of the current funding arrangements identified several disadvantages in continuing to fund services in the way we currently do. These include:

(a) Some services becoming dependent on council funding whilst others (non council funded services) find a business model that allows sustainability

(b) A limited budget continually funding the same services does not allow for innovation / change in the commissioning model

(c) Commissioning of services needing to reflect the current financial constraints and ways in which service delivery needs to be arrived at in partnership with the community.

9.4 The need for change

There are a number of services in the borough which have been continuously funded for several years. Re-commissioning will provide the opportunity to include a new profile of the market. The 2012 Joint Strategic Needs Assessment indicators show increases in long term conditions affecting adults before the age of 65 resulting in a need for more universal services i.e. wellbeing hubs – day opportunities and drop in services. Austerity constraints also necessitate new models of commissioning which provide the greatest community value within a limited budget and any re-commissioning of future services will need to meet personalisation requirements, prevention and early intervention agendas.

10 MONITORING ARRANGEMENTS

10.1 Quality Assurance

Slough is currently developing its Quality Assurance policy which will include tools such as the Adult Social Care Outcomes Framework (ASCOF). This is in addition to the Care Quality Commission and will include processes in place for monitoring progress and creating regular feedback opportunities for people who use our services and their carers. Our outcome-based contract and monitoring arrangements ensure that services are based on best practice and give value for money. There are also quality thresholds for health services and quality requirements which include stroke care, end of life, care for the elderly and safeguarding.

Health Services will be monitored using the Clinical Commissioning Group Outcomes Indicator Set 2013/14. Indicators include helping older people to recover their independence after illness or injury, reducing premature mortality from the major causes of death, enhancing the quality of life for people with dementia, improving recovery from stroke, improving recovery from fragility fractures and enhancing quality of care for carers.

It is also essential that we monitor the progress of this strategy against the outcomes framework to ensure that any changes continue to focus on high quality care and support.

APPENDIX A

1 ACTION PLANS – OUTCOMES AND THEMES

The results of our older people's services review and consultation indicated that although improvements have been made, there is still scope to do more to enhance the quality of life of older people and to ensure they are supported to live full and independent lives.

The commissioning strategy focuses on our service developments from 2013 – 2018. The detail of how we aim to deliver our objectives is shown in the action plan which will be regularly updated as the changing political and financial landscape dictates. It is difficult at this stage to anticipate the impact of future budget constraints but we will do as much as is possible to ensure that throughout this period regular reviews are undertaken to manage the financial pressures. Our reviews will also take account of our population profile, challenges, opportunities and the outcomes of our key actions

Our action plans for externally commissioned services and service needs incorporate the Adult Social Care Outcomes Framework (2013/14) together with the NHS Outcomes Framework (2013/14) as a guide for our intended outcomes. As the outcomes often overlap all service areas, the intended outcomes shown below are the minimum expected.

The frameworks will help us to drive up standards of care and support and give people genuine choice and control over the services they use. The areas of our focus have been placed into four key themes:

Theme ❶ Promoting and sustaining health and wellbeing for older people including prevention
Theme ❷ Increased support to enable independence in the community and improving quality of life
Theme ❸ Managing long-term conditions
Theme ❹ Supporting people at the end of their lives

2 ACTION PLANS – EXTERNALLY COMMISSIONED SERVICES

Day Activities and Opportunities		Theme 1 Theme 2	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Day Activities and Opportunities can play an essential role towards the prevention agenda. They help reduce isolation, provide opportunities for increased health and wellbeing through a range of activities and where lunch is provided, healthy and nutritious meals. **What we have** Slough has some very vibrant community day centres which are also intergenerational. They focus on the community as a whole and provide a range of beneficial and preventative services. Many of these services are culturally specific and given Sloughs' ethnic diversity, these services are vital. Three of these services are either council run or subject to eligibility criteria. Others are run by the voluntary or community sector and five receive funding through the Council. **Areas of development** • **Greater service flexibility to provide extended hours and services 7 days a week including weekend drop in services.** • **Additional day service provision for our growing dementia needs** • **Services which reflect the cultural and diverse needs of the local community**	• Increase in quality of life for both service users and carers • Increase in the number of people who use services and their carers being able to have as much social contact as they would like • Ensuring everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support to help them achieve this • Supporting people to remain more independently in their own home and in their own communities and reducing the need for acute service interventions • Increase in numbers of people enabled to contribute to community life and be more actively involved • A provider market providing more localised support	• Working with providers in creating more community opportunities which promote good health and wellbeing • Ensure continuous working with older people in developing services • Work with all partners to build and further develop the day opportunities. We need to create a more flexible market which enables people to have more choice. • Encourage development of services to meet personalisation requirements and opportunities • Re-commissioning services which meet the needs of diverse groups	2013 - 2014

