DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE ADULT CARE BOARD

THURSDAY 16TH JANUARY 2014
2:00PM TO 4:00PM
MEMBERS ROOM, COUNTY HALL, MATLOCK, DERBYSHIRE, DE4 3AG

A G E N D A

	Time	Item	Lead	Information/ Discussion/ Decision
1	2:30pm	Welcome & Introductions	Cllr Neill	
2	2:35pm	Minutes from the meeting held on 14th November 2013 (attached)	Cllr Neill	Information
3	2:45pm	Draft Carers (MOU) (attached)	J Vollor	Decision
4	3:00pm	Better Care Plan (attached)	J Matthews/ L Wilmott-Shepherd	Consider draft paper and timetable
5	3:20pm	Learning Disabilities – Self Assessments Framework (attached)	J Vollor	Decision
6	3:30pm	Integrated Care establishing the baseline across Adult Care	A Milroy	Update
7	3:40pm	Adult Care Cabinet Reports (attached)	B Robertson	Information
8	3:50pm	Update from CCG Integration Boards: • Lynne Wilmott-Shepherd – Erewash CCG • Andy Gregory – Hardwick CCG • Andrew Moody – North Derbyshire CCG • Andy Layzell – Southern Derbyshire CCG • Clare Watson – Tameside & Glossop CCG		Information
9	4:00pm	**FINISH** The next meeting of the Adult Care Board will take place on Thursday 13th March 2014 at 2:00pm in Members Room, County Hall, Matlock.		

Pauline Innes
PA to Bill Robertson, Strategic Director - Adult Care Department
Tel: 01629 532008
E-mail: Pauline.innes@derbyshire.gov.uk

DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

MINUTES OF A MEETING HELD ON THURSDAY 14TH NOVEMBER 2013 AT 2:00PM DERBYSHIRE COUNTY COUNCIL, COMMITTEE ROOM 1, MATLOCK HQ

PRESENT:

Cllr Clare Neill	CN	Derbyshire County Council Cabinet Member (Adult Care) **Chair**
Bill Robertson	BR	Derbyshire County Council – Strategic Director Adult Care
Umar Zamman	UZ	Derbyshire Fire & Rescue
Andrew Milroy	AMi	Derbyshire County Council – Adult Care
Dr Andrew Mott	AM	Southern Derbyshire CCG
Brian McKeown	BMc	Derbyshire Police
Karen Macleod	KM	Derbyshire Probation
Jim Connolly	JC	Hardwick CCG
CllrBarbara Harrison	BH	Erewash
Cllr Wayne Major	WM	Derbyshire County Council - Members
Roger Miller	RM	Derbyshire County Council – Adult Care
Tony Morkane	TM	DCC (Public Health)
Andrew Moody	AMo	North Derbyshire CCG
Karen Ritchie	KR	Healthwatch Derbyshire
Helen Robinson	HR	Derbyshire Carers
Jaqui Willis	JW	Derbyshire Carers Association
Sue Knowles	SK	Derbyshire County Council – Adult Care
Pam Wood	PM	Southern Derbyshire Health & Social Care Forum

IN ATTENDANCE:

Pauline Innes	PI	Derbyshire County Council Adult Care (Minutes)
Julie Vollor	JV	Derbyshire County Council – Adult Care
David Gardner	DG	Hardwick CCG
Tony Ellingham	TE	Derbyshire County Council – Adult Care
Steve Phillips	SP	Derbyshire County Council – Adult Care

APOLOGIES:

Andy Layzell	Southern Derbyshire CCG
Mary McElvaney	Derbyshire County Council – Adult Care
Avi Bhatia	Erewash CCG
David Collins	North Derbyshire CCG
Andy Gregory	Hardwick CCG
Cllr John Lemmon	South Derbyshire District Council
Steven Lloyd	Hardwick Health CCG
Rakesh Marwaha	Erewash CCG

James Matthews	Derbyshire County Council –Adult Care
Jackie Pendelton	North Derbyshire CCG
Cllr Lillian Robinson	North East Derbyshire District Council
Jo Smith	South Derbyshire CVS
Gavin Tomlinson	Derbyshire Fire and Rescue
Clare Watson	Tameside & Glossop CCG
Lynn Wilmott-Shepherd	Erewash CCG

Minute No	Item	Action
ACB 032/13	**WELCOME FROM CLLR NEILL AND APOLOGIES NOTED** **MINUTES FROM THE MEETING ON 12TH SEPTEMBER 2013 & MATTERS ARISING** The minutes from 12th September 2013 were accepted as a true and accurate record. **MATTERS ARISING:** 028/13: **Derbyshire Mental Health Partnership Board:** David Gardner provided an update and outlined the complexities of establishing a Partnership Board for Mental Health. DG advised this is still an on-going piece of work. 030/13: **Lead Commissioning:** JV advised the Board that the Joint Commissioning Board have agreed for Reps to be involved and that this is being finalised at the moment. 031/13: **Integrated Care:** AM informed the Board that arrangements for access to social care records system on a reciprocal basis for GPs and other NHS professionals, was reported to the Derbyshire Chief Executive Meeting.	
033/13	**INTEGRATION TRANSFORMATION FUND AND RELATED DEVELOPMENTS** • BR provided an update to the Board on implementing the Integration Transformation Fund (letter circulated for information). Further guidance will be available on or after 16th December 2013. • BR talked to a presentation providing the Board with an update from an Integrated Care meeting which was held on 11th November 2013. • BR advised the Board that Andrew Milroy, Assistant Director; Adult Care has been seconded to focus on the integration agenda to consolidate developments in working relationships with primary care and acute hospitals. AM	

	will focus on the below: o Ensuring every fieldwork team has clearly established working relationships with relevant GP practices to support the development of person centered coordinated care; o The delivery of an enhanced and flexible Adult Care response this winter to Chesterfield North and District Royal Hospital (CNDRH), Royal Derby Hospitals and Erewash CCG SPA. o Ensuring consistency and coherence in plans for integrated seven day working which will be reflected in the Integration Transformation Fund plan and the SCCG plans in response to the NHS 'Call to Action'. These plans will reflect the learning from the arrangements which we put in place this winter. • J Willis commented that this would be an opportunity to expand on work with isolated people. • It was noted that Telecare will form an important part as well as falls prevention work. • Cllr Neill informed the Board that submission for the national fund must be made by 14 February. The Plan has to be signed off by the Health and Wellbeing Board. Councillor Dave Allen (Chair of the Health and Wellbeing Board). • Cllr Neill requested the draft plan is produced for discussion at the next Adult Care Board Meeting which is taking place on Thursday 16th January 2014, in advance of the Health & Wellbeing Board.	**All**
034/13	**<u>FEEDBACK FROM CCG INTEGRATION BOARDS</u>** • BR advised the Board that a joint meeting between CCGs/DCHS/CRHFT and Mental Health Trust has now arranged to take place over two days 5th and 6th December, to be held at The Derbyshire Hotel. A separate group has been established for 24/7 offer which would include Providers, Direct Care and Fieldwork Staff. • AM noted that CCG locality developments already underway were relevant for the Integrated Transformation Fund approach and there was already substantial pilot development work to build on. • Southern Derbyshire Clinical Group, work on-going.	

035/13	**SUPPORT & ASPIRATION** • Tony Ellingham presented the board with an overview and update on the progress for Support and Aspiration. • The Support and Aspiration project takes forward the legal duty Derbyshire County Council will have to provide Education Health and Care Plans (EHCPs) from September 2014. The plans will replace Statements of Special Educational Need. Young disabled adults up to the age of 25 and their families will be able to request the plans. • T Ellingham advised that there will be a further visioning day taking place on 30th January 2014, letters of invite to be circulated. • The main implications for the provision of services in Derbyshire were highlighted: o Eligibility for EHCPs o Assessment and planning with children and young people needs to be better coordinated across agencies to ensure that families will not need to repeat their stories, assessment system much more streamlined.. o Greater flexibility around transition points between the ages of 18 to 25. o Possible co-location or integration of some teams. o Agreeing mechanisms for personal health, education and care budgets. o Review joint commissioning arrangements. o Andy Mott advised the board that SDCCG are involved in a couple of work streams and wished it to be noted that SDCCG are happy to support TE. • The Adult Care Board noted the contents of the presentation provided and that there will be a further visioning day taking place on 30th January 2014. • For further information please contact Tony Ellingham tony.ellingham@derbyshrie.gov.uk Tel: 01629 537427.	
036/13	**DERBYSHIRE JOINT DEMENTIA STRATEGY REVIEW AND REFRESH** • Steve Phillips presented the Board of a refresh of the current Derbyshire Dementia Strategy based on the 'direction of travel'. • Adult Care Engagement team have visited local BME, travelers and farmers providing them with information of how to manage dementia and what it means to them. Proposed Further Action • It is proposed to work with the themes through the joint	

	Derbyshire Dementia Commissioning co-ordination group and develop/deliver precise plans and costed priorities. • Hardwick CCG has a County lead role on the group for commissioning of dementia services and each CCG has a structure for local development of dementia commissioning plans. • It is proposed that a framework for on-going public engagement will continue through existing engagement structures such as the over 50's forums and patient participation groups so that co-design is a feature of a service design as the details are developed. We are already building in feedback mechanisms for all commissioned services to promote continuous improvement. • D Gardner advised the Board that DCHS, Voluntary Sector and Acute Hospitals are involved and attend various meetings held. • The Adult Care Board noted and endorsed the recommendations in the 'Proposed Further Actions' section of the report as the way of enabling people in Derbyshire to live well with dementia. • For more information please contact Steve Phillips steve.phillips@derbyshire.gov.uk or David Gardner david.gardner@hardwickccg.nhs.uk	
037/13	**AUTISM SAF** • D Gardner provided an update on the findings of the 2013 Autism Self Evaluation, as part of the implementation of the Adult Autism Strategy. To propose an update report in spring 2014, following a national review of the Strategy. • The on-line return was completed and agreed by the multi-agency Autism Co-ordination Group submitted by the closing date of September 30th. The format is a mixture of data entry, RAG (Red / Amber / Green) rating yes/no responses and optional self-advocate stories which provides positive experience by a person with Asperger's Syndrome who is currently undertaking an apprenticeship with Derbyshire County Council. • The department of Health is currently leading a formal review of progress against the national Strategy. The investigative stage of the Review will be concluded by the end of October and the Strategy will be revised as necessary by March 2014. The aims are: o To assess whether the objectives of the Strategy	

	remain fundamentally the right ones; o To be assured of the progress that is being achieved by Local Authorities and the NHS, and o To consider what should happen to continue to make progress. • The Adult Care Board noted and approved the contents of the 2013 Autism Self-Evaluation and further noted that update report on progress will be presented to the Board in spring 2014. • For more information please contact Deborah Jenkinson Deborah.jenkinson@derbyshire.gov.uk Tel: 01629 532028	
038/13	**ANY OTHER BUSINESS** • None noted.	
	The next meeting of the Adult Care Board will take place on Thursday 16th January 2014 at 2:00pm in Members Room, County Hall, Matlock.	

Public

DERBYSHIRE COUNTY COUNCIL

REPORT FOR ADULT CARE BOARD

16TH January 2014

Development of Lead Commissioning for Carers

Purpose of the Report

To seek the Board's agreement to the Memorandum of Understanding for lead commissioning for carers.

Background

The Adult Care Board approved the report 'Adult Care and Joint Commissioning Priorities 2012 – 13', on 15th March 2012, which included the priority *'Adult Care is proposing to be the Lead Commissioner for Carers'.*

In November 2012, March 2013, and July 2013 further update Reports were presented to the Board setting out the next steps and proposed timeline. The Board noted the content of the Reports and agreed the proposed actions and timeline.

In September 2013 a Report was considered by the Board to inform it of a change of direction regarding the partnership arrangements.

Information and Analysis

On 8th August 2013 a joint statement on the Health and Social Care Integration Transformation Fund (ITF) was issued by the Local Government Association and NHS England. This is now known as the Better Care Fund.

The funding is described as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities'.

The Better Care Fund comes into full effect in 2015/16.The composition of the Better Care Fund includes the NHS funding for carers breaks.

It was agreed, in the light of the NHS funded carers breaks funding being part of the Better Care Fund transfer in 2015/16, to establish a Memorandum of Understanding (MOU) between the Derbyshire CCGs and Derbyshire county council , to be put in place for 2014/15. The difference in approach means that:

- Adult Care will still be the lead commissioner

- The MOU (rather than a Section 75 agreement) will be the formal agreement between the partners for 2014/15, but there will not be a pooled budget for carers in 2014/15.

The MOU will safeguard the spend on carers support, and establish a work plan and a work programme for the Carers Joint Commissioning Board. It will enable the reshaping of services for carers in forthcoming years.

It is intended that the Carers Joint Commissioning Board will operate as the strategic lead for planning and commissioning carers support across all Derbyshire County Council Departments and the Derbyshire CCGs.

OFFICERS RECOMMENDATIONS

1. Adult Care Board is asked to approve the contents of the Memorandum of Understanding so that it can be in place for April 2014.

2. The Adult Care Board is asked to note that the Carers Joint Commissioning Board will be launched in April 2014.

Iseult Cocking

Commissioning Service Manager

Agenda item 4

DERBYSHIRE COUNTY COUNCIL

Adult Care Board

16th January 2014

Better Care Fund (formerly the Integration Transformation Fund)

Purpose of the Report:

To update the Adult Care Board on the progress in preparing a joint plan for delivering improved integration using the Better Care Fund.

Information and analysis:

In the Spending Review in 2013 the Government announced what is now the Better Care Fund (BCF) as a means to improve integrated support for people with health and social care needs.

The BCF will, in 2015/16, be a £3.8b national budget, based predominately on existing funding. In 2014/15 there will be an additional £200m added to the existing NHS budget for transfer to Councils for social care funding.

Locally we are required to prepare a joint BCF Plan that outlines how integration will be improved to deliver on four key priorities:

- Protecting Social Care services
- 7-day services to support hospital discharge
- Data sharing and use of the NHS number across health and social care
- Joint assessment and an accountable lead professional for people at the highest risk.

Also, we have to achieve improved performance on five national indicators and one locally determined indicator to secure the performance related elements of the BCF. The national indicators are:

- Delayed transfer of care from hospital
- Emergency admissions to acute hospital
- Effectiveness of re-ablement
- Admissions to residential and nursing care
- Patient and service user experience.

The proposed local indicator at this stage is: the estimated diagnosis rate for people with dementia.

The BCF Plan has to be submitted to NHS England in its finalised form by 4th April 2014. An initial draft has to be submitted by 14th February 2014, with NHS England indicating that, due to the lateness of its guidance, this can be an early draft. Attached as Appendix One is the current draft of the plan.

To support the preparation of the Plan, NHS England and the Local Government Association have issued a range of guidance. A summary of this is included as Appendix Two.

The BCF for Derbyshire, excluding Derby City, will be £57m in 2015/16 and this will have to operate as a pooled budget. Central Government has identified some of the budgets that will be folded into the BCF and also some requirements for its usage. Listed below are the local estimated amounts for these:

Specific budgets included in the BCF.	Estimated amounts for Derbyshire 2015/16 £m
Transfer from NHS to Adult Care	16.002
Carers Services	1.963
Re-ablement	4.530
Disable Facilities Grant	3.200
Adult Social Care Capital Grant	2.020
Specific requirements for use of the BCF.	
Implementing specific aspects of the forthcoming Care Act	1.963
ICT costs of transition to capped cost system	0.755
Disabled Facilities Grant (minimum)	3.200

Work is continuing on the preparation of the BCF Plan, including looking at:

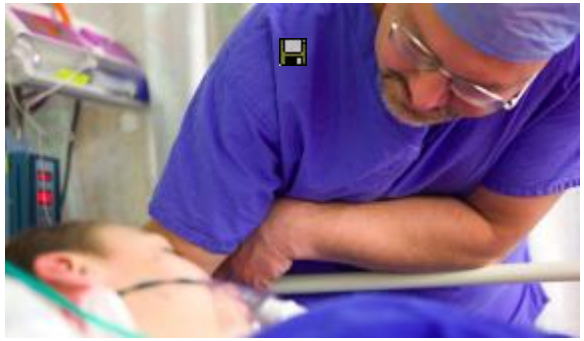
- The longer term vision for services
- The projected impact of integration services on acute NHS services
- The delivery of locally sensitive integrated services to reflect the different needs of the local population.

Recommendation

That the Adult Care Board:

- Supports the progress on the BCF Plan
- Receives an updated Plan at its next meeting prior to its final submission to the Health and Wellbeing Board and to NHS England.

Better Care Fund (BCF)
Support and Resources Pack for Integrated Care



December 2013

Note: This is a 'live document' that will be updated as and when more information or resources are made available to support local commissioners with BCF planning

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Publications Gateway Reference 00940

Aim of the Better Care Fund (formally the Integration Transformation Fund)

To improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs. The Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The NHS will make available a further £200 million in 2014-15 to accelerate this transformation.

Spending Review 2013, HMT

The Better Care Fund (BCF)

- Announced at Spending Round 2013
- £200m for Local Authorities (LAs) in 2014/15 (Section 256 of the NHS Act 2006)
- £3.8bn pooled budget in 2015/16 (Section 75 of the NHS Act 2006) for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities
- £1bn of £3.8bn 'payment by performance' in 2015/16
- Signed off by Health and Wellbeing Boards (HWBs)

Links to earlier letters:

- Joint LGA/NHS England narrative (Aug 2013)
- Joint letter & draft template (Oct 2013)

Plans must deliver on national conditions:

- Protecting social care services;
- 7-day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional

Pay for Performance based on:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service-user experience
- Local metric

BCF and the wider context

BCF and NHS & local government planning

- The BCF is integral to the NHS Strategic & Operational Planning process and local government planning.
- NHS England launched a Call to Action in July this year, which outlines the key national challenges facing the NHS over the next 10 years.
- Clinical Commissioning Groups (CCGs) are required to submit 5-year strategic, operational & financial plans, with the first two years at an operational level of detail.
- Timing for the BCF is aligned with the CCG 2-year operational plans:
  - **Draft BCF plan due by 14 February 2014**
  - **Final BCF plan due by 4 April 2014**
- The BCF is required at Health and Wellbeing Board (HWB) level.

BCF and wider integrated care agenda

- In May 2013 the national collaborative for integrated care and support published Integrated Care and Support: Our Shared Commitment.
- 14 localities were announced as integration health and care pioneers in November 2013. The pioneers will test local and national barriers that need to be addressed and act as exemplars from which lessons and experiences may be drawn for rapid dissemination, promotion and uptake across the country.

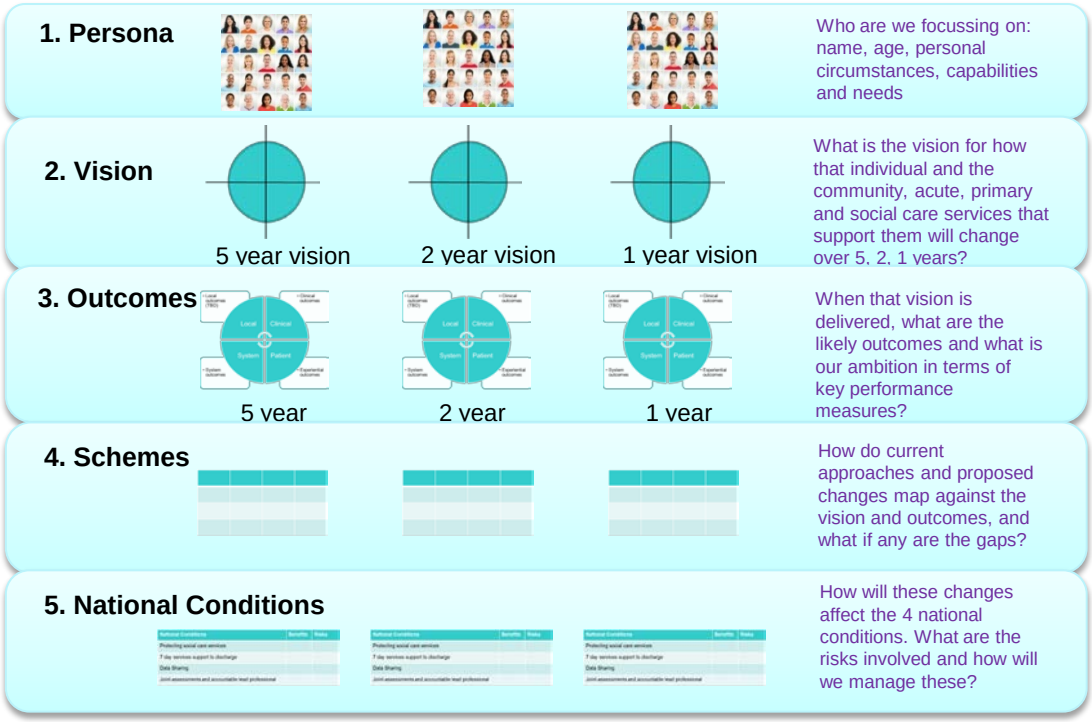
Contents

- This pack has been co-produced between NHS England and the LGA. The following slides aim to provide information, links or signposting to existing or forthcoming support and resources to support developing BCF plans. The selected topics are based on feedback we have had from local areas on what would be most helpful in developing plans.

- We plan to offer webinars on the BCF in general, and on specific topics related to integrated care and the BCF that local areas have indicated they would like further support on – see topic slides and slides 16-20 for how to register for the webinars.

Example BCF Plan and LGA Integrated Care Toolkit

NWL have developed a draft populated BCF plan. The below diagram sets out the steps they took to how they approached planning:



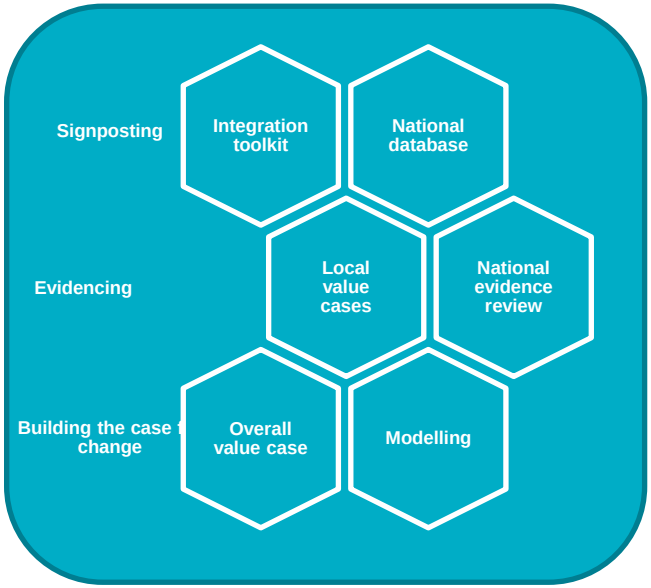
Click below for the populated documents from NWL Tri-borough:

- First draft submission
- Populated template (Appendix A)
- Populated outcomes and finances sections (Appendix B)

Click here for a worked example of the BCF for an 'Any town' Local Authority.

LGA Integrated Care Toolkit

Please see the LGA toolkit tools which may help with developing your BCF plan*



*Note that further products will be added to this webpage in January

Building a shared vision

Things you might want to consider

- ✓ Put patients and service users at the heart of your plan, using the National Voices and Think Local Act Personal's 'Narrative for Integrated Care', along with other local work with patients and service users, to define what better more coordinated care would look like locally.
- ✓ Use existing joint plans such as your Pioneer bid, Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and other local documents.
- ✓ Use the latest evidence of what will make the biggest improvements to care and support across the health and care system.
- ✓ Describe the pattern and configuration of the changes over at least a five year period, building on existing local successes e.g. risk stratification, joint commissioning arrangements, reablement services and innovative reward and contracting arrangements.
- ✓ Get sign off from your HWB.

Narrative tools

1. National Voices and TLAP's Narrative for Integrated Care
2. The LGA and NHS England Value Cases for integrated care
3. North West London example BCF plan and guide to completing the ITF
4. NWL ICP documents
5. PHE public health integration narrative

Analytical tools

1. Commissioning for Value Data Packs
2. The LGA Integrated Care Modelling tool
3. Outcomes benchmarking support packs: LA level
4. Any town health system (this will be available on the NHS England website in January)

Further Resources

1. POPPI
2. PANSI

Interactive Support

1. **Webinar** - We plan to run a webinar on this topic. See slide 20 for instructions on how to register your interest.

Patient, service user, and public engagement

Things you might want to consider

Information gathering

- ✓ Data from current local/national survey programmes
- ✓ PALS/complaints and compliments
- ✓ NHS choices, Patient Opinion, Care Opinion, etc.
- ✓ Crowd sourcing activities, online surveys, etc.

Consultation and participation

- ✓ Develop systems/processes that allow communities to engage in accessible ways, for example: existing patient support and user forums, use of social media, press releases, community support/social groups, faith settings
- ✓ Clearly communicate opportunities to engage and how systems work
- ✓ Support the process with 'fit for purpose' information on process and how to comment on developments
- ✓ Provide appropriate developmental and administrative support to enable communities to be involved effectively in the whole process
- ✓ Plan for on-going meetings/activities to shape/assure the design/delivery plans
- ✓ Agreed feedback method for participants

Case Studies

1. Dorset CCG, 'My care, my way'
2. Cardiff Council joint commissioning strategy
3. Whitstable Medical Practice, community integrated healthcare

Interactive Support

1. **Webinar** - We plan to run a webinar on this topic. See slide 20 for instructions on how to register your interest.
2. **Contact** – For further information or if you have any queries, please contact jennifer.kenward@nhs.net / dawn.stobbs@nhs.net or Tom.Shakespeare@local.gov.uk

Examples and Tools

- Think Local Act Personal (TLAP), Making it Real, marking progress towards personalised, community based support
- NHS England, Transforming participation in health and care
- NHS Institute (resources now within NHS IQ website) Experience Based Design: using patient and staff experience to design better healthcare services
- National Voices and TLAP narrative on person-centred care and support
- King's Fund Experience Based Co-Design Toolkit
- Integrating personal budgets – myths and misconceptions

Implications on the acute sector and reconfiguration

Things you might want to consider

- ✓ The potential implications of better care fund plan and investments on shifts in activity and services in the acute sector.
- ✓ Have you made use of the most up-to-date evidence and information, locally and nationally, to model the savings and reinvestments for providers within your local health and care system?
- ✓ Have you engaged providers on the potential impact and the approaches and solutions to maximise the benefits and opportunities from improved integration? This could include both incumbent providers and potential entrants to the market.
- ✓ Where you are considering major service changes as a result of five year strategy plans and the better care fund, have you considered how you will build alignment and evidence across the local health system on the benefits of change – and align plans with the Government's 'four tests'?

Case Studies

1. Lincolnshire Sustainable Services Review
2. Mid-Nottinghamshire Integrated Care Transformation Programme
3. Calderdale & Huddersfield Health and Social Care Strategic Review

Interactive Support

1. **Webinar** - We plan to run a webinar on this topic. See slide 20 for instructions on how to register your interest.
2. **Contact** – For further information or if you have any queries, please contact: ashley.moore1@nhs.net or tom.shakespeare@local.gov.uk or integration@monitor.gov.uk

Examples and Tools

- Shaping a Healthier Future
- The LGA Integrated Care Modelling tool
- Commissioning for Value datapacks
- Any town health system (due for publication in January)

Impact of the Care Bill

Summary

- ✓ The Bill contains provisions covering adult social care reform, care standards (and the government's response to the Francis Inquiry), and health education and research.
- ✓ The June Spending Round announced £335 million for local authorities in 2015 to support this reform. The funding is to help councils can prepare for reforms to the system of social care funding, including the introduction of a cap on people's care costs from April 2016, and a universal offer of deferred payment agreements from April 2015. This will mean that no-one will be forced to sell their home in their lifetime to pay for residential care.
- ✓ The £335 million covers:
  - £145 million for early assessments and reviews.
  - £110 million for deferred payment (cost of administering the loans and the loans themselves).
  - £20 million for capacity building including recruitment and training of staff.
  - £10 million for an information campaign.
  - £50 million for capital investment, including IT systems (which sits in the Better Care Fund).
- ✓ The Department for Health has also identified £130 million of other costs for 2015/16 relating to issues such as: putting carers on a par with users for assessment; implementing statutory Safeguarding Adults Boards; and setting national eligibility. The Department's position is that the Spending Round allocated funding to cover these costs as part of the Better Care Fund.

Interactive Support

Contact – For further information or if you have any queries, please contact Matthew.Hibberd@local.gov.uk

Examples and Tools

1. Care and Support Reform – Implementation toolkit
2. Summary of the Care Bill

Data-sharing for integrated care

Things you might want to consider

Information governance
- ✓ Suitable controls in all systems to ensure access is controlled and privacy maintained
- ✓ Identified strategy to capture consent for data sharing
- ✓ Established data sharing agreements outlining purpose and controls for sharing

NHS Number
- ✓ All services able to use the NHS Number as a primary identifier
- ✓ Demographics maintained and synchronised with national demographics service

Open APIs and Open Standards
- ✓ Allow information to be exchanged between systems through open standard interfaces (supported by open APIs where appropriate)
- ✓ National standards and services used wherever possible
- ✓ Regional agreements in place to define the approach for locating information and managing changes to ensure it is kept up-to-date

- ✓ Single ICT platform
- ✓ Online, remote access
- ✓ Clinical / non-clinical access
- ✓ 'Master' health record
- ✓ Real-time data updates
- ✓ Risk stratification approach
- ✓ Encourage patient ownership of data as well as partners
- ✓ Build in time for bedding in new data sharing

Case Studies

- **Isle of Wight:** Uses web based portal to facilitate delivery of integrated care virtually, and trialling a handheld "Patient Passport" data card.
- **Northamptonshire:** GP-Acute integrated system acting as master medical record for frail elderly patients, with input from other health and social care partners.
- **North West London:** Single IT platform linking and sharing provider information, allowing visibility of key integrated data sets for consenting patients.

Interactive Support

1. **Webinar** - We plan to run a webinar on this topic. See slide 20 for instructions on how to register your interest.
2. **Contact** – For further information or if you have any queries, please contact: England.Information-Governance@nhs.net

Further Resources

- Monitor's FAQs on integrated care
- Integrating personal budgets – myths and misconceptions (in particular see pages 34-37)
- NHS England IG Bulletin
- Go with the flow (improving flow of patient data)
- Costs and benefits of health information technology: an updated systematic review
- IT systems – an overlooked cog in the integration machine?

Joint Financing Arrangements (1)

What is a S75 pooled budget?

- Section 75 of the NHS Act 2006 allows partners (NHS bodies – commissioners and providers (with commissioner consent) – and councils) to make contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services, managed by a host partner – either the council or CCG.
- S75 also allows for lead commissioning and integrated management/provision (any of the 3 flexibilities can be combined)
- Pooled funds enable flexibility because expenditure is based on users' needs rather than the contributions of individual partners
- Delegated functions, as set out in the Act, are the statutory powers/duties of one partner that can be delivered by another (subject to agreed terms of delegation) to better meet shared objectives, e.g. NHS bodies providing residential care and welfare services for those with disabilities.
- While some partners see them as too technical & burdensome, others are in favour of the transparency & legitimacy they offer.

What do partners need to do to make pooled budgets work effectively?

- Partners must sign a joint funding agreement before starting the pool
- One agreement can cover multiple pools, but commissioners and providers should sign separate agreements where S75 agreements contain commissioning and providing arrangements
- Pooled budgets must be soundly based and follow the appropriate accounting arrangements, complying with up to date guidance, such as the Manual for Accounts 2013-14 (para 4.66 & Annex 1) and the CIPFA accounting code. IAS 31 Interests in Joint Ventures remains valid for 2013/14 and will be replaced by IFRS 11 Joint Arrangements from 2014/15:
    - Accounting and audit – the host partner is responsible for the accounts, although pooled budget notes to the annual accounts, and the audit requirement, are no longer mandatory (consider materiality)
    - Partnerships can not be designed to avoid tax – the host partner's VAT regime applies; VAT recovery is not permitted when a council delegates its functions and budgets to an NHS body; councils can recoup all VAT payments incurred in undertaking an NHS body's functions and budgets

What is a S256 payment transfer?

- Under Section 256 of the NHS Act 2006, CCGs can make payments (service revenue or capital contributions) to the LA to support specific additional LA services, e.g. where older people require a greater level of care in the community.
- Table 1 in Clarifying joint financing arrangements contains further information about how this can and cannot be used, including key criteria, e.g. it does not constitute a delegation of health functions to the LA and must show a more efficient use of resources.
- S76 is the equivalent for LA transfers to health bodies

Joint Financing Arrangements (2)

Things you might want to consider

- ✓ Is the right joint financing arrangement in place for the service's needs?
- ✓ Is a signed, robust joint funding agreement in place?
- ✓ Have outcomes been agreed, and arrangements put in place to regularly measure and monitor them?
- ✓ Has the S75 agreement been reviewed/evaluated by the partners within the time set in the agreement?
- ✓ Have the accounting/audit arrangements been followed according to the available guidance?

Case Studies

- Pooled budgets and integrated teams for Swindon's children's services
- *Means to an end*

Examples and Tools

- Commissioning Support Programme guidance* on drafting S75 agreements (also see Table 1 on page 28 for the areas that should be included and why)

Further Resources

1. NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000
2. Clarifying joint financing arrangements, Audit Commission, 2008*
3. Pooled Budgets: A Practical Guide for Councils and the National Health Service , CIPFA, 2009*

*While previous reports refer to PCTs, the lessons learned remain relevant for CCGs

Contracting and Procurement

We know that many local commissioners are exploring the use of innovative contracting models, such as prime provider, integrated pathway hubs & alliance contracting. The NHS Standard Contract for 2014/15 will enable commissioners to make use of some of these models:

- Both the prime provider and the IPH models can be used with the NHS Standard Contract, and we have specifically strengthened the provisions in the Contract around sub-contracting for 2014/15, so that they better support these models.
- Some forms of alliance contract are not currently compatible with the NHS Standard Contract, specifically where multiple providers are signatories to the same contract with the commissioner(s).
- We will continue to review whether there is a case for changing the Standard Contract to enable use for multi-provider contracts of this kind.

Interactive Support

1. **Contact** - Any commissioners who are keen to discuss an alliance contracting approach, or other forms of innovative contracting, are encouraged to contact the NHS Standard Contract Team for a discussion, via nhscb.contractshelp@nhs.net

2. **Contact** – for any queries relating to procurement, and choice & competition, and application of the regulations contact cooperationandcompetition@monitor.gov.uk

Further Resources

- Monitor's guidance on the Procurement, Patient Choice and Competition Regulations
- The NHS Standard Contract and associated Technical Guidance will be published shortly in December 2013.

Pricing and Incentives

The 2014/15 National Tariff Payment System gives commissioners and providers greater freedom to experiment with payment approaches to support new models of care. In particular, local variations can be used to agree adjustments to national currencies or prices as long as three principles are adhered to:

1. Local payment approaches must be in patients' best interests
2. They must be transparent; and
3. Providers and commissioners must engage constructively with each other when trying to agree local payment approaches.

Newly introduced flexibility in the application of CQUIN and contract sanctions as well as flexibility regarding contract durations will also support the delivery of integrated care.

Interactive Support

1. **Webinar** - We plan to run a webinar on this topic on. See slide 20 for instructions on how to register your interest.
2. **Contac**t – For further information or if you have any queries, please contact
   Bruno.Desormiere@Monitor.gov.uk
   david.wilcox@nhs.net

Further Resources

- 2014/15 National Tariff Payment System
- Monitor's pricing section on website
- Enabling Integrated Care
- Integrated Care FAQs

- *2014/15 CQUIN guidance - Dec. 2013*
- *Guidance for commissioners on the procurement of NHS-funded healthcare services in England – Jan. 2014*

BCF planning webinar 1 (6 January AM)

Date	Time	Lead by	Instructions to join webinar
6th January	11:15-12:15	Andrew Webster (LGA) & Anthony Kealy (NHS England)	Meeting Number: 847 878 923 Meeting Password: 1000 ---------- To join the online meeting (Now from mobile devices!) ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/j.php?ED=235972562&UID=1653311832&PW=NNWZkNDFjNWNk&RT=MiMyMA%3D%3D 2. If requested, enter your name and email address. 3. If a password is required, enter the meeting password: 1000 4. Click "Join". 5. Follow the instructions that appear on your screen. ---------- To join the teleconference only ---------- Call-in toll-free number: +44-800-9171950 (United Kingdom) Attendee access code: 724 819 02 ---------- For assistance ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/mc 2. On the left navigation bar, click "Support".

BCF planning webinar 2 (6 January PM)

Date	Time	Lead by	Instructions to join webinar
6th January	13:00-14:00	Andrew Webster (LGA) & Ivan Ellul / Anthony Kealy (NHS England)	Meeting Number: 849 763 532 Meeting Password: 1000 ---------- To join the online meeting (Now from mobile devices!) ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/j.php?ED=236150942&UID=1654020562&PW=NMTYxYzAwY2I5&RT=MiMyMA%3D%3D 2. If requested, enter your name and email address. 3. If a password is required, enter the meeting password: 1000 4. Click "Join". ---------- To join the teleconference only ---------- Call-in toll-free number: +44-800-9171950 (United Kingdom) Attendee access code: 724 819 02 ---------- For assistance ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/mc 2. On the left navigation bar, click "Support".

BCF planning webinar 3 (9 January)

Date	Time	Lead by	Instructions to join webinar
9th January	15:00-16:00	Andrew Webster (LGA) & Ivan Ellul / Anthony Kealy (NHS England)	Meeting Number: 849 234 470 Meeting Password: 1000 ---------- To join the online meeting (Now from mobile devices!) ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/j.php?ED=236151067&UID=1654021992&PW=NNmM1ZTNlYjA4&RT=MiMyMA%3D%3D 2. If requested, enter your name and email address. 3. If a password is required, enter the meeting password: 1000 4. Click "Join". ---------- To join the teleconference only ---------- Call-in toll-free number: +44-800-9171950 (United Kingdom) Attendee access code: 724 819 02 ---------- For assistance ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/mc 2. On the left navigation bar, click "Support".

BCF planning webinar 4 (17 January)

Date	Time	Lead by	Instructions to join webinar
17th January	15:00-16:00	Andrew Webster (LGA) & Ivan Ellul / Anthony Kealy (NHS England)	Meeting Number: 849 567 616 Meeting Password: 1000 ---------- To join the online meeting (Now from mobile devices!) ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/j.php?ED=236151567&UID=1654023727&PW=NZTYwNWM3ZjIx&RT=MiMyMA%3D%3D 2. If requested, enter your name and email address. 3. If a password is required, enter the meeting password: 1000 4. Click "Join". ---------- To join the teleconference only ---------- Call-in toll-free number: +44-800-9171950 (United Kingdom) Attendee access code: 724 819 02 ---------- For assistance ---------- 1. Go to https://n3-nhsengland.webex.com/n3-nhsengland/mc 2. On the left navigation bar, click "Support".

Please register your interest for specific webinar topics

Webinar Topic	Organisation
Patients, service users, and public engagement for integration	NHS England and LGA
Implications of the BCF on the acute sector and reconfiguration	NHS England, LGA and Monitor
Metrics and pay for performance for BCF	NHS England and LGA
Contracting, the NHS Standard Contract, and integration	NHS England and Monitor
Pricing and incentives for integration	NHS England and Monitor
How to complete BCF planning template – ask NWL	LGA, NHS England and NWL
Choice & competition and integration	NHS England and Monitor
Data sharing and information governance	NHS England, LGA, DH and NWL
LGA modelling toolkit – 'how to'	LGA
Role of HWBs for the BCF	LGA and NHS England

If you would like to register your interest for any of the above webinars, please email england.nhsevents@nhs.net

General integrated care resources

Link to resource	Short description
NHS Institute integration portal	Resources around supporting integrated care and integrated commissioning – although the NHS Institute has been closed down there are still valuable resources on this portal.
King's Fund integration portal	Portal of resources on the widespread adoption of integrated care to meet the needs of frail older people and others with complex health and social care needs.
ICASE	Integrated Care and Support Exchange (ICASE) is a national resource bringing together practical expertise from national partners, pioneers and the wider health and care system in order to spread and disseminate learning so that integrated care and support becomes the norm rather than the exception.
LGA Integrated Care: support page	This webpage contains information and links to specific tools and resources as part of the Integrated Care Value Case Toolkit.
NHS Change Model	The NHS Change Model has been created to support the NHS to adopt a shared approach to leading change and transformation. This portal brings together all resources associated with that model.
Personal health budgets across health and care	This website provides information and news about the personal health budgets policy being rolled out nationally in the NHS; and is home to a learning network for NHS and social care professionals involved in personal health budgets.
Care and support reform implementation	The LGA are working with partners to support local areas in implementation of the care and support reforms in the context of the other changes and challenges for local health and care systems, including the BCF. This webpage contains information and resources to support this.
Monitor's Integrated Care FAQs	FAQs to assist commissioners, providers and health and wellbeing boards to comply with their obligations relating to integrated care and to explain the relationship between these obligations and the other rules that Monitor enforces.

Key contacts

If you have any further queries you can get in touch via the below methods:

1. NHS England: Anthony.Kealy@nhs.net or LGA: Tom.Shakespeare@local.gov.uk
2. Post a question to the NHS England BCF planning page

Please also feel free to post questions and share learning at a local level on ICASE

DERBYSHIRE COUNTY COUNCIL

Adult Care Board

16th January 2014

Joint Health and Social Care Learning Disability Self-Assessment Framework

Purpose of the Report

To provide a summary of the recently completed Learning Disability Self-Assessment (SAF) and the next steps. That the Board agrees to seek support of the Health and Wellbeing Board, and to receive an update on the Learning Disability SAF following the public validation processes and subsequent improvement planning activity.

Introduction

In 2013, the Department of Health asked Local Authorities and Clinical Commissioning groups to jointly complete self-assessments, following a prescribed format, on their local response to learning disabilities. The new Joint Health and Social Care Self-Assessment Framework replaced the *Valuing People Now* Self-Assessment and the Learning Disability Health Self-Assessment. The intention of the Department of Health is that the new SAF becomes the main source of intelligence and data returns in future years.
There is a requirement that each local Health and Wellbeing Board receives a copy of the SAF and also considers the resulting actions. This report summarises the outcomes of the SAF to ensure that all partners are aware of, and updated on, the progress and implications of the self-assessment.

Learning Disability Self-Assessment

The Learning Disability SAF was completed against a standard national framework developed by the Public Health Observatory in conjunction with the Department of Health. The document is in three domains: Section A - Staying Healthy; Section B – Being Safe and Section C – Living Well. The format is a mixture of data entry, RAG (Red/ Amber/ Green) rating, yes/no responses and optional self -advocate stories.

The Learning Disability SAF was submitted on time on November 29th 2013 (Appendix 1). Partner challenge was conducted with the local NHS and Derby City colleagues before submission. The overall outcomes were positive although there were some areas of concern specifically regarding data collection and collation. Indicative priority areas for improvement are noted below.

RAG Rated Questions

The Learning Disability SAF required a large amount of health-related statistical input, followed by a RAG rating. The Derbyshire County response was submitted following a challenge session with Derby City and CCG leads; Derbyshire County officers in turn, provided challenges to the Derby City self-assessment.

The self-assessment was positive overall, with the majority of the RAG ratings recorded as amber. Reds were noted for the level of Health Action Plans completed (A4) and Primary Care communication of status (A6).
The SAF included examples of positive joint working arrangements, improved GP data collection, contract compliance and person centred planning. All commissioned services comply with multi-agency safeguarding policies and procedures, supported by an annual Derbyshire-wide provider forum to facilitate learning and sharing of best practice. The Derbyshire Dignity Challenge continues to be rolled-out and participants are now being encouraged to apply for the Silver Award.