Residential and Nursing		Theme 3 Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
The requirements for residential and nursing home care are changing. We need to consider the reducing need for elderly frail placements in residential care with the increased future demands for elderly mental health placements. There needs to be more whole system care approaches which could support people within their own homes. **What we have** The Borough has 6 nursing and 3 residential homes providing a range of care including Elderly Mental Health. **Areas of development** • **More quality specialist services particularity for advanced dementia required** • **Enhanced nursing care**	• Ensure when people develop care needs, the support they receive takes place in the most appropriate setting • Increase in numbers of people feeling they are being treated with dignity and respect • More people are satisfied with their experiences of care and support • Enhancing Quality of Life for people with care and support needs	• Re-commissioning taking account the current role of these services and predicted future demand • Closer monitoring of referrals for residential care • Further development of nursing care services for elderly mental health • Encourage establishment of Dignity Champions in care homes • Ensuring care homes are all aware of Deprivation of Liberty Safeguards	2015 - 2016

Housing options including Extra Care		Theme ❷	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
It is widely recognised there is a need for more well designed specialised housing that improves the health and wellbeing of many people. Extra Care housing can help reduce dependency and cost as people get older due to their being in a supported environment which can adapt around their needs. **What we have** Two Extra Care schemes, The Pines and Northampton Place, providing 126 Self contained flats with on-site care and support. **Areas of development** • **More specialist services particularly for those with advanced dementia** • **Improved flexible service models** • **Specialist housing that can accommodate those aged under 55 with long term conditions** • **Improved availability of a range of suitable housing and housing related support services** • **Application of Telecare and assistive technology effectively applied**	• Ensure when people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence. • Increase the effectiveness of availability of local Extra Care resources • Increase in numbers of people managing their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs. • Increase in the numbers of people who use services having control over their daily life • Increase in numbers of people feeling they are being treated with dignity and respect • More support tailored to meet the needs and personal circumstances of the individual • More people are satisfied with their experiences of care and support	• Identify opportunities for further development of Extra care provision using existing council housing stock • Development of additional Extra Care schemes appropriately designed with specifications and assistive technology that can provide high quality care especially for people with dementia. • Full review of suitability of current services	2014 - 2015

Community Meals		Theme ❶ Theme ❷	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
We recognise that community meals play a vital role in providing social contact and maintaining social links. Community meals can not only provide health and nutritious, they can also have a positive influence on older people's mental and physical health. **What we have** A single provider of community meals **Areas of development** • **Increased flexibility in delivering times** • **Limited choices for service users**	• Enhancing quality of life for people with care and support needs • Ensure the provision of community meals that deliver to nutritional standards and meet the needs of people whom are housebound and or have complex needs	• Full review of current service provision • Re-commissioning of community meals to ensure increased choice and flexibility of delivery	2013 -2014

Home Based Care including Personal Assistants		Theme 2 Theme 3	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Home based care is increasingly moving away from the traditional domiciliary and personal care services to offer more comprehensive innovative services which are more flexible, person centred, increase independence and can accommodate those in receipt of personal budgets. **What we have** A framework of 15 providers able to offer a range of home based care services **Areas of development** • **As a commissioned service in mid way of a contract, we are continually monitoring the service, identifying gaps and areas of further development** • **Services need to be more community based focused** • **There is a need for 24 hour live-in care which can be supported by personal assistants arrangements**	• When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence. • Increase in numbers of people managing their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs. • Increase in the numbers of people who use services having control over their daily life • Increase in numbers of people feeling they are being treated with dignity and respect • More support tailored to meet the needs and personal circumstances of the individual • More people are satisfied with their experiences of care and support	• Continue to ensure a wide range of services which are outcome focussed and person centred • Continuing to strengthen home based services which allow the user more choice and control • Ensure service delivery is consistent in quality and providers are working towards outcomes of individuals • Re-commission services to take account of changes in national and local polices	2015 - 2016