The need to improve data collection, particularly at primary care level, commitment to regular health checks and the completion of all annual reviews has been noted. Data collection and sharing also needs to be improved across agencies as does the effectiveness of transitions protocols. Further links could be made to improve access to transport, culture, employment and leisure facilities.

The Learning Disability Joint Commissioning Board is working to produce an action plan based upon the SAF outcomes. Agencies are required to participate in a half day validation session to secure formal sign off of the submission led by Department of Health representatives; it is anticipated that his will take place in the first quarter of 2014. The session will be attended by the health and social care leads for all the categories within the Framework, service users and their family carers. Each element of the SAF submission is scrutinised and officers are asked to explain the ratings and supporting comments and to provide further evidence if required.
The final Action Plan will be presented to the Learning Disability Partnership board and the Joint Commissioning Board.

Officer Recommendations

1. The Board notes and approves the content of the Joint Health and Social Care Learning Disability Self-Assessment;
2. An update report on the Action Plan is made to the Adult Care Board;
3. To seek support of the Health and Wellbeing Board.

Public Health England

Improving Health and Lives:
Learning Disabilities Observatory

Joint Health and Social Care Self-Assessment Framework

Healthcare

Demographics

You should obtain this information from general practices. You can do this directly either by the Clinical Commissioning Group (CCG) or Commissioning Support Unit (CSU) using MiQuest queries, or by direct liaison with practices. Primary Care Trusts and GP practices may also know this information from routine liaison in relation to Health Checks. In some areas, primary care contracting requires information flows to support this.

You should aim to provide this data broken down by **age bands** and **ethnicity**. However, if you are unable to provide an age breakdown at this level then **either** report the data by the number of people of aged **0 to 17** years old and aged **18 and over**, **Or** the numbers for **all ages**. These are the last three options in questions 1 to 3.

Please note recorded as being from an ethnic minority means that a person's ethnic category (if declared) is different from the English ethnic majority. That is to say they are not 'British (White)'. This refers to the term as defined for the NHS data dictionary.

1. How many people with any learning disability are there in your Partnership Board area?

1.1 Aged 0 to 13 years old

1.2 Aged 14 to 17 years old

1.3 Aged 18 to 34 years old

1.4 Aged 35 to 64 years old

1.5 Aged 65 years old and over

1.6 Aged 0 to 17 years old and recorded as being from an ethnic minority

1.7 Aged 18 years old and over and recorded as being from an ethnic minority

If you are unable to provide an age breakdown at this level of detail then complete either questions 1.8 and 1.9, question OR 1.10.

1.8 Aged 0 to 17 years old

729

1.9 Aged 18 years old and over

2779

1.10 All ages

3508

2. How many people with complex or profound learning disability are there in your Partnership Board area?

Complex or profound learning disability here means learning disability complicated by severe problems of continence, mobility or behaviour, or severe repetitive behaviour with no effective speech (i.e. representing severe autism) (Institute of Public Care, (2009) Estimating the prevalence of severe learning disability in adults. IPC working paper).

2.1 Aged 0 to 13 years old

2.2 Aged 14 to 17 years old

2.3 Aged 18 to 34 years old

2.4 Aged 35 to 64 years old

2.5 Aged 65 years old and over

2.6 Aged 0 to 17 years old and recorded as being from an ethnic minority

2.7 Aged 18 years old and over and recorded as being from an ethnic minority

If you are unable to provide an age breakdown at this level of detail then complete either questions 2.8 and 2.9, question OR 2.10.

2.8 Aged 0 to 17 years old

84

2.9 Aged 18 years old and over

2.10 All ages

3. How many people with both any learning disability and an Autistic Spectrum Disorder are there in your Partnership Board area?

3.1 Aged 0 to 13 years old

3.2 Aged 14 to 17 years old

3.3 Aged 18 to 34 years old

3.4 Aged 35 to 64 years old

3.5 Aged 65 years old and over

3.6 Aged 0 to 17 years old and recorded as being from an ethnic minority

3.7 Aged 18 years old and over and recorded as being from an ethnic minority

If you are unable to provide an age breakdown at this level of detail then complete either questions 3.8 and 3.9, question OR 3.10.

3.8 Aged 0 to 17 years old

247

3.9 Aged 18 years old and over

3.10 All ages

Screening

This information should be obtained from GP practices. This may either be done directly by the CCG or CSU using MiQuest queries, or by direct liaison with practices. Directors of Public Health should be monitoring this routinely as an equalities issue.

The total eligible population includes people with and without learning disabilities unless otherwise stated.

4. How many women are there eligible for cervical cancer screening?

- The eligible population are women aged 25 to 64 years old inclusive and who have not had a hysterectomy.
- The population who had a cervical smear test in the last three years (1st April 2010 to 31st March 2013 inclusive) if aged 25 to 49 years old or else in the last five years (1st April 2008 to 31st March 2013 inclusive) if aged 50 to 64 years old

4.1 Number of total eligible population

127305

4.2 Number of total eligible population who had a cervical smear test

95434

4.3 Number of eligible population with learning disabilities

645

4.4 Number of eligible population with learning disabilities who had a cervical smear test

212

5. How many women are eligible for breast cancer screening?

- Eligible population are women aged 50 to 69 years old, inclusive.

5.1 Number of total eligible population

113194

5.2 Number of total eligible population who had mammographic screening in the last three years (1st April 2010 to 31st March 2013)

55289

5.3 Number of eligible population with learning disabilities

468

5.4 Number of eligible population with learning disabilities who had mammographic screening in the last three years (1st April 2010 to 31st March 2013)

161

6. How many people are eligible for bowel cancer screening?

- Eligible population are people aged 60 to 69 years old, inclusive.

6.1 Number of total eligible population

93822

6.2 Number of total eligible population who satisfactorily completed bowel cancer screening in the last two years (1st April 2011 to 31st March 2013)

2616

6.3 Number of eligible population with learning disabilities

210

6.4 Number of eligible population with learning disabilities who satisfactorily completed bowel cancer screening in the last two years (1st April 2011 to 31st March 2013)

101

Wider Health

This information should be obtained from GP practices. This may either be done directly by the CCG or CSU using MiQuest queries, or by direct liaison with practices. These are routinely available measures of major health issues that should be monitored by Directors of Public Health.

Report how many people there were on the **31st March 2013**.

7. How many people with learning disabilities are there aged 18 and over who have a record of their body mass index (BMI) recorded during the last two years (1st April 2011 to 31st March 2013)?

1060

8. How many people with learning disabilities are there aged 18 and over who have a BMI in the obese range (30 or higher)?

821

9. How many people with learning disabilities are there aged 18 and over who have a BMI in the underweight range (where BMI is less than 15 as per Health Equalities Framework indicator 4C)?

10. How many people with learning disabilities aged 18 and over are known to their doctor to have coronary heart disease?

As per the Quality and Outcomes Framework (QOF) Established Cardiovascular Disease Primary Prevention Indicator Set.

35

11. How many people with learning disabilities of any age are known to their doctor to have diabetes?

As per the QOF Established Diabetes Indicator Set and include both type I and type II diabetes here.

161

12. How many people with learning disabilities of any age are known to their doctor to have asthma?

As per the QOF Established Asthma Indicator Set

164

13. How many people with learning disabilities of any age are known to their doctor to have dysphagia?

43

14. How many people with learning disabilities of any age are known to their doctor to have epilepsy?

As per the QOF Established Epilepsy Indicator Set

529

Mortality

Following the publication of the Confidential Inquiry, Directors of Public Health will want to set up mechanisms to monitor this. Relatively few are likely to be able to answer this question this year. In the longer term this will be produced as part of the NHS Outcomes Framework.

15. How many people with a learning disability resident in your Partnership Board area died between 1st April 2012 and 31 March 2013?

15.1 Aged 0 to 13 inclusive

15.2 Aged 14 to 17

15.3 Aged 18 to 34

15.4 Aged 35 to 64

15.5 Aged 65 and older

Annual Health Check & Health Action Plans

16. How many people with a learning disability aged 18 and over were agreed as eligible for an Annual Health Check under the Directed Enhanced Scheme between 01 April 2012 and 31 March 2013?

2779

17. How many people with a learning disability aged 18 and over had an Annual Health Check under the Directed Enhanced Scheme between 01 April 2012 and 31 March 2013?

1565

18. How many people aged 18 and over with a learning disability have a Health Action Plan?

18.1 Total number eligible

18.2 Total number completed

358

Practices participating in Health Checks

Report how many general practices there were on the **31st March 2013**.

19. How many GP practices are there in your Partnership Board area?

94

20. How many GP practices in your Partnership Board area signed up to a Locally Enhanced Services or Directed Enhanced Service for the learning disability annual health check in the year 2012-2013?

89

Acute & Specialist Care

Providers should know this as a result of the Compliance Framework.

Report the numbers between **1st April 2012 and 31st March 2013**.

21. How many spells of INPATIENT Secondary Care were received by people identified by the provider as having a learning disability under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715)?

Please note 21.2 has changed from "Number for people with learning disabilities as percentage of total spells". We are now asking for the denominator value as to ensure the accuracy of the information.

21.1 Number of spells for people identified as having a learning disability

248

21.2 Total number of spells

68921

22. How many OUTPATIENT Secondary Care Attendances were received by people identified by the provider as having a learning disability under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715)?

Please note this changed from "Number for people with learning disabilities as percentage of total attendances". We are now asking for the denominator value as to ensure the accuracy of the information.

22.1 Number of attendances identified as having a learning disability

2197

22.2 Total number of attendances

285918

23. How many attendances at Accident & Emergency involved a person with learning disabilities as the patient?

Please note this changed from "Number for people with learning disabilities as percentage of attendances". We are now asking for the denominator value as to ensure the accuracy of the information.

23.1 Number of attendances involving people with learning disabilities

23.2 Total number of attendances

24. How many people with a learning disability have attended Accident & Emergency more than 3 times?

Please note this changed from "Number for people with learning disabilities as percentage of total attendances". We are now asking for the denominator value as to ensure the accuracy of the information.

24.1 Number of people with a learning disability

24.2 Total number of attendances

Continuing Health Care and Aftercare

Your Local CCG or CSU/Function should have this information.

Report the numbers on the **31st March 2013**.

25. How many people with a learning disability are in receipt of Continuing Health Care (CHC)?

237

26. How many people with a learning disability are in receipt of care funded through the Section 117 arrangement of the Mental Health Act?

17

Location of mental health and learning disability in-patient care

In most cases, this should be known by CCG and possibly through CSU. Your Local CCG or CSU should have this information.

Report the numbers on the **31st March 2013**.

27. How many people with learning disability were in-patients in mental health or learning disability in-patient units (HES speciality function codes 700 to 715) run by providers that provide the normal psychiatric in-patient and community services for the CCGs in your Partnership Board area.

Note: the impact of this question is likely to be the 'missing figures' that relate to those placed out of area and this will be compared with the Winterbourne View data collection/registers.

27.1. Number of people placed primarily due to Challenging Behaviour

27.1.1 Age 0 to 17

27.1.2 Age 18 or older

5

27.2. Number of people placed primarily due to Mental Health Problems

27.2.1 Age 0 to 17

27.2.2 Age 18 or older

3

27.3. Number of people placed primarily due to complex physical health needs

27.3.1 Age 0 to 17

0

27.3.2 Age 18 or older

0

28. How many people with learning disability were in-patients in mental health or learning disability in-patient units commissioned by NHS England (specialised commissioning)?

Note: this question has been changed to clarify what is requested.

28.1. Located in your Partnership area or a CCG area bordering it

28.1.1. Number of people placed primarily due to Challenging Behaviour

28.1.1.1 Age 0 to 17

0

28.1.1.2 Age 18 or older

0

28.1.2. Number of people placed primarily due to Mental Health Problems

28.1.2.1 Age 0 to 17

0

28.1.2.2 Age 18 or older

0

28.1.3. Number of people placed primarily due to complex physical health needs

28.1.3.1 Age 0 to 17

0

28.1.3.2 Age 18 or older

0

28.2. Located elsewhere

28.2.1. Number of people placed primarily due to Challenging Behaviour

28.2.1.1 Age 0 to 17

0

28.2.2.2 Age 18 or older

0

28.2.2. Number of people placed primarily due to Mental Health Problems

28.2.2.1 Age 0 to 17

0

28.2.2.2 Age 18 or older

13

28.2.3. The Number of people placed primarily due to complex physical health needs

28.2.3.1 Age 0 to 17

0

28.2.3.2 Age 18 or older

0

Reasons for mental health and learning disability in-patient placements

CCG or CSU should have this information. In some cases where commissioning for this group has been partly subcontracted to providers, this may require their input too.

29. How many people with a learning disability have been admitted once or more often to both in-patient mental health and learning disability care (HES specialty function codes 700-715) at least once between 01 April 2012 and 31 March 2013?

Count each individual once only.

29.1 Primarily for management of challenging behaviour

22

29.2 Primarily for other reasons

26

29.3 Total number of individuals (One individual may in the year have had admissions for both reasons)

48

30. How many people with a learning disability were in both in-patient mental health and learning disability care (HES specialty function codes 700-715) on 31 March 2013?

30.1 Primarily for management of challenging behaviour

5

30.2 Primarily for other reasons

19

31. How many people with a learning disability were in both in-patient mental health and learning disability care (HES specialty function codes 700-715) on 31 March 2013 who had been in-patients continuously in this or other placements for more than 90 days.

31.1 Primarily for management of challenging behaviour

1

31.2 Primarily for other reasons

13

32. How many people with a learning disability were in both in-patient mental health and learning disability care (HES specialty function codes 700-715) on 31 March 2013 who had been in-patients continuously in this or other placements for more than 730 days (two years).

32.1 Primarily for management of challenging behaviour

0

32.2 Primarily for other reasons

11

Challenging Behaviour

CCG or CSU should have this information.

Report all NHS funded hospital care.

33. Number of people with a learning disability or autism, with challenging behaviour in NHS funded care on the PCT register handed over to the CCG at 31st March 2013.

33.1 Number in hospital at index date

24

33.2 Number NOT in hospital at index date

237

34. Number of people with a learning disability or autism, with challenging behaviour in NHS funded care on the CCG register at 30th June 2013.

34.1 Number in hospital at index date

22

34.2 Number NOT in hospital at index date

237

35. Number of people in learning disability or autism in-patient beds at 1st December 2012 (Publication of Transforming Care) and number of these whose care has been reviewed in line with the Ian Dalton Letter between the beginning of December and 1st June 2013.

35.1 Number in hospital at index date

23

35.2 Number NOT in hospital at index date

Assessment and provision of social care

You should refer to your Local Authority Referrals, Assessments and Packages of Care (RAP) Return data.

Report the numbers between 01 April 2012 and 31 March 2013.

36. How many people with learning disabilities received the following between 01 April 2012 and 31 March 2013?

36.1 Received a statutory assessment or reassessment of their social care need whose primary client type was learning disability. (A1 and assumedly knowable from sources capable of producing A6 and A7)

866

36.2 Received community-based services whose primary client type was learning disabilities (P1)

1530

36.3 Received residential care whose primary client type was learning disabilities (P1)

415

36.4 Received nursing care whose primary client type was learning disabilities (P1)

120

Inclusion & Where I Live

Social services statistics unit should have this information. Please note, these are data you should have reported to the Health & Social Care Information Centre (HSCIC) earlier in the year. They are included here so they can be seen in the context of the other data. They will not be published by HSCIC until March 2014.

Report the number of people with learning disability as primary client type.

Employment & Voluntary Work

Refer to Adult Social Care Combined Activity Returns data L1.

37. How many people with learning disabilities in paid employment (including self-employed known to Local Authorities)?

96

38. How many people with learning disabilities as a paid employee or self-employed (less than 16 hours per week) and not in unpaid voluntary work?

73

39. How many people with learning disabilities as a paid employee or self-employed (16 hours + per week) and not in unpaid voluntary work?

23

40. How many people with learning disabilities as a paid employee or self-employed and in unpaid voluntary work?

0

41. How many people with learning disabilities in unpaid voluntary work only?

22

Accommodation

Refer to Adult Social Care Combined Activity Returns data L2

Please note, the National Adult Social Care Intelligence Service rounds these numbers to nearest five prior to publication. As such, we will take similar precautions when publishing these data.

42. How many people with a learning disability live in or are registered as:

42.1. Rough sleeper/Squatting

0

42.2. Night shelter/emergency hostel/direct access hostel (temporary accommodation accepting self-referrals)

1

42.3. Refuge

0

42.4. Placed in temporary accommodation by Local Authority (including Homelessness resettlement)

6

42.5. Acute/long stay healthcare residential facility or hospital

9

42.6. Registered Care Home

254

42.7. Registered Nursing Home

79

42.8. Prison/Young Offenders Institution/Detention Centre

2

42.9. Other temporary accommodation

5

42.10. Owner Occupier/Shared ownership scheme

92

42.11. Tenant - Local Authority/Arm's Length Management Organisation/Registered Social Landlord/Housing Association

300

42.12. Tenant - Private Landlord

115

42.13. Settled mainstream housing with family/friends (including flat-sharing)

474

42.14. Supported accommodation/Supported lodgings/Supported group home (accommodation supported by staff or resident caretaker)

238

42.15. Adult placement scheme

31

42.16. Approved premises for offenders released from prison or under probation supervision (e.g., Probation Hostel)

6

42.17. Sheltered Housing/Extra care sheltered housing/Other sheltered housing

0

42.18. Mobile accommodation for Gypsy/Roma and Traveller community

2

42.19. What is the total number of people with a learning disability known to the Local Authority?

1626

Quality

For Health Commissioning Deprivation of Liberty Safeguards refer to Omnibus data collection
http://www.hscic.gov.uk/dols

Training

43. How many of Health & Social Care commissioned services implement mandatory learning disabilities awareness training? - We have withdrawn this question.

Complaints

44. How many complaints have directly led to service change or improvement in learning disabilities services?

6

Safeguarding

45. How many adult safeguarding concerns have there been in the year to 31st March 2013 concerning adults with learning disabilities?

245

46. How many adult safeguarding concerns have been raised in relation to people with learning disabilities that required escalation?

80

47. What percentage of commissioned accommodation, residential or nursing placements "in borough" have had unannounced visits in the past 12 months?

0

48. How many commissioned accommodation, residential or nursing placements "out of borough" have had unannounced visits in the past 12 months?

Note: this question has been changed. Please provide the total figure, not the percentage.

0

Mental Capacity Act, Deprivation of Liberty Safeguards and Best Interest referrals

49. How many Deprivation of Liberty Safeguards referrals were made by local authorities in 2012-13?

Note: this question has been changed to clarify what is requested.

208

50. How many Deprivation of Liberty Safeguards referrals were made by CCGs (formerly PCTs) in 2012-13?

Note: this question has been changed to clarify what is requested.

62

51. How many Best Interest Decisions referrals have been made in 2012-13?

344

52. What percentage and number of staff in commissioned services have undertaken DOLS training in the last 3 years?

52.1 Percentage

87

52.2 Number

333

53. What percentage and number of staff in commissioned services have undertaken Mental Capacity Act training in the last 3 years?

53.1 Percentage

107

53.2 Number

408

Transitions

54. The total school age population in your Partnership Board area

88019

55. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of moderate learning disability.

1269

56. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of severe learning disability.

230

57. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of profound or multiple learning disability.

105

58. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of autistic spectrum disorder.

688

59. The number of people with a learning disability aged 14 to 17 years old who are in receipt of a co-produced transition plan.

Self-Assessment Framework

This section allows you to rate each measure of the self-assessment framework green, amber or red. You should continually refer to the guidance in order to decide the ratings. The guidance can be downloaded here.

In addition, you can click on each measure which will take to the definition of the measure and the RAG ratings.

In order to rate yourself RED, you must meet the criteria described under this heading In order to rate yourself AMBER, you must meet the criteria described under BOTH the RED and AMBER headings In order to rate yourself GREEN, you must meet the criteria described under the RED, AMBER and GREEN headings

For each indicator, you should provide an explanation as to why you rated it green, amber or red and a link to a webpage containing further evidence to support this rating.

In addition, you can also provide a positive or negative real life stories of experience that explains why you think that indicator is strong or needs improvement.

Please note, we would like you to keep these explanations and stories concise. As such please limit these to 1,000 characters (including spaces). There is a counter underneath each comment box indicating how many characters out of the 1,000 you have used.

Section A

A1. LD QOF register in primary care

- ◯ Red
- ⊗ Amber
- ◯ Green

Explanation for this rating

**Please note that the submitted primary care data is based upon information from 66% (62 out of 94) practices.*
All GPs have QOF registers and registers for adults with Down Syndrome.GP Practices across Derbyshire have been visited by a LD Strategic Health Facilitator. The Practices are being supported to identify patients with mild, moderate,severe and profound learning disability. In addition people with Down Syndrome and LD with additional Autism are being identified.
We had identified a problem that some Children's service diagnosis of LD is added to GP registers and could not be removed by the practice if this was felt inappropriate when they reached adulthood.We have now resolved this issue with support from the Paediatricians and Informatic services.

Web link to further evidence

http://www.corecarestandards.co.uk/services/adult-and-older-adult-services/learning-disability/

Real life story

The Learning Disability Strategic Health facilitation Team each have a list of GP practices that they provide liaison for. They contact the practice and arrange to visit. They spend time with practice staff going through the electronic patient record and where information isn't available they also go through older patient records. Derbyshire County Council have provided an extensive list which identifies people known to them who have the predominant need of learning disability. A Team Clerk with 'Exeter system' rights is checking the information to ensure correct GP and other information is identified. The cleansed list is shared with GP practices.nformation from specialist learning disability services, social care and childrens/ education is used to help identify the correct codes.

A2. Screening

People with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease and Epilepsy

- ◯ Red
- ⊗ Amber
- ◯ Green

Explanation for this rating

Disease prevention is provided by a range of services across Derbyshire, including Derbyshire Community Health Services and Chesterfield Royal Hospital. Flagging is not applied consistently and therefore data relating to access to some services is not available.DCHS have a working group 'Healthcare4All' to support access.Community Health Practioners have been offerred awareness training and all the 'Hospital Communication Book' disseminated by the SHFs. Evidence suggest this is not being used. H4A are working to improve referral information captures LD , slow progress due to the numbers of services.We have statistics provided throughout the Primary care data section are from 62 out of 94 GPs. We have a steering group for LD obesity. working on care pathway for epilepsy and maternity services for LD.

Web link to further evidence

http://www.dchs.nhs.uk/dchs_service_directory/services

Real life story

This story came from a fitness instructor at Ashbourne Leisure Cente submitted as a successful, practical example of how a comprehensive approach from family, GP and programme can instil behaviour change.
A morbidly obese, 35yr old female with learning difficulties, who lives on her own. Her father and step-mother live locally and have recently taken steps to help her reduce weight. At the time of intervention her weight was 144kg and her BMI was 59.9.Support from family.Weekly weigh-in with a nurse at her surgery.Client referred to Active Health Referral. Now attends 2 to 3 times per week, bought a 12 month gym membership and she is confident enough to exercise on her own. She has also started a Maths and English course.
On completing the Scheme, her weight had reduced to 115.0kg, a 7kg weight loss whilst on the scheme and a total reduction of 29kg since March.
Further benefits of losing weight:puts own socks on.steps in out of the bath easily now.received advances from male friends.continued to lose weight regularly at weigh ins with practice nurse.gained more self-confidence. MUCH happier in herself. less dependance emotionally on father, now only speaks to him once a day.gets up the stairs to sleep in bed, (she had a period of 3 months, at her heaviest, where she was sleeping in a chair as she was unable to get up the stairs).
At the time of writing, my client's weight stands at 109.7kg, total loss of 34.3kg since March 2013.

A3. Annual Health Checks and Annual Health Check Registers

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation to rating

89 of 94 practices have agreed to deliver the Annual Health check. Of these the LD Strategic Health facilitators have verified and stratified 79 of 89 practices signed up to the Health checks (89%). Some Practices in the North & High Peak of the County still require verification & stratification
(Avondale Surgery/ Brimington Surgery/ Chatsworth rd/ Newbold Surgery/ Whittington Medical Practice / Avenue House/ Eyam/ Sett Valley/ Stewart), these will be finished within the next few months.
The SHFs support the Practices to identify people with a LD as identified in information for the QOF register.GP practices are supported by the LD Strategic Health facilitators The numbers of health checks provided have risen steadily since their introduction, however less than 60% of those people on the QOF list have had a health check. This does not represent the true figures linked to those eligible which at present we do not have, as not everyone on the QOF register is eligible

Web link to further evidence

http://www.improvinghealthandlives.org.uk/news/?nid=2454

Real life story

A GP practice was struggling to 'get started' with their Annual Health checks. They did not originally sign up to deliver health checks. They were pursuaded by the persistance of the SHF . Even though they signed up to the scheme they failed to complete any health checks in their first year of sign up. The SHF supported the practice with training, barrier identification, register, template and a range of easy read information. She planned with the practice how to start and supported the Practice Nurse with the first 2 health checks to build confidence. This model has been used with other practices.

A4. Health Action Plans

Health Action Plans are generated at the time of Annual Health Checks (AHC) in primary care and these include a small number of health improving activities. Refer to RCG guidance around health action plans.

- ⊗ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation to rating

From evidence gained from 62 of our 94 GP practices 1745 people were eligible for their Annual Health check. 358 of these were supported by their GP practice to have a Health Action Plan (21.5%).The SHF Team provide training to paid and family carers about Health Action Planning.HAPs are included in the GP practice training. An easy read planner (My Health File) is given to help with HAPs. People are encouraged to take this along to their health appointments.
The SHF team visited 24 care homes across City and County in 2012/13 to check standards of Health Action plans. everyone in a care home had some type of plan.
In training the GP practices are encouraged to use a Health Action plan easy read template to help the patient to understand the advice that they have been given.

Web link to further evidence

Real life story

L lives in a care home and has a number of health needs including foot care, healthy eating, weight management, female related health issues and understanding her medication. Her care team used tools provided by the SHF team to identify her needs. They worked with L on how she wanted to keep her Health Action plan and what should be in it. They used a talking photo book to help her remember and prompt her with her health actions.

A5. Screening

Comparative data of people with learning disability vs. similar age cohort of non-learning disabled population in each health screening area for:

a) Cervical screening

b) Breast screening

c) Bowel Screening (as applicable)

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Data is from 62 practices.a) women without LD 5% were removed or excepted. 75% had cervical screening. With LD, 41% were refused or excepted. 33% of had screening.
b)NB data problems.without LD 40-75, 49% had Breast screening.LD34% had and 19% are recorded as 'declined.'
c)Bowel: age extended to 74.data adapted for SAF, 52% without LD had.58% LD .
SHFs : booklet'how to keep people with learning disabilities healthy.' Awareness sessions.Working with the Breast screening units, reasonable adjustments implimented. LD CN provides support to attend. Sample takers awareness training .Focus groups developed pathways. SHFs worked with Regional lead to develop easy read resources which have shared in Derbyshire eg Bowel screening DVD.
SHFs working with Public Health and Hardwick CCGs 16 practices on CQINN to improve uptake, the results will be shared and methodolgy rolled out to other CCGs.Includes baseline and end data, pathways, information and support for the practices and patients, focus group with carers and a survey of the practices:
http://www.hardwickccg.nhs.uk/website/X24712/files/Hardwick-News-15.pdf

Web link to further evidence

http://observatory.derbyshire.gov.uk/IAS/healthandwellbeing/healthprofiles/healthneedsassessments.aspx

Real life story

B is a family carer and also has a learning disability. B has been helping to deliver LD awareness training to nurses that conduct the screening. B has supported the development of the pathway for cervical screening by being part of the focus group.

C's social worker was concerned that C was not being supported to access cervical screening. Her mother had made a the decision that C should not undergo the screening. The social worker asked the LD Community Nurse to help. The Nurse talked to the mother and to C about screening and risks. she helped the lady to understand the process and to discuss this with the practice nurse. Given the lady's history the nurse agreed it was appropriate for her to have screening. Supported by the CN and practice nurse c succesfully had cervical screening.

A6. Primary care communication of learning disability status to other healthcare providers

- ⊗ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Derbys GPs refer to other services using the service referral form or by letter. GP practices have been advised and requested to alert services to the LD and reasonable adjustments required in training, via use of GP on-line portal system and personal contact with SHF team.There is no one LAT or CCG system in place across.

Web link to further evidence

Real life story

During an annual health check the GP diagnosed that M had diabetes. The GP referred to the specialist diabetic nurse and identified that the patient had a learning disability and would require adapted information. The nurse was able to prepare for the first appointment and had an easy read booklet about diabetes with her.

A7. Learning disability liaison function or equivalent process in acute setting

For example, lead for Learning disabilities.

Known learning disability refers to data collated within Trusts regarding admission - HES data.

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Explanation for rating

A Learning disability Education Matron was in post at Chesterfield Royal Hospital for just over one year until February 2013.She introduced a range of resources, delivered formal training and supported the development of a flagging system within Chesterfield Royal.The Hospital has plans to advertise for a full time ALN in the New Year. A Healthcare Assistant has been provided with a grant to develop easy read information for the Hospital and has produced a wide range of information which can be accessed via the Hospital website.
Some people from Derbyshire use Hospital services comissioned in other areas eg Stockport, Nottingham.

Web link to further evidence

http://www.chesterfieldroyal.nhs.uk/patients/easy_read/index

Real life story

Derbyshire Learning Disability Partnership Board supported by MacIntyre has a number of self-advocates known as 'Reps on Board.' The reps were approached by a Healthcare Assistant from Chesterfield Royal Hospital who had been approved a grant to enable her to develop easy read information for the Hospital. With the help of the reps she has produced a range of information to help people understand what happens in different departments.

We also have a story from a mother about trying to access a procedure under GA. The hospital lost the referral and a Dr refused to provide the procedure due to seizure risk, even though the lady had been treated under GA before. The story ishow how persistent parents and carers have to be to advocacte for their relatives and the importance of clear communication between deaprtments in Hospitals.

A8. NHS commissioned primary and community care

* Dentistry

* Optometry

* Community Pharmacy

* Podiatry

* Community nursing and midwifery

This measure is about universal services NOT those services specifically commissioned for people with a learning disability.

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

We have evidence about many improvements and reasonable adjustements across our community health services however these are not consistent in all services across the county. we have worked on improvements in Optical services.We have organised a learning disability awareness Seeability event for LOCSU the Opticians. LD Good Health group are meeting with all contracts/ comissioners to raise issues of access and the need for this to be within contracts.Easy read medication info at Derby Royal and Psychiatry. LD Specialist NHS team support some women through maternity services and use a range of adapted resources. SHFs leading pathway across services for parents who have LD. IAPT pilot.All DCHS services have completed an internal SAF against monitor compliance and other key HC4A issues. This includes questions about service ability to flag and track LD service users & awareness of the HC4A agenda.
(round 3), self-assessment compliance Dentistry (LLR).
100% , Podiatry100% .DCHS community nursing work stream HC4A Action Plan 14/15. Families report good services across Community Dentistry and Optometry.

Web link to further evidence

http://www.dchs.nhs.uk/dchs_service_directory/services

Real life story

V has visited Boots Opticians on a number of occasions and has worked with the special learning disability service to develop photographic resources that Boots can use to help people understand their processes. A young gentleman attended for Community dental care. He has Cerebral palsy and communicates via his mother using a communication board. He required several fillings and an extraction.
We tried to provide this in the surgery but were unable to do so due to his posture and limited cooperation.
We offered to carry out care under GA. However, the patient indicated that he was very anxious about having a GA in view of the risks. On further discussion it was agreed he could attend the hospital and receive IV sedation in order to have his treatment.
This was carried out successfully.
This story demonstrates how services discuss courses of action with the patient listen to their views and adapt our service provision to meet these thus providing a patient focussed service.

A9. Offender Health & the Criminal Justice System

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

There are pathway developments taking place across the East Midlands Health and Justice team, there are areas piloting initial assessment tool to be used across secure estate but limited evidence to date, health and justice ask providers to RAG against performance indicators which include LD issues.
Our local prison inreach and LD nurse consultant are carrying out the LD awareness training and are commencing LD screening tools into Foson and Sudbury Prisons, which will then be carried out by the health team in the Prisons. Our Transfoming care action plan includes a refresh of existing Forensic pathways and training provided to CJS and offender teams.

Web link to further evidence

Real life story

Our LD Nurse Consultant has been working with Foston Prison, and the health inequlity manager from Health and Justice - East Midlands, they have have developed an accessible Prison Handbook to provide easy words and pictures for the everday slang terminolgy used.

Section B

B1. Regular Care Review

Commissioners know of all funded individual health and social care packages for people with learning disability across all life stages and have mechanisms in place for on-going placement monitoring and individual reviews.

Evidence should describe the type (face to face or telephone etc.)

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

If fieldwork officers identify poor practice then they complete a contract monitoring form that highlights the area of concern and what action they took to ensure it was remedied. This information is then used by contracting team officers to identify whether to undertake more in-depth review. The CHC team have case assessors and case managers in place to provide on-going monitoring and individual face to face reviews. we also have a case manager employed to review people in independent hospitals, along with a social worker covering City and County LA's.

Web link to further evidence

Real life story

D a client with an autistic spectrum disorder and moderate learning difficulties placed in a residential school by another local authority. A request was made for a Mental Health Act (1983) Assessment as the school began to have difficulty managing D's behaviour. The other local authority was slow to respond causing distress to the client. A solution was found and advice given to the residential school about ensuring that all clients should have a contingency plan in place in case of placement breakdown. The other loacl authority was advised of the need to hold a placement review prior to a request for a Mental Health Act (1983) Assessment.

B2. Contract compliance assurance

For services primarily commissioned for people with a learning disability and their family carers

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

A two year timetable is in place to undertake contracting and compliance visits of all care homes and providers of supported living services within Derbyshire. Contract officers evidence performance/activity in a care home using a standard contract monitoring framework. The priority for timetabling visits is informed by a risk management tool that has been developed to take account of the concerns highlighted by fieldwork, clients and their representatives, health colleagues and feedback from CQC as well as the outcome of safeguarding (where there are possible systemic concerns).
CCG Quality team is implementing a robust schedule of quality monitoring within Nursing care homes - this team has experienced LD nurse in post. Formal Contract management groups are in place across all NHS commissioned services, including LD quarerly updates in the specialist LD provider trust.

Web link to further evidence

Real life story

Strong joint working between Health, Adult Care Contracting, Field work, CQC and where appropriate to manage compliance.
Information sharing (includes whistleblowing and safeguarding) between stakeholders helps prioritise contract monitoring visits.
Contract monitoring visits result in development of improvement plan for the provider which is monitored for completion and sustained improvement.
Stakeholders are developing improved communication and action planning (escalation policy and business continuity plan - how to manage failing providers) to address concerns that in themselves do not trigger safeguarding but collectively are very worrying.
Where providers have been identified as having poor compliance in respect of available trained staff in a particular discipline - then either health or Adult Care have run specific courses within a home to shortfall

B3. Assurance of Monitor Compliance Framework for Foundation Trusts

Supporting organisations aspiring towards Foundation Trust Status

Governance Indicators (learning disability) per trust within the locality

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

CQUIN in place with DHcFT provider to ensure reasonable adjustments happen for people with LD. CQINN also in place for reportng on Equality delivery. Within DCHS Contract schedule includes quality indicators relating to tracking and flagging. Monitor Level Compliance in DCHS internal and then external assurance and reporting process is: Monthly Health Care for All Implementation Group meetings, monthly agenda item and dashboard report to Equality Diversity & Inclusion Forum, (EDIF), monthly compliance declaration to Monitor, quarterly summary report to Quality services Committee, (subgroup of Board), minimum of quarterly report to commissioner led Quality Assurance Group in regard to LD& HC4A Contract Performance Schedule.
EDS Compliance EDIF reports quarterly to QS and Quality People Committees and to QAG.
Commissioners do request EDS returns of foundation trust providers and working with one non-foundation trusts in their progress towards monitor level & EDS compliance - see details above. we recognise more work is required within contract monitoring in reveiwing evidence of monitor returns in relation to LD compliance particularly in acute/secondary care services.

Web link to further evidence

Real life story

'Real Life' HC4A paper went to QSC (DCHS) in October 13. Debate was had about how needed to move from declaring compliance by assuring 'process' to demonstrating 'impact'. Agreed action was for the HC4AIG to plan for 14/15 and how PWLD will influence and participate in proactive, peer service review.

B4. Assurance of safeguarding for people with learning disability in all provided services and support

This measure must be read in the context of an expectation that ALL sectors, Private, Public and Voluntary / Community are delivering equal safety and assurance.

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

All commissioned services comply with the multi-agency policies and procedures. NHS contracts include requirement to complete the Safeguarding Adult Assurance Framework and the CCG Safeguarding Adult lead meets with each provider to carryout a 'confirm and challenge' approach which the provider is monitored on throughout the year. There is a Derbyshire wide provider forum to facilitate learning and sharing of best practice etc. Contract meetings are used to monitor compliance with safeguarding indicators which are part of the contract. All main NHS providers are represented at a senior level on the local safeguarding adult and childrens boards. All pt facing staff in Specialist LD services undertook detailed, full days safeguarding training, in addition to essential training, led by named nurses. Adult Safeguarding Clinical Supervision policy has been written by NN and LD Clinical Services Manager and will sit in Adult Safeguarding policy. This has been implemented in Spec LD services. All Spec LD teams have had face to face meeting regarding assurance and escalation processes put into place in regard to safeguarding and legal issues. Dedicated NN time secured to support Spec LD staff with safeguarding issues and currently 42 people on NN caseload demonstrating active reporting/monitoring.

Web link to further evidence

http://www.saferderbyshire.gov.uk/what_we_do/safeguarding_adults/default.asp

Real life story

R has a LD & was in a temporary placement. During an ongoing assessment of R & his girlfriend's capacity to have a relationship, safeguarding concerns arose about R. In addition, the social situation at the temporary placement became complex requiring police & youth offending team involvement. A DoL was applied for to support the level of observation required for R within the placement. Following assessment the temporary placement was found to be inappropriate & alternative options were considered. R did not engage well with LD Services to gain an accurate understanding of his level of learning disability, daily living skills or future aspirations. Good information sharing between Derbyshire professionals helped support an increased understanding to R's history & risk. This helped inform lone working assessments & the potential vulnerability of the peers who he was residing with, carers & visiting professionals.

B5. Training and Recruitment - Involvement

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Explanation for rating

Derbyshire is embedding an inclusive culture of PWLD awareness across the organisations &, more widely, universal services. Through advocacy & voluntary orgs & our network of PWLD elected reps & family carers, we help the wider community welcome & enable PWLD to be part of their local communities. Eg:
** We've developed and co-delivered Autism & LD training with people with Autism/LD.*
** Some In-House and Supported Living services involve PWLD in recruiting & selecting staff.*
** PWLD Reps are elected by recruitment & selection. Candidates complete an easy read application & are selected for interview by a panel of elected Reps from other local boards.*
** Reps on Board is invaluable. Our 6 Local Partnership Boards have 4 PWLD reps who campaign for the rights of PWLD and develop awareness training for Police, LA, Courts, hospital staff & GPs. A new project monitors access to & PWLD awareness of leisure facilities with a view to replicating this across other community & private facilities.*

Statement from Occupational Therapist, Ash Green LD Service
We approached a group of people who attend the Freedom Centre to ask if they would be interested in helping us with our interview process for posts In OT and PT in LD. Those who took part informed us of the qualities they would like from staff who would be working with them. These formed the questions for the meet and greet sessions prior to the formal interviews. After each interview there was a consultation process to decide whether the candidates had met the criteria and the final question to the interviewers asked was 'would you like to work with this person'?
The results of the 'meet and greet' session were part of the overall decision process.
All those that were involved in this interview process would like to be involved in this type of work again. All were given a certificate stating their participation and were informed of the final outcome. It is important to our service that we select people who will be able to approach and communicate effectively with people who will have a wide range of abilities therefore the service users involvement in this part of the interview process was extremely valuable, a vital component of the interview process.

Web link to further evidence

Real life story

PADA, a charitable company limited by guarantee, has 8 Directors, of whom 2 are women with learning difficulties, 1 of whom is Deputy Chair. PADA is a user-led organisation under the strategic control and scrutiny of PWLD including recruitment, training and monitoring of staff.
Members of Our Vision Our Future are fully involved in running their office including employment, monitoring and supervision of workers and the involvement of Volunteers. Members have been supported to make some very difficult decisions, e.g. moving premises, process of voluntary redundancy, are involved in writing/updating policies and in giving training in self-advocacy and Disability Hate Crime, which they have taken into schools, given to the Police, Social Care Students and other organisations. Examples of training include an Autism Briefing developed with a person with Autism and Health Action Plan training co-delivered with a person with a learning disability.

B6. Commissioners can demonstrate that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture.

This is a challenging measure but it is felt to be vital that all areas consider this.

◯ Red
⊗ Amber
◯ Green

Explanation to rating

Local NHS and Adult Care have introduced a Dignity and Respect Award which providers are encouraged to apply for. Within this award provider is expected to demonstrate how the culture of their organisation/staff promotes dignity and respect. DCHS has signed up to the Derbyshire Dignity Challenge and all services across all divisions are expected to pursue bronze and silver level accreditation. From 2011 - Q2 2013, 38 DCHS services achieved bronze award, (11 last quarter), 33 working towards bronze, 1 team has been awarded silver and 2 are in process of submission.
Adult Care Directorate has agreed to work towards signing up to the Social Care Commitment and to encourage independent sector providers to do the same. Adult Care is working towards improving values-based recruitment using tools from the Values Based Recruitment Toolkit developed by the National Skills Academy for Social Care. The toolkit is also being promoted to the independent sector by Skills for Care and Adult Care.

Web link to further evidence

http://www.derbyshire.gov.uk/social_health/care_and_health_service_providers/dignity_respect/default.asp

Real life story

"Caring Never Grows Old" is the name of DCHS's recent recruitment campaigns partly undertaken to address "Safe Staffing" levels, (and also to provide flexible and responsive winter capacity). This campaign put value based behaviours, (compassionate leadership, patient focused care etc.), at the core of the selection criteria and process.

B7. Local Authority Strategies in relation to the provision of support, care and housing are the subject of Equality Impact Assessments and are clear about how they will address the needs and support requirements of people with learning disabilities.

◯ Red
⊗ Amber
◯ Green

Explanation for rating

Equality Impact Assessments (EIAs) are completed at the point of any proposed changes to services. The Joint Learning Disability Health and Social Care Commissioning Strategy will be refreshed in 2014. The current strategy was presented to the Learning Disability Partnership Board. For example, further EIAs will be completed as part of the developing Community Lives programme and the new Learning Disability Accommodation and Support Strategy. Strategies are evidence based using information from the Joint Strategic Needs Assessment. Presentation of findings and proposed plans to people who use services and their families are timetabled for 2014.

Web link to further evidence

http://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/disability_support/learning_disabilities/default.asp

Real life story

Mr P lives with one other person in a Shared Lives placement. The Shared Lives carer has provided support to the two men with learning disabilities for 2 years. The placement allows Mr P to live in his local community and maintain links with his family. Mr P, in the past, has displayed behaviour that challenges but the supported living placement and the support of the Shared Lives carer have enabled him to lead a calmer, more fulfilling life. He goes on holidays, visits museums and eats out with the support of the Shared Lives Carer.