Information, Advice and Advocacy		Theme 1	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
We need to ensure there is a wide range of accessible information and advice specifically aimed at older people, their families and carers to make the customer journey as smooth as possible. Information needs to be easily available especially at key points of when identifying need. **What we have** Although Information, Advice and Advocacy is widely provided through council offices, libraries, voluntary sector, community centres and our Gateway Service, a recurring theme throughout our consultations was the importance of timely and appropriate information in an accessible format which enables people to make informed choices. There is a 'What good look likes' initiative to making public information more widely available to assist people in making choices over their care. **Areas of development** • **Easy to use Council and Health information websites** • **Easy to use directories for all including council staff** • **Joint partnership working sharing knowledge and information** • **Improvement in Council's ability to signpost** • **Advocacy service for non-eligible services**	• Increase the number of people who use services and carers who find it easy to find information about care and support • Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs • Increase in people with adult social care needs will having wider access to a range of council services • Increase in numbers of people who know what choices are available to them and how to get help when they need it	• Increase access to information • Finding innovative and practical ways to make information more widely available • Further review of current service to provide a more centralised information and advice across the borough • Clinical Commissioning Group patient facing information website currently in development • Contract for non-eligible advocacy services being tendered	2013 - 2014

Carers Services		Theme 2 Theme 3 Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Carers are a vital and valuable resource but also need opportunities to have a life outside of caring. There are a number of ways that carers can take a break from caring but no matter what support the carer has they need reassurance that a quality service is being provided to the older person with needs. **What we have** A framework of 16 providers providing home based and community based respite and support. Emergency respite for up to 2 days **Areas of development** • **Additional support for older carers** • **Carers respite services in peoples own homes** • **Improved provision of respite beds** • **Transport access for carers** • **Inadequate supply of emergency respite beds** • **Services which meet a wider range of need including advancing dementia** • **Facility for GP's to purchase emergency respite for those not eligible for adult social care**	• Enhancing the quality of life for carers ensuring they can balance their caring roles and maintain their desired quality of life • Increase in the number of people who use services and their carers being able to have as much social contact as they would like • Increase in numbers of carers having received a carers assessment and are aware of their entitlements • Increase overall satisfaction levels of carers experiences, including the numbers who have been included or consulted in discussions about the person they care for • Increase the proportion of people who use services and carers who find it easy to find information about support • Carers are supported to balance their caring roles and maintain quality of life	• Continuous support for carers to maintain health and wellbeing through easier access to services and ensuring adequate take up • Review of Adult Social Care pathways to ensure carers access to assessments and onward referral • To continue to engage the User and Carers Reference Group to ensure representation in decision-making and directly influence the services we commission • A carers strategy which will provide the framework for future carers services	2013 - 2014

Physical Disability and Sensory Impairment		Theme ❷	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
The needs of people with a physical disability and or sensory impairment will change over time and this makes it particularly challenging when attempting to explore and quantify future service development. Services which are delivered need to be person centred and emphasise the individual's rights to independence and self-determination. **What we have** A Berkshire wide Community Equipment Store (BCES) provides equipment and aids for daily living to enable those individuals in need of support. A voluntary sector provider delivering services for those who are visually impaired. A deaf centre which provides various activities and also supports those with a visual impairment. Those who are visually impaired are referred to a specialist agency once they have been registered. **Areas of development** • **Sensory needs worker to co-ordinate, support and signpost those in need of support services**	• People who have a physical disability or sensory impairment are appropriately supported to live independently • Improved life outcomes for adults with a physical disability or sensory need and for people to feel supported to manage their condition • Promoting Independence and delaying or reducing the need for more intensive care and support • Increase in number of people managing their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs • Increase in the numbers of people who use services having control over their daily life	• Recruitment of a sensory needs worker in the overall adult social care restructure	2013 - 2014

Independent Mental Capacity Advocacy (IMCA)		Theme 1	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Everyone has the right to make a decision but not everyone has the capacity to do so. The role of an Independent Mental Capacity Advocate (IMCA) is to support and represent an individual who lacks capacity and has no family or friends appropriate to represent them in making decisions about their lives. The IMCA supports people in areas such as accommodation, serious medical treatment, care reviews, safeguarding and deprivation of safeguards. The IMCA does not make the decision on behalf of the person they are representing as the final decision will always be made by the decision-maker. **What we have** Slough and six unitary authorities within Berkshire jointly commission an IMCA service, currently being provided by Matrix. The current five year contract has come to an end and a tendering process is being undertaken by Wokingham BC on behalf of six authorities. Slough has made continued and consistent efforts to promote the Mental Capacity Act and the Deprivation of Liberty Safeguards **Areas of development** • **Evaluation of current service provided by Matrix has been positive with no gaps identified.**	• Ensuring decisions are based on thorough assessment of the options most suited to the views, wishes and needs of the clients • An holistic person centred approach to the decision making process • Ensuring that decisions are made timely and achieve the best outcome for the client • Delivery of a quality service that makes a real difference to peoples lives • Enhancing Quality of Life for people with care and support needs	Re-commission the service through the tendering process	2013 - 2018