B8. Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, whistleblowing experience

◯ Red
⊗ Amber
◯ Green

Explanation for rating

There is a clause in contracts with providers requiring both a whistler-blowing policy and that DCC must be notified. DCC monitors providers to ensure that they have a complaints and compliments process, and how this is shared with clients and their families and friends.
Also encourage providers and their staff to evidence knowledge of whistleblowing policy. Most whistleblowing is directed at Adult Care or CQC rather than at provider.

Web link to further evidence

Real life story

Adult Care Contract Compliance Team on identification of poor performance following whistleblowing/complaints identify actions to promote improvements. Fieldwork/Health colleagues undertake safe & well reviews of all clients who may be impacted by poor performance to ensure that they are safe & that other poor practice can be identified. Information sharing between stakeholders ensures that 'soft' information is shared to maximise intelligence about poor performance. A recent example of 'whistle blowing', as per the Public Interest Disclosure Act (2013), within DCHS resulted in disciplinary action by the Trust following investigation & recommendation on the issue by the NHS Counter Fraud Unit. Evidence of the DCHS Whistle Blowing Policy, (ref HRP34), being applied effectively is that although staff may believe issues regarding harassment & bullying come under 'whistle blowing', they are appropriately investigated & managed using the DCHS Dignity at Work Matters policy, (ref HRP26).

B9. Mental Capacity Act & Deprivation of Liberty

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Contract Compliance visits identify whether providers have undertaken DOLs training for staff. Providers are also asked to demonstrate how they have implemented this knowledge to ensure there is no deprivation of liberty.
Providers are also required to discuss demonstrate arrangements used for restraint, including training , recording of actions take and reporting actions to relevant commissioners.
There is evidence via the SAAF visits via the CCG safegurading Lead that progress has been made. Derby Royal Hosp have taken a proactive approach through eliminating practice and improving environments to preclude the necessity for a DoL authorisation. There are good links between the AS Team and the ALN - LD nurse.
MCA/DoLs remain a standard item for SAAF visits. We are in the middle of SAAF round 3 at present. Next year will see a peer review and again MCA will be a thematic element of the review process
An e information package was forwarded to all CCGs and healthcare providers

There has been increased resources across adult safeguarding teams and this has also helped raise focus upon MCA.

Web link to further evidence

Real life story

Adult care provider training for the care sector to promote good practice.
Evidence collected through the "getting ready and My Health Questionnaires asked particulary for decision making and consent - 2 particular examples one at the Eye Clinic at RDH where the person was fully involved in their decsion making and also an example that someoen said they had the procedure explained 3 times so that they could understand before making a decision.

Section C

C1. Effective Joint Working

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Joint health and social care commissioning boards are in place across County and City. Membership includes public health representation. A Joint Learning Disability Commissioning Strategy is in place and will be refreshed in 2014. The findings from the SAF and resulting joint action plan will inform the strategy refresh. 'Joint Solutions' process is in development ensuring shared commissioning and financial responses to complex support packages. Pooled budgets are being discussed as part of the current consideration of lead commissioning arrangements.
A number of partnership programmes with joint monitoring and reporting arrangements are in place. Examples include Transforming Lives, the SAF programme, Autism co-ordination and the joint health and social care review of short breaks; allocating resources re autism, Relate to provide counselling for people with Asperger's and their families.

Web link to further evidence

Real life story

We have in place a Joint Transforming Care action plan acorss two LA partners and the lead CCG for Derbyshire - shared resources/ shared investment and workstreams that run across the whole of the LD health and social care commissioning and provider services.

C2. Local amenities and transport

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Changing Places facilities continue to be developed across the county.
There are 14 Changing Places and Derbyshire County Council has a mobile changing places toilet which is available for use at events and venues around the county.
Some learners in our day services are undertaking 'Getting about safely' and 'Know your local area' courses which includes road safety, staying safe and journey planning. Travel training is offered by day services as a mainstream activity, preparing people for the Community Connector service and/or to meet individual outcomes.
We jointly fund the 'Hate Crime and Staying Safe' project with Macintyre.
Between 1st April 2012 & 31st March 2013 the Keeping Safe champions (who have learning disabilities) have delivered 8 Full Workshops to 103 people with learning disabilities and 11 Mini Workshops to 144 people with learning disabilities. Champions have also delivered Regional Advance Police Interview training on 3 occasions.

Web link to further evidence

(Changing places: Social care and health - Derbyshire County Council) Derbyshire Safe Place Scheme: Social care and health - Derbyshire County Council

Real life story

A had been attending the same day service for many years; she wanted to move more out into the community and after initial introductions, started as a charity shop volunteer. A had previously used buses near where she lived, always with a paid worker or member of her family. After a travel-training programme, A was able to walk to the bus stop, take the correct bus into Derby, volunteer in the charity shop and then make her own way home again. A said the first time she travelled alone she felt "chuffed"; since then A has travelled all over the county to visit tourist sites etc.; and has started going to the cinema using the bus. A is also now able to manage problems on the buses e.g. changes to routes or timetables, and feels much happier and more confident; because she knows how to cope with things when they go wrong.
http://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/disability_support/learning_disabilities/community_lives/feedback_from_workshops/default.asp

C3. Arts and culture

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Adult Care has developed and extended Befriending schemes via the Trusted Befriending Network. This will enable some people with learning disabilities to enjoy art and cultural activities with the support of a befriender.
The use of the Derbyshire County mobile changing places enables access to arts events such as the Melbourne Festival. There are a range of services supporting access to the arts for people with a disability including people with a learning disability. These include community based art and drama groups such as First Movement projects and programmes within learning disability services.
Cinema screenings for people with Autism are available in Derbyshire.
Adult Care and Macintyre are exploring ways of improving public perception, dignity and respect towards people with a learning disability in settings where people may wish to access cultural activities, e.g. theatres; cinemas.
Further work with providers will come out of the Community Lives programme.

Web link to further evidence

: http://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/getting_out_and_about/befriending/trusted_befriending_network/default.asp

Real life story

Ms A, a person with learning disabilities, is a frequent visitor to her local library. When, one day, her father collapsed and died at the library, staff were able to assist Ms A, who was initially unaware of the death of her father. Over the next few weeks, Ms A continued to visit the library and received help and reassurance from the library staff to assist her to accept the reality of her father's death.

C4. Sport & leisure

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Adult Care has developed & extended Befriending schemes via the Trusted Befriending Network to enable people with learning disabilities to enjoy sporting activities with the support of a befriender, eg. Football buddying supporting people to attend matches with another club fan.
Adult Care & Macintyre are exploring ways to improve public perception, dignity & respect towards people with a learning disability in settings where people wish to access sporting activities.
Reps on Board work with Derbyshire Sport & leisure centres in the county to check to see how well people with learning disabilities are served. The findings will be reported back to the Partnership Board & the individual Leisure centres.
Community Connectors work with people attending day services or young people in transition & have introduced several people to mainstream walking groups, gym & swimming as independent daytime activities.
The Brokerage Service assists clients seeking information about activities.

Web link to further evidence

http://www.derbyshiresport.co.uk/disability_sport/default.asp

Real life story

A male, aged 19, with physical and learning disabilities, was looking for sports and social activities. The family contacted Brokerage. This enquiry linked in with a Brokerage project, Opportunities for Young Adults aged 18-25, where information is available about activities. Several social groups, sports clubs and classes were available to meet his needs and the Broker was able to provide this information to his and his family's satisfaction. Brokerage also made a follow-up call to determine whether any further support was needed.

C5. Supporting people with learning disability into and in employment

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Using ASCOF indicator 1E, 5.3% of people with a learning disability are in paid work. This compares to a national average of 7%. The County Council continue to monitor ASCOF 1e. In previous years there has been direct investment and European funding to support specialist employment support. It is a concern that the European part of the funding will end December 2013. Exit strategies are in place to address changes to services.

Web link to further evidence

Real life story

Client A has Asperger's and associated OCD. Client A can become inappropriately focussed on one life goal, for example, finding employment. He is so focussed on the goal that he neglects himself and has suffered severe health issues arising from starvation. He is supported by his main carer, his Mental Health worker and his Psychiatrist to retain intermittent employment and access to relevant disability benefits.

C6. Effective Transitions for young people

A Single Education, Health and Care Plan for people with learning disability

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Health & Care Plans are not statutory requirements as relevant legislation is not implemented until 1/9/14. In preparation for the introduction of EHC Plans Derbyshire has a Steering Group and a dedicated Project Manager to drive the six work streams that are, with full parental engagement, making proposals to the Children's Trust Board and joint SMT to ensure that DCC is ready for implementation in Sept 2014. Derbyshire has a multi-agency transition pathway and there is evidence of effective transition planning. The Transition Programme Board meets bi-monthly to oversee improvements in delivery and evidence gathering to ensure that the pathway is delivering good outcomes for young people.DCHS involvement in implementation of SEH&CP limited.

Transitions for children with LD led by Education and DCHS, school nurses are involved only occasionally.

Web link to further evidence

http://www.derbyshire.gov.uk/education/schools/special_educational_needs/support_aspiration/what_we_are_doing/default.asp

Real life story

Concerns identified following the recent CQC CTAS inspection have reinvigorated promotion and monitoring of compliance with the Derbyshire Transition Planning Pathway amongst all agencies. The numbers of young people with an identified adult worker prior to reaching their 18th birthday is increasing.

C7. Community inclusion and Citizenship

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

For the last 2 years we have been developing a Community Lives programme which aims to review current day time opportunities, and ensure that in future there is more choice and different options available in community settings in line with personalisation and national policy. Community inclusion and citizenship are the bedrock of this approach.
The Community Connectors work with people who attend day services or are young people in transition, to help them to develop natural supports and get involved with community based activities. Evidence : link to Community Connector Leaflet.

As part of the programme we have held a number of Engagement workshops over the period December 2012 - September 2013 . 482 people with learning disabilities 259 family carers and 313 staff have attended. From these workshops we will have a co-produced Plan for the future of day opportunities which we will be consulting on in early spring 2014.

Web link to further evidence

http://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/disability_support/learning_disabilities/community_lives/feedback_from_workshops/default.asp

Real life story

C was 53 years old with a learning disability attending Day Services, 3 days a week, for 20+ years. C. was referred to the connector service for alternative universal community social activities. C. met the connector & social worker to agree a support plan & aims & objectives that C. would like to meet. The connector worked with C. to establish new links in his local community & identify any risk factors. At 6 wks a meeting was held to check that the aims & objectives were still correct & address any risks that may have arisen during the community inclusion. At 12 wks a meeting was held to review the Support Plan & outcomes. C. was now independently accessing Community Leisure Services & travel. He'd formed new friendships with people in the community & was no longer attending a Day Centre. Home reported his general & mental health had improved. 18 months later C. is still doing well & enjoying going to groups at the Leisure centre. He has also joined a local ramblers/walking group.

C8. People with learning disability and family carer involvement in service planning and decision making including personal budgets

This measure seeks to stimulate areas to examine what co-production means and demonstrate clear and committed work to embedding this in practice.

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Derbyshire has a strong LD Network which facilitates co-productive working with people with learning disabilities, family carers, partner agencies e.g health, housing, advocacy and other stakeholders with an interest in LD services e.g. voluntary sector, community based facilities. The LD Network consists of a County LD Partnership Board, 6 local LD Partnership Boards and a Task Force along with sub groups and task and finish groups looking at specific service planning and design, operational changes and universal services. We have a highly skilled group of clients called Reps on Board who are elected representatives serving their local LD community. We have Elected Carers in each locality whose role it is to represent the wider LD carer perspective. Also, Derbyshire is in the middle of a change programme called The Community Lives Programme developing a future plan for daytime opportunities for PWLD which includes community based initiatives and universal services.

Web link to further evidence

http://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/disability_support/learning_disabilities/partnership_board/default.asp

Real life story

DCC are celebrating the 2013 achievements of people with a learning disability and will be giving out award certificates to people attending the Taskforce groups who have been contributing to the developments for people with a LD.

C9. Family Carers

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Explanation for rating

Derbyshire has a robust engagement & needs assessment approach for family carers. Consultation takes place via the Derbyshire Carers Association Network, Carers Voice, Mental Health Carer Forums, the LD family carer network, the Stakeholder Engagement Board, & through a joint commissioning board for carers overseeing development of service changes, improvements & the Carers Joint Strategy. 5 carers sit on the Carers Commissioning Board with eg. health & vol sector partners. The Chair of the LD County Partnership Board is a LD carer.
Derbyshire co-produces work from service re-design to creating initiatives to support family carers, eg. development of the carer assessment process, emergency card scheme, respite carer grant & short term support. We are strengthening the Carer network by asking PPGs to nominate a key carer in each area to represent the carer network, and strengthen engagement with carers, not using existing forums, through IT, telephone contact, texting, & video links.

Web link to further evidence

http://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/caring_for_someone/carers_organisations/default.asp

Real life story

See link above for more information
The Erewash Carers group have been a key player in the LD Good Health Group for many years and a family carer chairs the local LDPB in the Erewash area.

Have you looked at the PDF output and agree that all the answers as they appear on it are correct?

To do this, click Return to front page then click on 'View' under **Start Questionnaire**.

This marks the end of principal data collection and at the closing date (currently set as 30th November) we will lock the questions in the principal entry against further change.

☒ *Yes*

Agenda Item 7a

DERBYSHIRE COUNTY COUNCIL

CABINET

21 JANUARY 2014

REPORT OF THE STRATEGIC DIRECTOR – ADULT CARE

CONSULTATION ON PROPOSED CHANGES TO ELIGIBILITY FOR ADULT SOCIAL CARE AND INCREASED CONTRIBUTIONS FOR NON RESIDENTIAL CARE

ADULT SOCIAL CARE

1. Purpose of the Report

To seek Cabinet approval to commence formal consultation on increasing the level of Co-funding for Personal Budgets and a change in eligibility for Social Care (Personal Budgets) to be established at substantial needs and above.

2. Information and Analysis

Context

Due to reductions in funding from Central Government, the Council must reduce its expenditure by £157m over the next 5 years.

In order to achieve this budget reduction, Cabinet is reviewing all areas of expenditure. At its meeting on 1 October 2013, Cabinet approved a joint report by the Chief Executive and the Director of Finance on the revised budget for 2013/14. In approving the joint report, Cabinet also:-

- Approved a revised 5 year financial plan
- Noted the changes to funding received since Council approved the budget in February 2013 and approved the uses to which it will be applied.
- Agreed the proposals for budget reductions outlined in Appendix 2 to that report
- Noted that the possible areas for budget reductions in Appendix 3 to that report will be considered and detailed proposals brought before Members as appropriate

The Council meeting on 2 October 2013 confirmed and accepted the proposals agreed by Cabinet in relation to the revision to the 2013/14 budget and to the reductions detailed in the report.

Two of the proposals set out in Appendix 3 of the joint report, subject to Cabinet consideration and necessary consultation, were to increase client contributions and increase the Fair Access to Care Services (FACS) eligibility threshold from Higher Moderate to Substantial. Detailed proposals relating to these changes are set out below.

Over recent years most councils have taken decisions or are consulting on proposals to revise the FACS eligibility thresholds for adult social care services. Many councils have also introduced or raised the level of charges and financial contributions made by individuals towards the cost of providing their adult social care support. Comparisons with other Councils is detailed in **Appendix 1.**

2.1 **Increase in Co-funding of Personal Budgets**

2.1.1 Legal Framework Underpinning Co-funding

Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 (HASSASSA Act 1983) gives councils a discretionary power to charge adult recipients of non-residential services.

Section 17 of the HASSASSA Act 1983 provides that councils may recover such contributions in respect of relevant services as they consider are reasonable and reasonably practicable for clients to pay.

To ensure consistency and fairness, the Department of Health has issued statutory guidance, *"Fairer Charging Policies for Home Care and other Non-Residential Services"* (June 2013) using powers conferred under Section 7 of the Local Authorities Social Services Act 1970

The Department of Health has also issued further statutory guidance to local authorities *"Fairer Contributions Guidance – Calculating an Individual's Contribution to their Personal Budget".* (November 2010):

2.1.2 Current Co-funding Policy and Principles

Co-funding, introduced in April 2011, is the term adopted by Derbyshire County Council in relation to the cost sharing partnership arrangements for those clients who receive non-residential services, and has been designed to comply with the Department of Health's Fairer Charging and Fairer Contributions Guidance.

To ensure compliance with the requirements of this guidance, local authorities' contribution polices must adhere to the following principles:

- Ensuring clients' net income is not taken below the basic level of income support/employment support allowance/guarantee element of pension credit plus a 'buffer' of 25%
- The value of the main residence of the client will be disregarded
- Capital assets and savings will be assessed at a minimum level in line with those prescribed for long term residential care, in accordance with "Charging for Residential Accommodation Guide" (CRAG)
- Clients who work will not have their earnings included in the calculation of household income
- Partners' income and savings will be disregarded
- The additional cost of disability will be recognised and appropriate allowances made
- Clients with CJD will not be asked to contribute
- The total of any contributions made within the financial year will not exceed the total cost of services provided in that period.

The current policy in Derbyshire is based on receipt of attendance allowance/disability living allowance (care), except where individuals have capital resources in excess of £50,000. A summary of the current policy is set out below.

Attendance Allowance/Disability Living Allowance (Care)

Attendance Allowance (AA) and Disability Living Allowance (DLA) (Care) are non-means tested tax-free benefits for people who are physically or mentally disabled and who need help with personal care or supervision to remain safe.

The 2013/14 current rates are:

Attendance Allowance
Low Rate: £53.00 per week
High Rate: £79.15 per week

Disability Living Allowance (Care)
Low Rate: £21.00 per week
Middle Rate: £53.00 per week
High Rate: £79.15 per week

Where a client declares:
Income above the protected threshold,
Is in receipt of AA or at least middle rate DLA (Care)
But has less than £50,000

Under the current policy, clients are required to contribute 50% of the Low Rate Attendance Allowance/Middle Rate DLA (Care), even if the higher rates

are in payment. This AA/DLA (Care) 'standard' contribution currently, therefore, is £26.50 per week.

Co-funding Contributions from Capital

Where clients declare that they have in excess of £50,000 capital (excluding the value of a property owned which is their main residence) they will, depending on the value of the client's personal budget and level of capital, make a contribution on the following basis:

Above £50,000 but below £100,000 the first 25% of their personal budget
OR
Above £100,000 the first 50% of their personal budget

e.g.

A client with capital of £60,000 and a personal budget of £120.00 per week would make a Co-funding contribution of £30.00 per week.

A client with capital in excess of £100,000 and a personal budget of £120.00 per week would make a Co-funding contribution of £60.00 per week.

NB: The minimum contribution for a client with capital in excess of £50,000 is an amount equivalent to 50% low rate AA/middle rate DLA (Care) i.e. £26.50 per week.

2.1.3 National and Local Co-funding Policy Safeguards

- **Income Maximisation** Under national guidance as an integral part of the financial contribution assessment process all clients are offered appropriate benefits advice and assistance. This is to ensure that clients' incomes are maximised and is not limited to those benefits in relation to Co-funding.

- **Disability Related Expenditure Reviews** Under national guidance where a client feels that the additional cost related to their disability is over and above that already allowed in the contribution determination, they are entitled to an individual assessment of their disability related expenditure. The purpose of this review is to establish whether a full or partial reduction in the Co-funding contribution would be appropriate.

- **Protected Level of Income:** The County Council has used its discretion to increase the minimum income level to an amount equivalent to basic level of benefits plus a buffer of 32%. This has the effect of protecting 7% more of a client's income before they are required to make a financial contribution.

- **Sources from which contributions will be made:** Under current Derbyshire policy, clients are only required to contribute from those non means tested benefits already made available, on the basis of their care and/or support needs, i.e. Attendance Allowance and Disability Living Allowance (Care), or where they have capital above £50,000.

- **Capital Thresholds:** The Co-funding policy has regard for the capital levels as determined in CRAG; however, the Authority has applied its discretion to allow clients to retain a greater proportion of their capital before it is included in the determination of any contribution.

- **Terminal Illness:** Under Derbyshire's policy, we do not require a financial contribution from those clients who are terminally ill. Terminal illness for these purposes is defined as being where a person has received a prognosis of less than six months life expectancy.

- **Carers:** Under Derbyshire's policy, we do not require a financial contribution from carers who receive an individual support package.

2.1.4 Proposals to increase Co-funding contributions

The following three proposals are being put forward for consideration during the consultation process. Cabinet will decide, whether any, or all of these proposals will be implemented following the further report to Cabinet.

Proposal 1: It is proposed that there is a reduction in the income protection buffer.

The current Co-funding policy has an additional 7% protection for clients' income over and above that required by the Fairer Charging and Fairer Contribution guidance.

By removing this additional protection and only applying the standard protection of 25% above basic benefit rates, this would reduce the protected thresholds to:

- Over Pension Age: From £191.93 to £181.75 (a reduction of £10.18 per week)
- Under Pension age: From £160.58 to £152.06 (a reduction of £8.52 per week)

Proposal 2: It is proposed to increase the percentage contribution from 50% to either 60%, 75% or 90% of low rate AA or middle rate DLA (Care).

The combined effect of proposals 1 and 2 would be as follows:-

Level of AA / DLA	Standard Weekly Contribution	Annual Increase in Income
Current Level (50%)	£26.50	£0
60%	£31.80	£0.869m
75%	£39.75	£1.773m
90%	£47.70	£2.367m

Proposal 3: It is proposed that clients with in excess of £50,000 capital become responsible for 100% of their care package costs.

The current Co-funding policy has significantly more generous capital thresholds than the Department of Health guidance requires.

Current guidance does not require local authorities to provide financial assistance to a client where they have capital assets (as defined) in excess of those prescribed for care in a residential care home setting (CRAG). This threshold for 2013/14 is £23,250.

The current Co-funding policy requires that:

- Where a client has below £50,000 they only make a contribution from their Attendance Allowance or Disability Living Allowance (Care) if their other means warrant it.