Community Equipment		Theme 1 Theme 2 Theme 3 Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Community Equipment is provided on loan to individuals living in the Borough enabling them to carry out daily living tasks they would otherwise be unable to do or to provide support to a carer to facilitate ongoing care. **What we have** A Berkshire wide Community Equipment Store (BCES) that provides both simple and complex aids for daily living to enable residents to maintain their independence in their chosen location. A voluntary sector provider delivering a Handyperson Service for small scale repairs for older people **Areas of development** • **Availability of minor adaptations service for private home owners**	• Enhancing Quality of Life for people with care and support needs • Promoting Independence – delaying and reducing the need for more intensive care and support • Achieve value for money • Deliver high quality services to meet local needs • People will remain or achieve independence for as long as possible where appropriate • Reductions in the number of people admitted into nursing and residential care	• Work with our Clinical Commissioning Group (CCG) partners in Health to ensure a continuation of service • Continue to work with our Health and Berkshire Local Authority partners to provide a timely and efficient equipment loan service across the County that meets the needs of our older population • Review service provision of minor / small scale repairs • Expand the service as need dictates and provide Assistive Technology, Minor Adaptations and retail and demonstration centres enabling residents to trail and purchase simple aids to daily living	2013 - 2014

3 ACTION PLANS – INTERNALLY PROVIDED HEALTH AND SOCIAL CARE SERVICES

Hospital Avoidance / Timely Discharge		Theme 2 Theme 3 Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Several approaches have been identified which can help avoid unnecessary hospital admissions including; integrating health and social care services, supporting patient self-management, developing personalised health care programmes and structured discharge planning. **What we have** Our intermediate care team and social work discharge teams facilitate timely discharges and help avoid unnecessary admission into hospital. The Community Equipment Service also contributes to facilitation of timely hospital discharges. There are Multi-agency escalation plans for those with frequent hospital admissions and Rapid Access (2 hour response) to district nurses. **Areas of development** • **New model of service required with improved Multi-agency approach** • **Improved GP out of hours services** • **24/7 emergency responder service** • **Improvements in Nursing homes approach to residents hospital admissions and acceptance following discharges** • **Improved knowledge and education of out of hours care staff**	• Improved process for fewer admissions into hospital • Clear and understood pathways between Health and Social care services • Reductions is the number of people admitted into nursing and residential care • Reductions in time spent in hospital for those with long term conditions • Improving peoples experiences of care • Improving peoples experiences of integrated care	• Major review of all systems to include; development of an enhanced multi agency joined up discharge approach, pathways and ensuring timely intervention • Continuation of GP led cluster meetings with integrated care teams • Urgent care centres placed in front of house at Accident and Emergency • Re-location of out of hours services into urgent care centres • Implementation of 24 hour responder service	2013 - 2014

Enhanced Recovery and Reablement		Theme 2 Theme 3 Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Recovery and reablement are the cornerstones of the prevention agenda and supports the strategic aim to delay or reduce the need for more intensive forms of care. **What we have** Enhanced Multidisciplinary recovery / Intermediate Care teams where care can be provided within people own homes or in residential care beds/homes. The service can be provided 24 hours, seven day a week. **Areas of development** • **Increase in provision of services which can support and help keep people at home, to increase or maintain their independence, particularly those with long term conditions** • **Increase in provision of services which can support people with advancing dementia** • **A joint task force which includes community nurses, speech and language therapists, stroke co-ordinators, specialist nurses and local pharmacy working in partnership to provide more comprehensive support**	• Helping older people (in particular) to recover their independence following illness or injury • Increase the number of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/ rehabilitation service • Ensure support received takes place in the most appropriate setting, and enables people to regain their independence. • Increase the optimum level of independence for the patient with the lowest level of ongoing support • Reductions in the number of people admitted into nursing and residential care • Improved process for fewer admissions into hospital • Minimise delayed transfers of care to agreed local expectations	• To continue to provide comprehensive Intermediate Care and Reablement in partnership with Health to ensure those with higher levels of need can be supported • To work more closely with GPs, Community Health Staff and local community groups • Increase the number of days older people remain independent at home following discharge from hospital • Better planning of timelier multi agency discharge intervention particularly for those with unmanaged long-term conditions • Further development with health of joined up approaches towards prevention	2013 - 2018