- Where a client has above £50,000 but below £100,000 they are responsible for the first 25% of their personal budget (with a minimum contribution of £26.50 in line with AA/DLA (Care) contributions)

- Where a client has in excess of £100,000 they are responsible to the first 50% of their personal budget (with a minimum contribution of £26.50 in line with AA/DLA (Care) contributions)

It is proposed to retain the capital threshold at £50,000. However, it is also proposed that clients with in excess of £50,000 become responsible for 100% of their care package costs.

The introduction of this proposal is expected to affect up to approximately 640 people and generate income/savings of around £3.7m per annum.

2.1.5 Proposal to Introduce a Fairer Charging Financial Assessments Team

If, following consultation, Cabinet decides to implement any or all of these proposals it will be necessary to establish a much more rigours financial

assessments to complete the full financial declaration which would be required, with evidence of clients' income and savings. It would therefore be no longer appropriate for Social Workers to undertake this work. This would free up Social Workers' capacity to deal with assessments, reviews and complex casework and would mitigate revisions in fieldwork capacity, which may be required as a result of the proposals outlined in this report and the new financial plan generally.

It would therefore also be necessary to establish a financial assessments team and additional Benefit, Information and Advice Officers posts to support clients to maximise their income.

2.2 Eligibility for Social Care

The current statutory guidance to local authorities on eligibility criteria for Adult Social Care was issued by the Department of Health in February 2010. This superceded the 'Fair Access to Care Services: - Guidance on Eligibility Criteria for Adult Social Care 2003'.

Clause 13 of the Care Bill 2013, currently before Parliament, contains provision for regulations to set a national minimum threshold for eligibility. This is currently being consulted upon by the Department of Health but, it is anticipated that this will be set at 'Substantial'. The implementation of the new national framework is currently expected to be with effect from April 2016.

An individual's eligibility for statutory support is determined following an assessment. Under Section 47 of the NHS and Community Care Act 1990, local authorities have a duty to assess the needs of any person for whom the authority may provide or arrange the provision of community care services and who may be in need of such services.

As part of the assessment, information about an individual's presenting needs and related circumstances should be established and recorded. The NHS and Community Care Act 1990 requires that, having conducted the assessment, councils must decide whether a person's needs call for the provision by it of any community care services. Councils have to use a national eligibility criteria framework to draw up their own eligibility criteria. These should then be used to identify the needs which call for the provision of services (eligible needs) according to the risks to independence and well-being, both in the immediate and longer term.

In constructing the eligibility criteria and also in determining eligibility for individuals, councils should prioritise needs that have immediate and longer term critical consequences for independence and well-being ahead of needs with substantial consequences. Similarly needs that have substantial

consequences should be placed before needs with moderate consequences and so on.

The statutory guidance provides that councils should review their eligibility criteria in line with their usual budget cycles. Such reviews may be brought forward if there are major or unexpected changes, including those with significant resource consequences. Councils should be mindful of the evidence that suggests that raising eligibility criteria thresholds without a parallel investment in preventative strategies may lead to an increase in demand for services in the longer term.

Derbyshire County Council currently has its eligibility threshold set at 'Higher Moderate and above'. This level was agreed by Cabinet on the 29 March 2011, following a period of public consultation and the carrying out of an Equality Impact Assessment based on raising the eligibility threshold from Moderate to Substantial. The Higher Moderate threshold is based on criteria established locally by Derbyshire County Council with advice from Leading Counsel **(Appendix 2 to this report)**

Taking account of the current financial challenges faced by the Council and the revised 5 year financial plan, it is proposed that, subject to full public consultation, the threshold should now be raised to Substantial. This will affect up to 2,700 people currently assisted by the Council who are assessed as having FACS eligible care needs below the Substantial threshold. A reduction in the number of people eligible to receive Adult Care support would in turn affect workforce planning and would be a factor taken into account when deciding future requirements for the fieldwork service capacity.

Under national guidance, the Council would need to exercise considerable caution and sensitivity when considering the withdrawal of support to clients who may fall below the 'Substantial' threshold. In some individual cases it may not be practicable or safe to withdraw support even though needs may initially appear to fall outside the eligibility criteria. The Council would also check any commitments they gave to service users or their carers at the outset about the longevity of support provided. If, following a review, the Council did decide to withdraw support from an individual, it would be essential to be certain that their needs were not likely to worsen or increase in the short-term and the individual become eligible for help again as independence or well-being was undermined.

2.3 Consultation

The introduction of an increase in Co-funding contributions and proposals for a 'Substantial' FACS eligible care needs threshold would potentially affect all

people currently assisted by the Council with the provision of adult social care community based services and would require a period of a full public consultation prior to any decisions being made. The proposals also affect other departments of the Council, partner organisations including district and borough councils, local NHS services and community organisations. The extent of the potential impact will be determined through the period of consultation and will be taken into consideration and reported to Cabinet as part of the final decision-making on the proposals. The proposals would also be subject to a full Equality Impact Assessment.

The consultation process would involve a leaflet of explanation being sent to people currently in receipt of services along with the establishment of a helpline/phone-line to answer queries. The direct implications of the proposals on individuals would be set out in this leaflet. It is important for clients to understand how the proposals could impact on them personally in order for them to be able to participate in the consultation process in a meaningful way. The leaflet will also be provided in an easy read format.

Consultation would also involve the use of community newspapers and other media outlets as appropriate. The consultation would include engagement and workshops with forums and voluntary organisations who are representative of community interests in Derbyshire and engagement with partnership boards, commissioning partners and providers as relevant stakeholders for the consultation process. There would also be consultation with advocacy groups and frontline staff would engage with local people assisted by services, particularly those who need some assistance to participate with the consultation process. The process would at all times ensure consultation with hard to reach groups. The results of the consultation would be subject to a further report to Cabinet.

3. Financial Considerations

The income/savings generated as a result of the proposals set out in this report would amount to between £4.57m and £6.07m from increased contributions and a minimum of £4.5m for FACS. It should be recognised, however, that there will be an interplay between the eligibility criteria and income from Co-funding, which will be refined during the coming period and will draw on information arising from the consultation.

The potential costs of the financial assessment team and Benefit, Information and Advice Officers, if relevant, will be detailed within the further report to Cabinet following consultation.

4. Human Resources Considerations

In addition to the arrangements for public consultation outlined in the report, the workforce planning implications arising from the proposals will be the subject of consultation with staff and Trade Unions. The result of these consultations will be included in the further report to Cabinet as proposed by the officer recommendation.

5. Legal and Human Rights Considerations

The Director of Legal Services has advised that the proposals outlined in this report need to be considered with the proposed changes in other Cabinet reports, in particular, Consultation on Proposed Changes to Housing Related Support Services Programme and Consultation on the Introduction of an Adult Social Care Transport Policy.

Consultation on all the proposals should, as far as practicable, take place at the same time. The information provided to consultees, in each consultation pack, must link to the other proposed changes in order for them to fully understand the global impact of the proposals and allow them to provide informed comment. Consultees should be specifically asked to comment on whether other changes proposed by the Council will, in their view, make the consequences of the proposed changes outlined in this report better or worse and, if so, in what ways.

When considering the proposals it will be essential for Members to have due regard to protecting and promoting the welfare and interests of persons who share a relevant protected characteristic (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation). The proposals will therefore be subject to an Equality Impact Assessment, which will be linked to the Equality Impact Assessments for the other proposed changes, in order for Members to fully consider the impact of all the changes in the round. The assessment of impact on protected groups will include an assessment of any safeguarding issues arising.

6. Equality of Opportunity Considerations

The proposals will be subject to an Equality Impact Assessment. This will be prepared in the light of the consultation and will be included with the subsequent report to Cabinet.

7. Other Considerations

In preparing this report, the relevance of the following factors has been considered: Prevention of crime and disorder; equality of opportunity; environmental; health, property and transport considerations.

8. Key Decision

No

9. Is it required that call-in be waived in respect of the decisions proposed in the report?

No

10. OFFICER'S RECOMMENDATION

1. That Cabinet approves the commencement of a period of full public consultation on the proposals set out in the report on the introduction of an increase in the rate of Co-funding for Personal Budgets and a change in eligibility for Social Care (Personal Budget) to be established at 'Substantial' needs and above.
2. That a further report is brought to Cabinet following the period of public consultation and an Equality Impact Assessment being carried out.

Bill Robertson
Strategic Director - Adult Care
County Hall
MATLOCK

APPENDIX 1

Derbyshire County Council Comparison with Other Local Authorities

Eligibility thresholds for Adult Care

Local Authority	**Eligibility threshold**
East Midlands Authorities	
Northamptonshire	Higher Substantial
Derby City	Substantial
Lincolnshire	
Leicester City	
Leicestershire	
Nottinghamshire	
Rutland	
Derbyshire	Higher Moderate
Nottingham	
Nearby authorities	
Rotherham	Substantial
Sheffield	
Tameside	

LA	**Nos receiving services after a FACS Assessment**
Rutland (510)	1095
Milton Keynes (613)	4865
Rotherham (206)	6615
Derby (507)	6990
Nottingham (512)	7285
Tameside (311)	7440
Leicester (509)	8015
Sheffield (207)	12480
Northamptonshire (504)	12565
Nottinghamshire (511)	13585
Leicestershire (508)	14195
Derbyshire (506)	17290
Lincolnshire (503)	17875

Finance

The Derbyshire County Council Co-funding Policy, for non-residential services, is distinctive because the contribution is directly linked to the payment of Attendance Allowance or Disability Living Allowance (Care) or clients with capital in excess of £50,000. Comparisons with other local authorities show that by far the vast majority charge hourly rates for services delivered.

From information available through CIPFA Benchmarking and National Association member it is believed that Derbyshire County Council is the only authority which charge for non-residential services with a protected threshold 'Buffer' of greater than 25%.

CIPFA Benchmarking Data (2012/13)

NB: Information collected from those authorities in the Council's regional audit group which are also members of the CIPFA Benchmarking Club.

Maximum Weekly Contributions:

Derbyshire County Council	£210.00
Lincolnshire County Council	£250.00
Norfolk County Council	£283.55
Northumberland County Council	£251.75
Leicestershire County Council	£No Maximum

Charges per hour (2012/13)

Derbyshire County Council	Standard AA/DLA max £25.92 per week irrespective of hours received
Lincolnshire County Council	£11.93
Norfolk County Council	£14.62
Northumberland County Council	£12.84
Leicestershire County Council	£13.25

Percentage of Clients financially assessed for Nil Contributions:

Derbyshire County Council	39.8%
Lincolnshire County Council	41%
Norfolk County Council	28.7%
Northumberland County Council	45%
Leicestershire County Council	23.5%

The national average for clients assessed as not requiring to make a financial contribution is 42.9%

Costs of Collecting Financial Information per new client

Derbyshire County Council	£33.00
Lincolnshire County Council	£40.00
Norfolk County Council	£67.00

Northumberland County Council	£67.00
Leicestershire County Council	£47.00

The national average collection costs £37.00

APPENDIX 2

DERBYSHIRE COUNTY COUNCIL ADULT CARE ELIGIBILITY FRAMEWORK

	Critical Risk Band *There is a critical risk to the person's current or future independence in one or more of the areas below if help is not provided.*	**Substantial Risk Band** *There is a substantial risk to the person's current or future independence in one or more of the areas below if help*	**Higher Moderate** *There is a higher moderate risk to the person's current or future independence in one or more of the areas below if help is not provided*	**Current DCC Adult Care Eligibility Threshold**	**Moderate Risk Band** *There is a moderate risk to the person's current or future independence in one or more of the areas below if help is*	**Low Risk Band** *There is a low risk to the person's current or future independence in one or more of the areas below if*
Health and Safety	Life is or will be threatened. Significant health problems have developed or will develop. Serious Abuse or neglect has occurred, or will occur.	Abuse or neglect has occurred, or will occur.				
Autonomy and Control Over a Person's Environment	There is, or will be, little or no choice and control over vital aspects of the immediate environment.	There is, or will be, only partial choice and control over the immediate environment.				
Management of Daily Routines	There is, or will be, an inability to carry out vital personal care or domestic routines.	There is, or will be, an inability to carry out the majority of personal care or domestic routines.	There is, or will be, an inability to carry out several personal care or domestic routines: - Has personal care needs in excess of 2 hours per week - There is a single or several routines which if not sustained will cause a significant risk to independence and wellbeing - Has a need or needs which if not addressed would rapidly result in a substantial risk to independence and wellbeing		There is, or will be, an inability to carry out several personal care or domestic routines.	There is, or will be, an inability to carry out one or two personal care or domestic routines.

Social and Economic Participation	Vital involvement in work, education or learning cannot, or will, not be sustained. Vital social support systems and relationships cannot, or will not be sustained. Vital family and other social roles and responsibilities cannot, or will not, be undertaken.	Involvement in many aspects of work, education or learning cannot, or will not, be sustained. The majority of social support systems and relationships cannot, or will not, be sustained. The majority of family and other social roles and responsibilities cannot, or will not, be undertaken.	Involvement in several aspects of work, education or learning cannot or will not be sustained: - There are needs relating to aspects of work, education or learning which, if not provided for, will cause a significant risk to independence and wellbeing - Has a need or needs which, if not addressed, would rapidly result in a substantial risk to independence and wellbeing Several social support systems or relationships cannot or will not be sustained: - There is one single, or several in combination, support systems or relationships which if not sustained will produce a significant risk to independence and wellbeing - Has a need or needs which, if not addressed, would rapidly result in a substantial risk to independence and wellbeing Several family and other social roles and responsibilities cannot or will not be undertaken: - There is one single, or several in combination, social roles and responsibilities which if not undertaken will produce a significant risk to independence and wellbeing Has a need or needs, which if not addressed would rapidly result in a substantial risk to independence and wellbeing.	**Current DCC Adult Care Eligibility Threshold**	Involvement in several aspects of work, education or learning cannot or, will not, be sustained. Several social support systems and relationships cannot, or will not, be sustained. Several family and other social roles and responsibilities cannot, or will not, be undertaken	Involvement in one or two aspects of work, education or learning cannot, or will not, be sustained. One or two social support systems and relationships cannot, or will not, be sustained. One or two family and other social roles and responsibilities cannot or will not be undertaken.

PUBLIC

Agenda Item 7b

DERBYSHIRE COUNTY COUNCIL

CABINET

21 JANUARY 2014

REPORT OF THE STRATEGIC DIRECTOR - ADULT CARE

DIRECT CARE TRADING POLICY WITHIN ADULT CARE

ADULT SOCIAL CARE

1. Purpose of the Report

This report considers the proposal to allow citizens of Derbyshire who wish to privately purchase day services, home care or other services from DCC Adult Care Direct Care Division to do so.

2. Information and Analysis

Background

Feedback from Adult Care clients and their carers has indicated that some individuals wish to privately purchase care services from the authority to supplement their provision that is funded by Adult Care.

At present any client wishing to buy additional services needs to purchase these from the independent sector. Not only does this place our in-house provision at a disadvantage, it also causes disruption for clients who would prefer to supplement their services using the provider they are familiar with.

In addition, we are aware that some services provided in-house are not being fully utilised. As staff are already employed to provide these, it would be of financial benefit for the authority to sell any unused capacity.

Finally, going forward there is some evidence that clients would be interested in purchasing services that may not be currently offered by the Department. This report raises the possibility that this new provision could be developed and made available. It is particularly relevant in Extra Care schemes where staff are located on site but potentially could also be considered for people living independently in the community.

In the past the authority has not developed a trading policy however, given the fact that legal advice recently received confirms that such a service can be legitimately provided by the Department, and the fact that it could offer significant benefits to both Derbyshire citizens and the County Council, it is recommended that this is considered.

It is proposed that this service would cover the provision of Derbyshire County Council Direct Care Day Services and Home Care services. It also considers the possibility of new 'Household Services' being made available.

2.1 Eligibility for the service

To receive services under a Trading Policy, recipients in the vast majority of cases will need to be Derbyshire citizens. On occasion we have been approached by non-Derbyshire residents to provide services. This would be considered on a case by case basis.

They will also need to have received a Community Care Assessment from Derbyshire Adult Care within the last eight weeks and fall into one of the following categories-

- Be determined as having some FACs eligible needs for which a personal budget is provided but wish to privately buy additional services that go above and beyond the meeting of their assessed outcomes

- Are assessed as not meeting the FACs criteria but who wish to purchase some home care or day care services or other services directly from DCC.

It is considered important that "Household Services" for non-personal care are offered to meet ineligible needs rather than eligible needs. As a person's circumstances will change over time, the Department will need to ensure, through regular review that their ineligible needs have not subsequently become eligible needs.

2.2. New services

People living in Extra Care housing in particular, have expressed an interest in buying services from Adult Care that are not currently on offer. These would include domestic cleaning services, assistance with laundry, assistance with shopping and other errands. It is proposed that these 'Household Services' be offered by DCC staff working in Extra Care schemes where they have capacity. A charge for this new service will be dealt with on the same basis as other services covered by this proposed policy.

2.3. Day Care

Initially the service provided by this Trading Policy relates to current older persons' day care where there is additional capacity to provide for extra self – funding customers. Services will be purchased on a sessional basis enabling customers to buy half a day or more. Transport will be arranged as per the Derbyshire County Council transport policy or with individuals making their own transport arrangements.

2.4. Home Care

Although there may be some slight unused capacity in home care, defining the precise level is difficult as it will fluctuate as the needs of our eligible clients change. It will be necessary to calculate what level of service needs to be reserved for eligible clients so that spare capacity can be determined.

Currently, to meet variable demand, the Department is able to flex up to 10% extra home care resource in order to be assured that there is sufficient capacity without putting existing client services at risk. Supplementary services will only be available, and will only be offered, where doing so will not lead to any loss of service or any deterioration in service quality for FACS eligible clients who require the service as part of their support plan. To ensure this, supplementary home care will only be offered for tasks that are not time sensitive.

2.5. Information for citizens about supplementary services

Guidance will be developed for clients considering supplementing their care to ensure that the distinction between their eligible needs and their ineligible ones is clearly described. In addition, clients will be reminded of their right to make a complaint if they feel their needs have not been accurately assessed.

2.6. Brokerage

If a customer indicates that they would like to purchase additional services, over and above any identified in their support plan, they will be advised that the DCC brokerage service can provide them with impartial information about the options available. This will include giving them details of the DCC Direct Care services.

2.7. Growing the service

Although a key premise of this Trading Policy is that it will be built using unused capacity within existing services, going forward it may be that demand leads to a decision to expand services.

At present however, it is essential that current statutory responsibilities can be met before any additional ones are offered. To do this it is necessary to calculate what level of service needs to be reserved for eligible clients so that spare capacity can be determined.

2.8. Cost

The cost of the service purchased will be calculated by the Adult Care Department and will be based upon the actual average cost of providing the service. For home care in Extra Care settings this currently stands at £13.68 per hour, the rate for community based clients would be higher at £20.76 due to the additional costs such as travel. For day care the charge will be based on the average daily day care rate across all Council provision. This currently stands at £36.26 in Older People's Services and in LD Services £47.52.

A charge for the hourly provision of a 'Household Service' will be determined if a decision is made to proceed to offer this.

2.9. Charging policy

There are a number of ways in which customers could be charged for services under this policy. One proposal is that those purchasing supplementary day care or supplementary home care in an Extra Care setting could be charged for their service on a 4 weekly basis in arrears, in line with other collection policies. This will be done by the County Council's preferred collection method of Direct Debit. A new and specific financial ledger code for services purchased under this Trading Policy will be created to ensure accurate monitoring and reporting of this proposed new income stream.

It will not normally be possible to refund a customer if during the month they fail to utilise all of the supplementary service purchased, due to the administrative burden and associated costs that this would require. Any policy devised would take account of instances where it would not be reasonable to request payment for services not delivered and would have regard to existing charging regimes exception and refund rules.

For customers receiving supplementary home care outside an Extra Care housing scheme, charging could be dealt with as above or alternatively the Telephone Timesheets system could be used. Further work will need to be done to identify the best option.

An integral aspect of agreeing to provide supplementary services will be the requirement to ensure that a client affordability assessment is undertaken. Where clients have an eligible need and services are being provided they are required to have a financial assessment to determine if they are liable to make a contribution towards their personal budget under the current Co-funding policy. The Co-funding contribution must remain the primary contribution that is made by clients and this should not be reduced or waived in order to allow clients' additional income to be used to purchase supplementary Direct Care Services. The advancement of this proposal will require current charging and contribution polices to be reviewed to take account of these points.

2.10. Notice period

Customers will be required to provide the Department with a period of four weeks' notice should they wish to change or terminate the service provided under this Trading Policy. Any policy developed will also need to allow Direct Care to give notice in instances where the client fails to meet their part of the service delivery agreement, such as by non- payment of charges.

2.11. Communication

It is important that the DCC Trading Policy does not have any adverse effects on either clients or independent care sector providers. Full dialogue is planned with representatives of the independent sector. DCC will ensure that competition with private sector providers will not be unfair or abusive and will not unduly distort the market.

3. Legal Considerations

Legal advice has been sought from Leading Counsel and his advice has confirmed the legality of this proposal. The Care and Support Bill, clauses 14, 18 and 19 would allow local authorities to provide ineligible services and charge for the same. The Department must ensure that any traded services provided are over and above the assessed eligible needs of the client.

4. Financial Considerations

By maximising staffing capacity, unit costs will be reduced. The exact amount will depend upon take-up which is likely to be quite low in the first year.

5. HR Considerations

By being able to trade, the Department will be able to utilise any unused staffing capacity across its Direct Care services. This will act as both an efficiency and assist the Department in maintaining its position as a key provider of services across the County.

6. Officer Recommendations:

That Cabinet:

1. Approves the proposal to pilot a Trading Policy for an initial period of 6 months facilitating Derbyshire citizens to purchase DCC Adult Care Direct Care services.

2. Notes that it is proposed that this service would cover the provision of Derbyshire County Council Direct Care Day Services and Home Care Services.

3. Notes that following a 6 month pilot Cabinet will receive an evaluation report prior to any potential roll out of the Policy.

Bill Robertson,
Strategic Director
Adult Care, County Hall, Matlock

Agenda Item 7c

DERBYSHIRE COUNTY COUNCIL

CABINET

21 JANUARY 2014

REPORT OF THE STRATEGIC DIRECTOR FOR ADULT CARE

CONSULTATION ON THE INTRODUCTION OF AN ADULT SOCIAL CARE TRANSPORT POLICY

ADULT SOCIAL CARE

1. Purpose of the Report

To seek Cabinet approval to commence a formal consultation process in respect of the proposal to introduce an Adult Social Care Transport Policy and the introduction of a charge for transport provided or arranged by the County Council.

2. Information and Analysis

2.1 Context

Due to reductions in funding from central government, Derbyshire County Council must reduce its expenditure by £157m over the next 5 years.

In order to meet these targets, Cabinet is reviewing all areas of income and expenditure. Cabinet will be guided in its decision making by the priorities contained within the new Council Plan, as it is developed.

Currently there is no Adult Care Transport Policy; this has caused a lack of clarity for individuals, their family carers and staff about access to transport provided or arranged by the County Council. There is no specific charge for the transport. Adult Care spends around £3.034m per year on transport (this amount varies slightly year-on-year according to usage); it includes paying for drivers and passenger assistants.

2.1.1 Legal Framework Underpinning the Provision of Transport by Adult Care

The arrangement or provision of transport by the council may be an eligible need under section 2(1)(d) of the *Chronically Sick and Disabled Persons Act*

1970 and the current statutory guidance on eligibility for adult social care *Fair Access to Care* (FACS) 2010.
Charging for eligible transport is subject to the statutory guidance *Fairer Charging for Home Care and other Non-Residential Services* June 2013) using powers conferred under section 7 of the *Local Authorities Social Services Act* 1970; and statutory guidance to local authorities *Fairer Contributions Guidance – Calculating an Individual's Contribution to their Personal Budget* November 2010.

Transport can also be provided and charged for as a general welfare service under sections 1 to 3 of the *Localism Act* 2011.

2.2 **Current Provision**

Around 1,150 people per year have transport funded by Adult Care; of whom approximately 625 have a Learning Disability or a Physical Disability and 525 are Older People. In addition, some people make their own transport arrangements, for example by travelling independently or being transported by a family member.

Transport is generally recharged to Adult Care via a Service Level Agreement (SLA) between Adult Care and Environmental Services, which is projected to be £2.5m in 2013/14. Adult Care also provides transport using centre-based vehicles and drivers funded through each centre's budget, which is projected to be £534k in 2013/14.

Included in the SLA re-charge is approximately £50K (amount varies according to use) per year to provide transport (including driver overtime) for a number of clubs for people who have a physical disability, luncheon clubs and craft groups. Four of the luncheon clubs also receive an annual grant from Adult Care towards their running costs.

The SLA accompanied the transfer of vehicles, staff (drivers and business support assistants) commitments from the former social services transport department to Environmental Services. Consequently, it is based on the resources, commitments and costs that existed at the point of transfer on the 1st January 2007 rather than any pre-determined level of service/unit cost.

3. Transport Policy: Proposals

In the current financial climate the County Council aims to focus its resources for social care on those people who need them the most, as set out in the proposed Transport Policy attached as **Appendix 1**. The County Council is committed to promoting people's independence, and that means every effort will be made to encourage people who access community services to travel as independently as possible.

The proposed Adult Care Transport policy would need to be implemented appropriately and equitably to ensure that people do not become dependent on unsustainable travel arrangements as a means of accessing the support and services they need.

Carers' views and needs would need to be taken into account in determining travel arrangements: this would reduce the potential for a negative impact on the sustainability of the caring role.

3.1 Proposed Transport Policy - Purpose

The Adult Care Transport Policy would apply to transport provided or arranged by the County Council to ensure:

- Support with transport is provided in a fair and equitable way, for people with eligible assessed needs on the basis of clear criteria.
- Eligibility for transport for people is identified through the social care needs assessment process.
- The independence and inclusion of people is promoted by encouraging and supporting a range of travel options including independent travel and the use of concessionary travel passes.
- Co-funding contributions for FACS eligible transport complies with the "Fairer Charging" Policy.
- Efficient use of resources and avoiding spending public money unreasonably.
- The reduction in air pollution and to encourage the use of sustainable resources by promoting the use of public and shared transport.

3.2 Detailed Transport Policy Criteria Proposals

It is proposed that the following are the subject of consultation:

3.2.1 Scope

The Adult Care Transport Policy would apply to people:

- Who have an assessed eligible social care need for transport.
- Are aged over 18 and not in fulltime education.
- Are ordinarily resident in Derbyshire.

3.2.2 Adult Care Transport Policy Criteria

1. Although a person may attend a specific community service/ activity to meet their Derbyshire Fair Access to Care Services (FACS) eligible needs, they will not be eligible automatically for transport to and from the service/ activity.

2. A person will be assessed as having an eligible need for transport through the application of the Adult Care Transport Policy as part of the FACS assessment or review. This will include consideration of whether they have other 'reasonable' alternative methods of transport, as defined in the policy and whether or not it is reasonable to expect them to make their own arrangements.

3. The identification of transport needs will be part of the regular assessment and support planning reviews.

4. Transport will only be provided or arranged to the closest appropriate setting to meet the eligible needs. If a client chooses to access a community service or activity that is further away, transport would only be provided to the closest appropriate setting – see below for non-eligible transport.

5. Due to a previous inconsistent approach, fuel or other associated travel costs will not be reimbursed by the Council, for example if a person is transported by a family member or if they live in a residential care home.

6. Transport will be provided or arranged in the safest and most cost effective way, this may include using shared transport with different client groups. The 'Procedure for Safe Transportation of Social Care Service Users in Derbyshire' will apply.

7. Appropriate risk assessments will be completed, if required, for example when using shared transport.

8. Determining the best way to meet the eligible transport need will be addressed at the support planning stage. This may be partially or wholly provided or arranged by the Council and will include consideration of the following:

    - Promoting independence and inclusion, and not increasing a client's dependence on others.
    - Ensuring clients and their family carers are aware of options for transport and that these are reflected in their support plans.
    - The need to provide passenger assistance, where required, due to health and safety reasons.
    - The support plan will have regard to the sustainability of the caring role.
    - Making good and effective use of the resources available.

3.2.3 People who do not have an eligible need for transport provided by the Council

Where a person is not eligible for the provision or arrangement of transport as an assessed need / community care service, including where a client chooses to access a community service or activity that is further away than the closest appropriate setting to meet their eligible needs then either:

- They would need to make their own transport arrangements, if they are able, or with support.

Or

- It may be possible for people to arrange to use transport provided or arranged by the County Council for general wellbeing purposes subject to the availability of transport at the time. There would be a charge reflecting the full cost of the transport.

4. Consultation

This proposal has implications for people receiving services commissioned/funded by Adult Care and as such a period of consultation will be required. The length of the consultation will be 12 weeks. A communication plan will be required to make sure that all people who are potentially affected are fully aware of the proposals contained in the Cabinet report and have an opportunity to comment. It is estimated that approximately 1,150 people will be affected by this proposal, some of whom may be contacted as part of other consultation exercises being run by Adult Care or other departments. This consultation will need to extend to include other stakeholders such as statutory agencies and appropriate independent sector groups. Particular consideration will need to be given in this instance to communicating with any hard to reach groups who do not receive a service directly through Adult Care but rather through an organisation commissioned/funded by Adult Care. In all instances material will be prepared in Easy Read format and the proposal will be available both in leaflet/letter format as well as on-line. In addition to this there will be the opportunity for the public to make their views known verbally either by a help-line or through existing forums. Officers will also attend appropriate Board and user group meetings as a further avenue of eliciting opinion on the proposals. The results of the consultation will be subject to a report going to Cabinet accompanied by an Equality Impact Assessment.

5. Financial Considerations

Charging for Transport: Proposals

5.1 People for whom transport is an eligible need

To avoid having to conduct a lengthy financial assessment, the charge for the provision of transport is proposed to be at a flat rate of £5 to each service regardless of whether it be a single or return journey and not based on the journey time or mileage. If a client travels to more than one service in the same day they would be charged the flat rate for each single or return journey, per service. For example, if they travel to a day service and then to a short break service after that, they will be charged £10 for the transport (i.e. £5 to go to the day service and £5 to go to the short break service).

In most cases this charge will be in addition to the contribution clients are obliged to make under the Council's "Fairer Charging" Policy.

The assessment of the client co-funding contribution will comply with Fairer Charging; this will include the safeguard that the sum total of flat rate transport charges and any other disability-related expenditure, in combination with any other care charges, will not reduce the client's income below Income Support/ the Guarantee Credit element of Pension Credit plus 25%.

5.2 Transport provided as a welfare service

Where transport is provided as a welfare service and not an eligible care service, the charging policy must not charge more than cost, overall, over the year. The total sum would be accounted for as "disability-related" expenditure for the purpose of charging for eligible care services.

5.3 People who would not pay for transport

Some people will not have to pay for transport, including where:

- Transport costs are paid by another local authority or by the NHS.
- The client is already paying towards an Independent Living Fund package.
- The client has been discharged from hospital on a Section 117 Agreement (under the Mental Health Act 1983) and this is still in place for after-care.
- Services provided to anyone with Creuzfeldt-Jakob Disease.

6. Legal and Human Rights Considerations

The Director of Legal Services has advised that the proposals outlined in this report need to be considered with the proposed changes in other Cabinet reports, in particular Consultation on Proposed Changes to Housing Related Support Services Programme and Consultation on Proposed Changes to

Eligibility for Adult Social Care and Increased Contributions for Non-Residential Care.
Consultation on all the proposals should, as far as practicable, take place at the same time. The information provided to consultees, in each consultation pack, must link to the other proposed changes in order for them to fully understand the global impact of the proposals and allow them to provide informed comment. Consultees should be specifically asked to comment on whether other changes proposed by the Council will, in their view, make the consequences of the proposed changes outlined in this report better or worse and, if so, in what ways.

When considering the proposals it will be essential for Members to have due regard to protecting and promoting the welfare and interests of persons who share a relevant protected characteristic (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation). The proposals will therefore be subject to an Equality Impact Assessment, which will be linked to the Equality Impact Assessments for the other proposed changes, in order for Members to fully consider the impact of all the changes in the round. The assessment of impact on protected groups will include an assessment of any safeguarding issues arising.

7. Considerations

In preparing this report the relevance of the following factors has been considered: financial, prevention of crime and disorder, equality and diversity, human resources, health and property considerations.

8. Key Decision

No

9. Call-in

Is it required that call-in be waived in respect of the decisions proposed in the report?
No

10. Background Papers

None

11. OFFICER'S RECOMMENDATION

To seek Cabinet approval to commence a formal consultation process in respect of the proposal to introduce an Adult Social Care Transport Policy

and the introduction of a charge for transport provided or arranged by the County Council.

A further report will be made to Cabinet with recommendations, following the consultation, accompanied by an Equality Impact Assessment.

Bill Robertson
Strategic Director – Adult Care
County Hall
MATLOCK

Appendix 1

DRAFT

ADULT CARE

POLICY FOR TRANSPORT

CONTENTS

1. INTRODUCTION

The new transport policy introduces eligibility criteria to ensure that support with transport is fair and applies consistently across the county.
Adult Care will only arrange or provide transport where it is an agreed eligible need under Fair Access to Care (FACS) or section 2(1)(d) of the *Chronically Sick and Disabled Persons Act* 1970 .

2. LEGAL FRAMEWORK

Whether transport may be an eligible social care need requires Derbyshire Council to be satisfied it is necessary to provide the service to meet an eligible need [section 2(1)(d) of the *Chronically Sick and Disabled Persons Act* 1970 and the current statutory guidance on eligibility for adult social care *Fair Access to Care* (FACS) 2010].
People with assessed eligible needs and their carers have the right to have their views taken into account by the Council when it is assessing and considering provision for support or services.
Transport can also be provided and charged for as a general welfare service under sections 1 to 3 of the *Localism Act* 2011.

Charging for eligible transport is subject to the statutory guidance *Fairer Charging for Home Care and other Non-Residential Services* June 2013) using powers conferred under section 7 of the *Local Authorities Social Services Act* 1970; and statutory guidance to local authorities *Fairer*

Contributions Guidance – Calculating an Individual's Contribution to their Personal Budget November 2010.

Transport can also be provided and charged for as a general welfare service under sections 1 to 3 of the *Localism Act* 2011.

3. SCOPE

The Adult Care Transport Policy applies to people:

- Who have an assessed eligible social care need for transport.
- Are aged over 18 and not in fulltime education.
- Are ordinarily resident in Derbyshire.

4. PURPOSE

The Adult Care Transport Policy will apply to transport provided or arranged by the County Council to ensure:

- Support with transport is provided in a fair and equitable way, for people with eligible assessed needs on the basis of clear criteria.
- Eligibility for transport for people aged over 18, who are not in full-time education is identified through the social care needs assessment process.
- The independence and inclusion of people is promoted by encouraging and supporting a range of travel options including independent travel and the use of concessionary travel passes.
- Co-funding contributions for FACS eligible transport will comply with "Fairer Charging".
- Efficient use of resources and avoid spending public money unreasonably.
- The reduction in air pollution and encourage the use of sustainable resources by promoting the use of public and shared transport.

5. ELIGIBILITY FOR TRANSPORT

- The person is assessed as having an eligible social care need for transport – see Appendix 1 for details of the criteria;
- Although a client may attend a specific community service/ activity to meet their assessed needs, they will not be eligible automatically for transport to and from the service/ activity.

6. PROCESS

1. Part of the needs assessment process will consider what support, if any, is needed in getting out and about; including for example, risk management (see section below), accessing reasonable alternative

methods of transport and whether or not it is reasonable to expect people to make their own arrangements (Eligibility Criteria for transport are set out in Appendix 1).
2. Where the way a person physically accesses a service is resolved by one of the alternative methods identified below in Appendix 1, this should be recorded in the support plan.
3. Where there is no alternative means of travel provision, the person has an eligible social care transport need.
4. Transport may be provided on a temporary basis and reviewed when the client is able to use an alternative method of transport, for example, public transport.

Then:

5. The best way to meet the eligible transport need will be determined at the support planning stage. This may be partially or wholly provided or arranged by the Council.
6. The transport will be arranged, if required;
7. Transport needs will be included as part of the regular assessment and support planning reviews.

7. SUPPORT PLANNING

Where there is more than one service or support being accessed, or accessed on more than one day, there may be more than one solution or option available and so each journey needs to be considered separately, as part of the client's Support Plan. Each day, service or journey may require different travel arrangements or no travel arrangements at all. Each situation is different and specific to the client's assessed eligible social care transport needs.

Support planning should consider the impact the travel arrangements will have on the sustainability of the plan and on family carers. This needs to be considered through assessment of the person's and the carer's needs.

Determining the best way to meet the eligible transport need will be addressed at the support planning stage. Transport may be partially or wholly provided or arranged by the Council and will include consideration of the following:

- Promoting independence and inclusion, and not increasing a client's dependence on others.
- How transport support or services that can help people meet their eligible needs will be accessed.
- The clear identification of travel arrangements including a contingency plan in cases of unforeseen changes.

- Ensuring clients and their family carers are aware of options for transport and that these are reflected in their support plans.
- The need to provide passenger assistance, where required due to health and safety reasons.
- The support plan will have regard to the sustainability of the caring role.
- Making good and effective use of the resources available.

8. RISK MANAGEMENT AND SAFEGUARDING

The 'Procedure for Safe Transportation of Social Care Service Users in Derbyshire' will apply.
In order to make a safe and fair decision, assessors and clients will need to consider the risks involved in accessing one of the transport options, and whether there are actions that can be put in place to ensure the option selected is safe and reasonable.

To determine the risks involved in getting out and about or travel arrangements, the following factors will have been considered as part of the social care assessment of need:

- Does the person have a disability, frailty, physical health issue?
- Is there any reason to doubt the person's the ability to make safe decisions regarding their transport arrangements?
- Can the person travel independently and is it safe for them to do so?
- Are there any barriers to independent travel? Can these barriers be resolved?
- What public transport is available to the person? Is it safe for them to access the public transport? Do they need help to use public transport?
- Is there a risk to other people, for example in shared transport?

9. PEOPLE WHO DO NOT HAVE AN ELIGIBLE FOR TRANSPORT PROVIDED BY THE COUNCIL

Where a person is not eligible for the provision or arrangement of transport as an assessed need/ community care service, including where a client chooses to access a community service or activity that is further away than the closest appropriate setting to meet their eligible needs then either:

- They would need to make their own transport arrangements, if they are able, or with support

Or

- It may be possible for people to arrange to use transport provided or arranged by the County Council for general wellbeing purposes subject to

the availability of transport at the time. There would be a charge reflecting the full cost of the transport.

10. APPEALS

The assessment for an Eligible Social Care Need which including any assessed need for support with transport, will be carried out by an operational team member with the client and/ or their family/carer representative.

In cases where agreement cannot be reached the matter will be referred to a Service Manager. The disputes resolution process could follow the Adult Care complaints procedure.

APPENDIX 1

ELIGIBILITY FOR TRANSPORT

The needs assessment process will consider what support, if any, is needed in getting out and about. It will include:

- Whether people can access reasonable alternative methods of transport: as set out in the 'Definitions' Appendix 2 below.
- Whether or not it is reasonable to expect people to make their own arrangements; with or without support.

In order to identify if transport needs to be part of the support plan the checklist below need to be asked, in conjunction with the definitions set out in Appendix 2, to assist with the decision-making process:

1. *How far is the support or service from where you live?*
   People will be expected to access support and community services based nearest to where they live, as long as they are appropriate to meet the assessed, eligible needs.

2. *Can you walk or cycle to the service?*
   Being able to walk might mean by walking alone or with the assistance from someone else, for example, using a buddying scheme or assistance from family, friends or a carer.

3. *Can you use your own transport?*
   If you have your own motor vehicle, a vehicle obtained through the Motability scheme, a specially adapted vehicle or some other vehicle that you have access to, it is expected that this would be available for use.

4. *Can you arrange your own transport from an independent source and meet the cost of transport from any mobility allowance awarded to you?*
   A client who receives a benefit for example, the mobility component of Disability Living Allowance (DLA) or Personal Independence Payment (PIP), to facilitate their mobility needs, a reasonable proportion of it should be available for transport needs in accessing support and services.

   The actual amount will depend on individual needs and requirements but 70% is a suggested starting point. Consideration will need to be given about other critical demands placed on the allowance.

   If the client is not in receipt of mobility allowance, then support can be provided to make an application.

5. *Can you use public transport?*
   This might be travelling independently or with assistance from someone else for example, a buddying scheme, family, friends or a carer.

6. *Do you have a concessionary bus pass? If not, could you be assisted to apply for one?*
   If an escort assistant is essential, are they eligible for a bus pass?
   If you cannot currently use public transport services, could you do so following a period of reassurance, support, enablement and transport training?

7. *Can you access transport with a carer, family member or friend?*
   Sharing transport with another person may be an option.

8. *Do you live in:*
- *Residential care?*
- *Supported living scheme?*
- *Shared Lives?*
- *Some other supported housing setting?*
  Where clients are living in settings funded by the council there is an expectation that the cost of the placement will meet the full range of support needs, including transport to and from community activities, unless assessed as otherwise.

9. *Should another agency be providing the transport?*
   A client may be eligible for funding for their transport from another agency or organisation, for example to attend a service to meet an assessed health need.

APPENDIX 2

DEFINITIONS

Closest Appropriate Setting/ Local Area - a geographical area to which a client has reasonable access around where he or she lives.

To promote local inclusion, it is not generally appropriate to arrange a community service outside of a client's local area, unless it is not possible to meet their assessed need in that area. The perception of a local area can be different for people who live in rural areas compared to those who live in towns. But broadly, people will be expected to access support and community services based nearest to where they live, as long as they are appropriate to meet the assessed, eligible needs.

Community Activity - the service/s that a client accesses in the local community (short breaks/ respite/ day service/ volunteering opportunity etc.)

Concessionary Travel - a bus pass for those who are eligible, which allows clients to use the local transport network at a reduced rate or free, as per the conditions of the pass.
A 'pre-09:30 bus pass' scheme is available, in addition to the Derbyshire Gold Card (based on the English National Concessionary Fare Scheme), which would allow clients to use buses before 9:30am. Previously, some clients were unable to travel on public transport to their given location due to the time restrains of their Derbyshire Gold Card. Clients who have received independent travel training and are able to safely travel on public transport can use the 'pre 09:30 bus pass' to enable them to attend community services on time.
With a 'pre 09:30 pass' clients can travel independently at a predetermined and agreed cost to the authority, which may be significantly less than a taxi/group transport.

'Reasonable' alternative methods of transport:
To promote independence and social inclusion a client who can travel to a community activity, either independently or with assistance from family, friends or support providers will not normally be provided with transport. Transport may be provided on a temporary basis and reviewed when the client is able to use an alternative method of transport, for example, public transport.

- Where a client can use public transport, voluntary transport, Dial-a-Bus etc. either independently or with support.
- Part of the support planning process may involve investing resources in the short term, to support people to be able to use public or community transport options, for example through transport training to support them to develop their skills around independent travel.

- Where it is identified that a carer will provide transport it is important to record that the impact of this has been appropriately considered in the carer's. Where it is concluded that the carer cannot provide transport because it would place an unreasonable demand on them, then the assessment may lead to transport being provided or arranged by the Council.
- Where carers or friends have been identified as being able to provide transport, alternative arrangements should be detailed in a contingency plan to cover periods where they are unable to assist.
- A client who receives a benefit for example, the mobility component of Disability Living Allowance (DLA) or Personal Independence Payment (PIP), to facilitate their mobility needs, a reasonable proportion of it should be available for transport needs in accessing support and services. The actual amount will depend on individual needs and requirements but 70% is a suggested starting point.
- Where a client has access to their own transport, for example a Motability car. Where a person uses their own or Motability vehicle, not fuel or other costs will be met by the council. It will not be acceptable for family members to claim priority over the use of such vehicles.
- Suitable alternative transport is available, for example clients living in settings funded by the council including: residential care, supported living, shared lives. There is an expectation that the cost of the placement will meet the full range of support needs, including transport to and from community activities, unless assessed as otherwise.
- People who qualify for concessionary travel will be expected to apply for and use this, to meet the costs of transport to community services or activities that meet their social care needs.
- A client is eligible for funding for their transport from another agency or organisation, for example to attend a service to meet an assessed health need.