Dementia including Early Diagnosis		Theme ❶ Theme ❷	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Dementia is a growing concern as rates of prevalence are increasing as is our older population. It is essential that services are in place to improve the quality of life of those affected and their carers. **What we have** A dementia advisor and carers champion who supports patients and carers, liaises with external agencies, provides advice information and signposting A dementia Saturday service which provides respite for carers of people with dementia. This is an activity based service. **Areas of development** • **A stock of good quality, standardised information in appropriate formats for service users and carers, appropriate to their needs depending upon their stage in the care pathway** • **A 'Medication calls' service which can help support with non-compliance of medication including engagement with key pharmacies**	• Increase the effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia • Earlier diagnosis, intervention and reablement means so that people and their carers are less dependent on intensive services • GP registration to closely reflect expected incidences • Good quality advice and information made available to service users and carers including reviewing choices exercised through self directed support. • Relevant timely and appropriate additional information provided as required and tailored to needs	• Continued promotion and publicity on dementia awareness including campaigns and events • Work with key stakeholders including voluntary and community sector for future joint funding bids for dementia care and support services • Increase registration on GP registers and continuous review of projected future demand of dementia related services • Explore possibility of establishing specialist dementia support in dementia day services • Carers involvement in Dementia strategy implementation • Explore potential for joint commissioning between health and social care and with neighbouring boroughs • Development of dementia pathways for older people with learning disabilities • Reviewing the current range of information available amongst different services including diverse needs i.e. language, culture, literacy and how information is provided. Also identify best examples including 'what good looks like'	2013 - 2014

Early Onset Dementia		Theme ❶ Theme ❷	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
As with dementia we need to be aware of the prevalence of early onset dementia and ensure effective services are available. **What we have** Our dementia services support those in the main with a diagnosis of dementia. It is recognised that more needs to be done to support those diagnosed with early onset dementia. **Areas of development** • **Effective systems which identify those at high risk of early onset dementia**	• All client groups having access to appropriate information and specialist support • Streamlined pathways to access diagnosis and treatment • Earlier diagnosis, intervention and reablement so that people and their carers are less dependent on intensive services	• Establishing effective systems and database so those at high risk of early onset dementia are identified and provided appropriate screening • Establishing links with relevant practitioners to ensure that a pathway exists for screening, diagnosis and treatment for those identified as 'at risk'. • Review information materials, particularly in relation to those with Learning Disabilities and for their carers	2013 - 2015

Older Adults Mental Health		Theme 1 Theme 2 Theme 3	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Mental health and emotional well-being are as important in older age as at any other time of life and a decline in mental wellbeing should not be viewed as a natural and inevitable part of ageing. Older people can have good mental health but are more likely to experience events that affect emotional well-being, such as bereavement or disability. The Department of Health estimates that around 40 per cent of older people seeing their GP have a mental health problem. **What we have** A large range of support including memory clinics, consultancy psychiatric services providing cognitive stimulation and a day activities and opportunities service providing support to promote recovery and wellbeing. GP referrals for assessment and signposting through the local 'Common Point of Entry' Community mental health beds provided at Prospect Park Hospital (Reading) and a hospital ward liaison team identifying inpatients indicating MH problems. **Areas of development** • **No service gaps indentified however there are concerns around transportation for older people accessing services at Prospect Park Hospital**	• Reduction in premature mortality rates for those with severe mental health conditions • Increased access to community health and psychological therapy services by people from BME groups • Improved rated of recovery following talking therapies	• Enhanced care planning to enable improved quality care and support • Phased approach in moving services to Prospect Park Hospital • Reviewing impact of move of psychiatric services • Review of reimbursement of transport costs for (local) relatives to Prospect Park	2013 - 2015

Telecare / Telehealth/Assistive Technology		Theme 1 Theme 2 Theme 3	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Slough's aim is to ensure everyone is 'Telecare Aware' Telecare can provide a range of equipment to people with support needs to help them lead independent lives. Telecare equipment makes it possible for people to call for help and assistance and is fundamental for people with dementia to live safely in their own home **What we have** A comprehensive range of Telecare and Assistive Technology equipment is available to residents through the Berkshire Community Equipment Store. **Areas of development** • **Adequate support for service users to be able to use equipment** • **Further exploration of installation of equipment in care homes** • **Infrastructure required to promote the service** • **Telecare links into urgent care centre** • **Further development of Telehealth including targeting Telehealth services for people with Long Term Conditions**	• The support received takes place in the most appropriate setting, and enables people to regain their independence. • Increase in numbers of people feeling safe within their own home • Enhancing Quality of Life for people with care and support needs • Promoting Independence – delaying and reducing the need for more intensive care and support • People will remain or achieve independence for as long as possible where appropriate • Re- launch of assistive technology and Telecare services	• Re-organisation of operational adult social care to provide infrastructure to promote and support the service (currently underway) • Development of champions in the workplace • Development of Personal Assistants, through providers to support service users in use of equipment • Set up of Telehealth pilot scheme for small number of users	2013 - 2014

Out of Hours response service		Theme 1 Theme 2 Theme 3 Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
Not all unexpected major social care problems happen during normal office hours or can wait until the next day. Issues that the out of hours team can help with include: - Older people who are at risk or who need immediate help - Concerns about a person with a physical or a sensory disability - Support in coping with someone who has severe learning difficulties or mental health problems Good out-of-hours provision can lead to better health outcomes for patients and reduce acute hospital emergency admissions **What we have** - Enhanced intermediate care services - Out of hours palliative care drug scheme - Rapid access (2 hour response) to district nurses - Emergency duty team - 24 hour on call service **Areas of development** • **A review is about to get underway to assess the gaps in service provision**	• Improved processes for fewer admissions into hospital • Reductions in number of people being admitted unnecessarily into hospital	• Re-location of out of hours services into urgent care centres	

Continuing Healthcare		Theme 3 Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
NHS continuing healthcare is a package of continuing care provided outside of hospital, arranged and funded solely by the NHS, for people with ongoing healthcare needs. People eligible, can receive NHS continuing healthcare in any setting i.e. their own home or in a care home. Continuing care not provided in a timely way can contribute towards delayed hospital discharges where it has been evidenced that between 65/70% of delayed hospital discharges are due the requirement of a Continuing Health care assessment **What we have** Continuing Healthcare is provided by Berkshire healthcare NHS Foundation Trust **Areas of development** • **Innovation and joint working with agreed protocols between health and social care** • **Flexibility of use of community beds which allow hospital discharge until completion of comprehensive assessments** • **Improved managements of clients health needs including those with learning disabilities** • **Timely reviews and clarification of appropriate equipment**	• Clear and understood pathways between health and social care services • Minimised delayed transfers of care to agreed local expectations • Increase in timely actions including reviews which support discharge to appropriate placements	• Closer partnership working with the health arm of Continuing Health Care • Shifting the focus to patients needs • Establishment of a working group to look at all areas of continuing care include timely and joint assessments and how reviews are undertaken	2013 - 2015

End of Life Care (EOLC)		Theme 4	
Commissioning/Development Intentions	**Commissioning Outcomes**	**Actions Required**	**Timescale**
End of life care (which includes palliative care) is support for people who are approaching death. The service helps people to live as well as possible until they die, to die with dignity and includes support for family or carers. End of life care is not just about the physical side but emotional support must be provided also. End of life care is an holistic approach and deals with the 'whole' person rather than just one aspect of their care. **What we have** - Multi-disciplinary intermediate care and palliative care teams which supports End Of Life Care including 24 hour medical consultant on call **Areas of development** • **Increased opportunities for end of life care to take place in people's own homes and care homes with more than 6 weeks prognosis** • **Improved education, knowledge and support of care and support workers including supporting families** • **Increased support and education for care staff around equipment and process for those at end of life stage** • **Low numbers of care homes signed up for the 'Gold Standard Framework' and improvements in homes working with community matrons** • **Appropriate application of the Mental capacity Act during 'end of life ' stage**	• Improving the experience of care for people at the end of their lives • Increase in numbers who are able to express their wishes and preferences about how they are cared for and where they wish to die through appropriate care planning • Increase in numbers of those approaching end of life receiving co-ordinated are in accordance with their care plan, across all sectors and at all times of day and night • Increase in carers being provided with practical and emotional support during the persons life and following bereavement	• Increase recognition and identification of patients in the last year of life and sharing of recognition across all relevant sectors through developing a robust locality register accessible by all sectors • Supporting Care homes to keep patients approaching end of life with necessary support and ensuring workforce are trained and competent to care for EOL patients. • Continue supporting patients at EOL stage that can be maintained within home environment thereby preventing hospital admission. This also includes ensuring staff in domiciliary care and other agencies are trained and competent. • Ensuring EOL patients who are able to and choose to be cared for at home are discharged with full support • Ensuring ongoing carer support for those caring for EOL patients and are that they are closely involved in any decision making • Ensuring carers rights to have their own needs assessed and reviews and to have a carers care plan	

APPENDIX B

FUTURE DEMAND FORECASTS

The forecasts below are taken from the Projecting Older People Population Information system (POPPI) developed by the Institute of Public Care (IPC). The system is used by local authority planners and commissioners of social care and is designed to help explore the possible impact that demography and certain conditions may have on populations aged 65 and over.

Population	2012	2014	2016	2018	2020
Population aged 65 to 69	3,800	4,200	4,600	4,800	5,000
Population aged 70 to 74	3,100	3,100	3,100	3,500	3,900
Population aged 75 to 79	2,600	2,600	2,600	2,700	2,700
Population aged 80 to 84	1,900	2,000	2,000	2,100	2,100
Population aged 85 to 89	1,100	1,100	1,200	1,300	1,400
Population aged 90 and over	700	800	900	1,000	1,100
Total population aged 65 and over	**13,200**	**13,800**	**14,400**	**15,400**	**16,200**

Slough	2012	2014	2016	2018	2020
Projected population of people aged 55-64	11,800	12,400	12,900	13,600	14,300

Physical Disability / Sensory Impairment	2012	2014	2016	2018	2020
People aged 55-64 predicted to have a moderate physical disability	1,758	1,848	1,922	2,026	2,131
People aged 55-64 predicted to have a serious physical disability	684	719	748	789	829

Learning Disability	2012	2014	2016	2018	2020
People aged 55-64 predicted to have a learning disability	268	282	293	309	325
Total population aged 65 and over predicted to have a learning disability	273	285	297	319	337

Dementia including Early Onset Dementia	2012	2014	2016	2018	2020
Total population aged 50-64 predicted to have early onset dementia	22	24	24	26	26
Total population aged 65 and over predicted to have dementia	963	990	1,075	1,119	1,221

Limiting Long Term Conditions	2012	2014	2016	2018	2020
Total population aged 65 and over predicted to have limiting long term illness	6,515	6,800	7,154	7,578	7,953

Stroke	2012	2014	2016	2018	2020
Total population aged **45- 64** predicted to have a longstanding health condition caused by a stroke	219	229	237	246	251
Total population aged 65 and over predicted to have a longstanding health condition caused by a stroke	308	318	339	358	386

APPENDIX C

CONSULTATION & ENGAGEMENT

The older people strategy was developed following extensive consultation involving older people and key stakeholders in various ways.

Engagement

We established an older people's steering group which provided the lead which enabled us to strategically consult with as many older people as possible in a way that best suited them. The group also contributed to the design of the questionnaire for wider consultation. We also engaged with the voluntary sector in arranging a consultation event.

Consultation

Separate consultation events were organised to seek the views of both older people and internal and external stakeholders on the future provision of older people services.

- The consultation period lasted 12 weeks from August to October 2012
- A questionnaire for completion (available throughout the consultation)
- Visits made to local voluntary and community groups (throughout the consultation)
- Event 1 – Internal and external stakeholders
- Event 2 – Service users

At each event different questions were asked in order to gather as wider views as possible. The members of the older people's steering group were kept regularly updated throughout the process and a feedback event was held to share the results of the consultation.

The outcome of the consultation informed us what older people considered was important and what they valued most. These included:

- Carers and respite and support services – allows carers valuable time away from their caring role
- Day centres / day opportunities, lunch clubs – helps reduce loneliness and isolation as well as providing a healthy meal and activities
- Information, advice and advocacy services – to help make informed choices
- Care-line services – providing emergency support

- Bus passes – allows people to get out and about and reduce isolation
- Home from hospital services – Supports those newly discharged from hospital
- Handypersons service

Many older people wanted to be enabled to keep fit and healthy and remain an active member of the community. They told us they would like to see:

- Improved health services across the borough
- Improved facilities for people with long tem conditions including those with dementia, physical and sensory needs
- Wider variety of activities including weekend services which help maintain independence and promote healthy and active lifestyles
- Improved partnership working between Social services, health, housing and voluntary and community groups in service development, planning and delivery
- Increased monitoring of service provision and more joint responsibility
- Improved Community Transport services
- More opportunities for older people to be consulted and involved in local issues which directly affect them
- Increased public safety i.e. better lighting and more visibility of community police officers
- Improved and innovative ways of providing older people with advice and information of various older people activities including BME specific services

The information below provides more detailed responses from the questionnaires returned. A number of the questions on the survey were specifically to carers or those in receipt of care and or support. The results represent the percentage of those who responded.

Health and Wellbeing

Where and how do you access to physical activities?		What stops you from accessing physical activities?		Are you able to maintain your own health needs?	
Day Centre	40%	Other (including not interested)	25%	Yes	71%
Community Group	27%	Lack of information	24%	No	29%
Local leisure centre	25%	Lack of transport	22%		
None	5%	Cost	17%		
Other	3%	Lack of physical help	12%		

Quality of Life

Do you feel safe in your own home?		What makes you feel safe outside your home?		What makes you feel unsafe outside your home?	
Yes	85%	Regular calls from family and friends	30%	Fear of anti-social behaviour	7%
No	15%	Security system in place	24%	Fear of crime or abuse	6%
		No security concerns	12%	Lack of security equipment	5%
		Regular calls from support or care workers	8%	Other	5%
		Quality care/support provided in the home	3%		

Do you feel safe outside your home?		What makes you feel safe outside your home?		What makes you feel unsafe outside your home?	
Yes	69%	Feeling confident	21%	Anti-social behaviour	11%
No	31%	Good or safe neighbourhood	21%	Other	11%
		Good street lighting	18%	Quality of pavements	9%
				Poor street lighting	5%
				Alerts at pedestrian crossings	4%

Do you have easy access to transport?		What transport do you use?		Why are transport services not good for you?	
Yes	75%	Good local bus service	37%	Lack of hospital transport	30%
No	25%	Concessionary travel	32%	Lack of local bus services	26%
		Other (including access to own transport)	21%	Lack of access to community transport	26%
		Community transport	10%	Other	18%

Carers

If you are a carer, have you had a carer's assessment?		If you are a carer, are you able to have a life outside of caring?		If you are a carer are you in receipt of carers respite	
No	66%	Yes	53%	No	75%
Yes	34%	No	47%	Yes	25%

Local Involvement

Do you feel you are consulted about local changes in your area?		How do you know about or get involved in local area decisions?		What stops you form getting involved?	
No	57%	Reading local news	67%	Lack of information about what is going on	31%
Yes	43%	Local community groups	16%	Not interested	18%
		Local meetings/clubs	15%	Lack of feedback	15%
		Other	2%	Timing of meetings	10%
				Other	10%
				Lack of accessible venue	9%
				Travel costs	7%

Choice and Control

Do you feel you have opportunities to learn new skills?		Where do you go to learn new skills?		What stops you from learning new skills?	
Yes	56%	Local library	32%	Other (including not interested)	23%
No	44%	Day centres	25%	Lack of information	19%
		Community activities	17%	Lack of transport	17%
		Other	17%	Lack of confidence	14%
		Education centres	9%	Cost	16%
				Language barriers	11%

Do you feel you have choice and control about your care or support?		Why do you feel you do have choice or control?		Why do you feel you do not have any choice or control?	
Yes	67%	Pay for own care	27%	Lack of information and advice	18%
No	33%	Other (including support from family/friends)	27%	Lack of advocacy and support	13%
		Council personal budget	15%		

Discrimination and Harassment

Do you feel as an older person you have been discriminated against?		Do you fell as an older person you have experienced harassment?		Are you aware there are rules to safeguard you against abuse?	
No	79%	No	83%	Yes	61%
Yes	21%	Yes	17%	No	39%

Do you know how to report abuse?		Would you feel confident to report abuse?		Would you feel afraid to report abuse?	
Yes	65%	Yes	79%	No	78%
No	35%	No	21%	Yes	22%

Financial and housing

Do you know how to access information to benefit entitlement?		Is your home suitable for your needs?	
Yes	57%	Yes	86%
No	43%	No	14%

Dignity and respect

If you are in receipt of care or support, do you feel your privacy, dignity and choice are respected?		If you are in receipt of personal care, are your needs being met?	
Yes	78%	Yes	66%
No	22%	No	34%