APPENDIX 3

CHARGING

Background

Charging for eligible transport is subject to the statutory guidance *Fairer Charging for Home Care and other Non-Residential Services* June 2013) using powers conferred under section 7 of the *Local Authorities Social Services Act* 1970; and statutory guidance to local authorities *Fairer Contributions Guidance – Calculating an Individual's Contribution to their Personal Budget* November 2010.

Transport can also be provided and charged for as a general welfare service under sections 1 to 3 of the *Localism Act* 2011.

General

Clients would be charged for each day that transport has been booked. However if 48 hours' notice is given to the service that transport is not needed on a particular day, there will be no charge. If there is a good reason why notice cannot be given, for example a hospital admission, the charge may be waived.

People for whom transport is an eligible need

The charge for the provision of transport is proposed to be at a flat rate of £5 to each service regardless whether it be a single or return journey and not based on the journey time or mileage. If a client travels to more than one service in the same day they would be charged the flat rate for each single or return journey, per service. For example, if they travel to a day service and then to a short break service after that, they will be charged £10 for the transport (i.e. £5 to go to the day service and £5 to go to the short break service).

The assessment of the client co-funding contribution will comply with Fairer Charging; this will include the safeguard that the sum total of flat rate transport charges, in combination with any other care charges, will not reduce the client's income below Income Support/ the Guarantee Credit element of Pension Credit plus 25%.

Transport provided as a welfare service

Where a person is not eligible for the provision or arrangement of transport as an assessed need/ community care service, including where a client chooses to access a community service or activity that is further away than the closest appropriate setting to meet their eligible need, then:

- It may be possible for people to arrange to use transport provided or arranged by the County Council for general wellbeing purposes subject to the availability of transport at the time.
- There would be a charge at the full cost of the transport.
- Where transport is provided as a welfare service and not an eligible care service, the charging policy must not charge more than cost, overall, over the year.
- The total sum would be accounted for as “disability-related” expenditure for the purpose of charging for eligible care services.

People who do not pay for transport

Some people will not have to pay the transport charge, including where:

- Transport costs are paid by another local authority or by the NHS.
- The client is already paying towards an Independent Living Fund package.
- The client has been discharged from hospital on a Section 117 Agreement (under the Mental Health Act 1983) and this is still in place for after-care.
- Services provided to anyone with Creuzfeldt-Jakob Disease.

APPENDIX 4

FREQUENTLY ASKED QUESTIONS

1. **Why do we need a Transport Policy?**
   Answer: We need to make sure that support with transport arrangements is fair and equitable, and provided for people with eligible assessed needs on the basis of clear criteria.

2. **What services may be affected?**
   Answer: mainly day opportunities and respite care, but other regular journey may also be affected.

3. **Will this affect my free Travel Pass e.g. Gold Card?**
   No.

4. **Who makes the decision as to whether the Council will provide transport for me?**
   The decision will be made as part of your needs assessment or review through discussion with you and/or your carer.

5. **Can I appeal if I disagree?**
   You can either contact your allocated worker or make a formal complaint.

6. **Who do I contact if I need more help?**
   You should contact your allocated worker.

PUBLIC

Agenda Item: 7d

DERBYSHIRE COUNTY COUNCIL

CABINET

21 JANUARY 2014

REPORT OF THE STRATEGIC DIRECTOR – ADULT CARE

CONSULTATION AND ENGAGEMENT ON PROPOSED CHANGES TO HOUSING RELATED SUPPORT SERVICES PROGRAMME

ADULT SOCIAL CARE

1. Purpose of the Report

To seek Cabinet approval to commence a two phased process of formal consultation and engagement with organisations and their clients on a proposal to make £9m savings in the Housing Related Support (HRS) services programme, approximately £1m of which would be saved in 2014/15.

2. Information and Analysis

Context

Due to reductions in funding from Central Government, the Council must reduce its expenditure by £157m over the next 5 years.

In order to achieve this budget reduction, Cabinet is reviewing all areas of expenditure. At its meeting on 1 October 2013, Cabinet approved a joint report by the Chief Executive and the Director of Finance on the revised budget for 2013/14. In approving the joint report, Cabinet also:-

- Approved a revised 5 year financial plan.
- Noted the changes to funding received since Council approved the budget in February 2013 and approved the uses to which it will be applied.
- Agreed the proposals for budget reductions outlined in Appendix 2 to that report.
- Noted that the possible areas for budget reductions in Appendix 3 to that report will be considered and detailed proposals brought before Members as appropriate.

The Council meeting on 2 October 2013 confirmed and accepted the proposals agreed by Cabinet in relation to the revision to the 2013/14 budget and to the reductions detailed in the report.

Proposals set out in Appendix 3 of the joint report, subject to Cabinet consideration and necessary consultation, included the Housing Related Support Services programme. Detailed proposals relating to these changes are set out below.

Funding for Housing Related Support originally came to the County Council as a ring fenced grant. In April 2009 the ring fence was removed and the funding has been incorporated into the more general grant funding from Central Government to the County Council. Since 2009, many Councils have made significant reductions in this budget. Research was conducted by the Local Government Information Unit and Circle Housing Group into cuts to Supporting People budgets in 2011. This surveyed 139 local authorities and 44 per cent of councils stated that they were reducing the level of service they could offer in order to make savings. For example, Worcestershire County Council's programme expects to achieve a £3m (21%) reduction in its base budget, Nottinghamshire County Council to achieve a £10m saving and Derby City Council aims to reduce its HRS budget from £9.5m in 2012/13 to £3.3m in 2014/15.

2.1 **Current Provision**

HRS services enable vulnerable people to achieve or maintain independent living in the community. These services can prevent individuals from being admitted to hospital/residential care and accessing other health services. They can also help people to avoid homelessness. Support workers help the person to draw up a support plan that is tailored to meet their individual needs and aspirations.

It provides predominantly non-care based support including supporting people to:

- Claim benefits and fill in forms.
- Develop skills to maintain and manage their tenancy.
- Gain access to other services they need.
- Participate in training or education.
- Contact family and friends.
- Manage their own physical and/or mental health.
- Stay safe.
- Find or keep their home.

A wide range of vulnerable people currently receive HRS including:

- Older people.
- People with Mental Ill Health.

- People with Learning Disabilities.
- Young People.
- People with Drug or Alcohol problems.
- People at risk of Domestic Abuse.
- People at risk of offending.

HRS Services can be provided in two ways:

1. Floating Support: these are HRS services provided predominantly by support workers to people wherever they live. This service is not linked to people living in specific settings such as a refuge.

2. Accommodation based Support; these are HRS services that are based on living in specific accommodation such as a hostel or a refuge.

A more detailed explanation of the types of services provided to these client groups that may be affected by these proposals and some case examples of people using HRS services are included at Appendix Two.

The HRS Programme currently has a total budget of £14,644,699. This preventative programme enables over 31,000 vulnerable local people to live independently in their own homes. The programme is instrumental in the delivery of prevention services for Derbyshire County Council, local district and borough Councils, the NHS and the National Offender Management Service (NOMS). Currently there are 140 local services delivered by 57 providers.

The provision of HRS services is not in itself a statutory requirement for the Council, but these services do provide cost effective preventive support for vulnerable people.

There is strong evidence that many partner agencies as well as the Council benefit from the provision of HRS services and national research indicates that it has a positive financial return on investment for these agencies.

The proposed changes to the currently funded HRS services will have a direct impact on the clients who use the service, those who might have benefited from them in the future and the current service providers.

A breakdown of the current Accommodation and Support Budget for 2013/14 and services are detailed in table 1 below.

Table 1

Client Group	Service Type	Annual Budget	No of Clients	No of Services
All Client Groups	Alarm/On Call system	**£1,097,121**	**10,370**	**29**
Adults (under 65)	Accommodation-based & floating support	**£1,775,016**	**530**	**4**
Offenders / people at risk of offending	Accommodation-based services	**£109,424**	**15**	**1**
Older People with Support Needs	Accommodation-based & floating support	**£4,310,664**	**19,383**	**44**
People at risk from domestic violence	Accommodation-based & floating support	**£849,838**	**204**	**4**
People with a Physical or Sensory Disability	Accommodation-based services	**£32,441**	**14**	**2**
People with Learning Disabilities	Accommodation-based services	**£3,475,940**	**446**	**43**
People with Mental Health Problems	Accommodation-based & floating support	**£1,962,887**	**490**	**9**
Young People	Accommodation-based & floating support	**£1,031,367**	**294**	**4**
GRAND TOTAL		**£14,644,698**	**31,746**	**140**

2.1.2 Proposed changes to the HRS programme.

This report outlines a range of proposed measures including efficiencies, service re-design, and service reduction and de-commissioning which could deliver a total of £9m of savings. The plan would be phased over the two year period 2014-16 due to consultation, engagement, contractual agreements and, where appropriate, completing community care assessments.

The Council proposes to implement these changes over 2 phases. The first phase would take effect in 2014/15 and it is these proposals upon which the Council wishes now to formally consult. Phase Two will be the subject of further discussions with all interested parties and a subsequent process of consultation.

PHASE ONE

The proposed decommissioning of services due to be the subject of formal consultation during Phase One have been arrived at by using the following criteria:

- Maintain so far as possible services which complement the Council's statutory responsibilities and deliver on the Council Plan.
- De-commission services that could be commissioned by other partners for example district and borough councils, local NHS and the National Offender Management Service.
- Where appropriate identify services for client groups which could be re-designed as generic services for a wide range of vulnerable people and deliver best value.

Table 2 - Phase One - 2014-15 proposed services to be decommissioned			
Client Group / Service Type	**Provider**	**No. Of Services Affected**	**Annual Contract Value**
Adults (U65)	Action Housing	2	£954,100
	Derbyshire Connections Consortium (NCHA, Amber Trust, YMCA, NACRO, P3 & Riverside)	2	£820,916
	Sub Total	4	£1,775,016
Offenders & People at Risk of Offending	Action Housing	1	£109,424
Housing options for People with Learning Disabilities	Nottingham Community Housing Association	1	£35,000
Leaseholders	7 Individuals	7	£5,545
Totals		**13**	**£1,924,985**

If the proposals are agreed in Phase One there will be a six month saving of £962,493 in 2014/15 followed by a further saving of £962,492 in 2015/16.

Phase One is also dependent on ensuring that community care assessments are completed for relevant clients affected by this proposal and appropriate support plans are in place.

PHASE TWO

It is proposed that Phase Two would achieve a further £7m of savings, in addition to the £2m saved in Phase One. In order for the Council to finalise its proposals in respect of these further savings it is necessary to carry out a period of engagements with clients, providers and other interested parties. These proposals will form the basis of discussions with clients and providers. Contractual negotiations will also take place with providers to remodel services to achieve targeted savings, including possible retendering of services.

Proposals in Phase Two could involve:

- Making reductions in the services commissioned. These are outlined in Table Three.
- Remodelling and re-procuring the services that will continue. These are outlined in Table Four.

Table 3 Phase Two: Proposed Reductions in Services 2015/16

Client group/Service Type	**No of Services Affected**	**Total Budget Reduction**
Older People – Housing Options	1	£197,426
Older People Sheltered Housing with warden on site	18	£801,492
Older People – Home Improvement Agencies	2	£35,926
Older People – Handy Van Network	7	£91,488
Older People Including falls recovery	8	£2,138,206
People with mental health problems	9	£1,400,000
People with a learning disability – Supported living schemes jointly funded with care	35	£1,181,760
People at risk from domestic violence	4	£369,649
Young people's services	4	£859,185
Total	88	£7,075,132

The relevant providers affected by the proposed reductions highlighted in the table above are detailed in Appendix One.
Table 4 below outlines the services that it is proposed to retain in the HRS Programme assuming no additional funding is received from other sources.

Table 4 Phase Two: Remodelled and Retained services 2015/16

Client Group	Service Type	No of Clients	Annual Budget
People at Risk from Domestic Violence	Accommodation-Based & Floating Support Services	**198**	**£480,189**
All Client Groups	Alarm/On Call system	**10,370**	**£1,097,121**
Older People with Support Needs	Accommodation-Based & Floating Support Services	**15,000**	**£1,040,581**
People with a Physical or Sensory Disability	Accommodation-Based Support Services	**160**	**£32,441**
People with Learning Disabilities	Accommodation-Based & Floating Support Services	**170**	**£2,259,180**
People with Mental Health Problems	Accommodation-Based & Floating Support Services	**141**	**£562,887**
Young People	Accommodation-Based & Floating Support Services	**49**	**£172,182**
GRAND TOTAL		**26,088**	**£5,644,581**

2.1.3 As a consequence of the proposed £9m saving from the HRS programme covered by the two phases; at least six providers and seven lease holders would have their services de-commissioned and this could result in job losses of up to 587 of which approximately 60 could be from Adult Care. There would also be a reduction in the number of clients supported due to a reduced range of services available. The proposed changes in services may lead to reduced support for vulnerable adults including those with protected characteristics of age, disability and gender and those in receipt of a care package for assessed care needs.

Where the benefit from the programme falls to other organisations we will engage with them over alternative ways of working for, for example providers

are invited to consider intensive housing management as an alternative way of delivering their services. This will take place during the consultation and engagement processes and will include, within the Council, Children and Younger Adults and Public Health and externally the Clinical Commissioning Groups, other local NHS organisations, Probation, Police service and the district and borough councils.

3 Consultation and Engagement

This proposal has implications for organisations providing services and for people receiving services commissioned/funded by Adult Care and as such a period of consultation will be required. The length of the consultation in respect of Phase One will be 12 weeks. A communication plan will be required to make sure that all people and providers who are potentially affected are fully aware of the proposals contained in the Cabinet report and have an opportunity to comment. In some instances this will involve engaging with hard to reach groups. It is estimated that approximately 5,660 people would be affected by the two phases of this proposal; all those affected by Phase One will be contacted as part of the consultation exercises being run by Adult Care and providers of HRS services. This consultation will need to extend to include other stakeholders such as statutory agencies and appropriate independent sector groups. As part of the consultation process the public will be invited to suggest alternative ways of making additional savings.
Particular consideration will need to be given in this instance to communicating with any hard to reach groups who do not receive a service directly through Adult Care but rather through an organisation commissioned/funded by Adult Care.

The consultation will be carried out by the Stakeholder Engagement Team with assistance in preparing materials from colleagues in the Press Office. In all instances material will need to be prepared in Easy Read format and the proposal will be available both in leaflet/letter format as well as on-line. In addition to this there will be the opportunity for the public to make their views known verbally either by a help-line or through public events. Officers will also attend appropriate Board and user group meetings as a further avenue of eliciting opinion on the proposals.

At the same time as formal consultation is undertaken in respect of Phase One, officers will also engage with interested parties in respect of the future of the service from 2015. This period of engagement will determine a set of proposals (Phase Two) which will be the subject of a further report to Cabinet and a further period of formal consultation.

As part of the engagement process, providers will invited to enter into a dialogue with the Council as to how they could reduce their contract value and achieve efficiency savings in other ways.

4. Financial Considerations

The proposed £9m saving would be phased over two years 2014-16.

5. Human Resources Considerations

In addition to the arrangements for public consultation outlined in the report, the workforce planning implications for County Council staff arising from the proposals will be the subject of informal consultation with staff and Trade Unions. Formal consultation may be required subsequently, dependent on the whether a decision is made to proceed with the proposals.

6. Legal and Human Rights Considerations

The Director of Legal Services has advised that the proposals outlined in this report need to be considered with the proposed changes in other Cabinet reports, in particular, consultation on proposed changes to eligibility for Adult Social Care and increased contributions for non-residential care and consultation on the introduction of an Adult Social Care Transport Policy.

Consultation on all the proposals should, as far as practicable, take place at the same time. The information provided to consultees, in each consultation pack, must link to the other proposed changes in order for them to fully understand the global impact of the proposals and allow them to provide informed comment. Consultees should be specifically asked to comment on whether other changes proposed by the Council will, in their view, make the consequences of the proposed changes outlined in this report better or worse and, if so, in what ways.

When considering the proposals it will be essential for Members to have due regard to protecting and promoting the welfare and interests of persons who share a relevant protected characteristic (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation). The proposals will therefore be subject to an Equality Impact Assessment, which will be linked to the Equality Impact Assessments for the other proposed changes, in order for Members to fully consider the impact of all the changes in the round. The assessment of impact on protected groups will include an assessment of any safeguarding issues arising.

7. Equality of Opportunity Considerations

The proposals will be subject to an Equality Impact Assessment. This will be prepared in the light of the consultation and will be included with the subsequent report to Cabinet.

8. Other Considerations

In preparing this report, the relevance of the following factors has been considered: Prevention of crime and disorder; equality of opportunity; environmental; health, property and transport considerations.

9. Key Decision

No

10. Is it required that call-in be waived in respect of the decisions proposed in the report?

No

11. OFFICER'S RECOMMENDATION

1. That Cabinet approves the commencement of a period of full public consultation on Phase One of the proposals and a period of engagement in respect of Phase Two as set out in the report.

2. That further reports are brought to Cabinet following the period of public consultation and engagement and Equality Impact Assessments are carried out.

Bill Robertson
Strategic Director - Adult Care
County Hall
MATLOCK

Appendix One

Relevant providers affected by the proposed reductions

Client Group / Service Type	Provider
Older People Housing Options	P3
Older People Sheltered Housing with warden on site	Anchor Trust
	Bolsover District Council
	Chesterfield Borough Council
	Chesterfield Churches
	Dales Housing
	Derwent
	EMH Homes
	Equity
	Guinness Partnership Ltd
	High Peak Borough Council
	Housing 21
	JJ Housing
	Metropolitan
	Riverside ECHG (English Churches)
	Raglan Housing Association
	Rykneld Home
	Sanctuary Housing Association
Older People HIA	Chesterfield Borough Council
	Metropolitan
Older People - Handy Van Network	Bolsover District Council
	Chesterfield Borough Council
	Medequip
	Metropolitan
	Rykneld Home
	South Derbyshire CVS
	Voluntary & Com Services Peaks & Dales
Older People Includes falls recovery	Bolsover District Council
	Chesterfield Borough Council
	Futures
	High Peak Borough Council
	Making Space
	Rykneld Home
	South Derbyshire District Council

People with mental health problems	P3
	Rethink
	Morning Rise
People with a learning disability - Supported living schemes jointly funded with care	Derbyshire County Council
	Enable
	Mencap
	Metropolitan
	Moore Care
	Norsaca
	Positive Horizons
	SLC Paragon
	Thera Trust
	United Response
People at risk from domestic violence	Nottingham Community Housing Association
	Trident
Young People's services	Framework

Appendix Two

Case Studies of Housing Related Support Services

Most vulnerable people find themselves in transition at various points in their lives. If they cannot access adequate housing at the right time their attempts to achieve positive outcomes can be seriously undermined. Housing Related Support services in Derbyshire help tackle multiple disadvantages by assisting:

- Former rough sleepers, and other single homeless people living in hostels, to move on into self-contained accommodation.

- Recovering substance mis-users, to settle down after treatment and rehabilitation.
- Offenders, who have lost their homes while in prison, to plan for their Release.
- People supported by domestic abuse providers to move on into private rented accommodation with floating support and / or Telecare.
- Young people leaving care, to live independently for the first time.
- Substantial public funds have often been invested in helping people to recover, re-engage and change. Without adequate housing, this investment can be lost. It is far more costly to deal with the implications of repeat homelessness than to manage the risks while someone is living in settled accommodation.

The commissioned services for this client group encompass clients aged over 25 years assessed with any of the following criteria:

- Single Homeless.
- Drugs and Alcohol issues.
- Offenders, Ex Offenders and those at Risk of Offending.
- Generic (i.e low level support needs).
- Other Complex Needs (including Dual Diagnosis).

Adults – Case Study

Action Housing and Support - Mark had recently been released from prison after serving a sentence for drug dealing and had suffered episodes of drug induced psychosis including being sectioned under the mental health act for his own safety on a number of occasions. He was referred by his Community Psychiatric Nurse for support in setting up and maintaining a tenancy.

His engagement was sporadic at first and Action supported him to access the Community Drug Team, he was prescribed methadone and began to feel more stable. This had a positive effect on his mental health and he re-engaged with his CPN and started taking his prescribed medication. Mark was supported to establish a payment schedule to cover his rent arrears to prevent possible eviction.

Mark continued to make progress and asked for support in looking at training options. A meeting with a careers advisor was facilitated and Mark enrolled on some courses at Chesterfield College.

Mark took great satisfaction in being able to do something well (painting and decorating) and sought opportunities to develop his skills. His support worker arranged for him to spend a few days working alongside the in house maintenance team and also to apply for a small grant through a trust to purchase the paint and materials he needed to decorate his own property.

After 15 months Mark decided he no longer needed support having achieved the goals he had identified. At the time of exit he had completed a detox and was no longer using methadone. He had cleared his rent arrears and achieved the status of a secure tenant. He was continuing to engage with both the Drug Team and the Mental Health Team and successfully reached the end of his prison licence with no further offending. He is now looking for opportunities to gain employment or further develop his employability skills.

Older People

The majority of older people want to live in their own homes. They might be home owners or private sector tenants or may live in sheltered housing provided by a housing association or local council. Whatever their circumstances, **Housing Related Support** can help older people to live where they want to.

By providing an individually tailored service, it can help them to maintain maximum independence.

A Range of Services

Some older people just need help with repairs – and **housing related support** includes this in the form of Home Improvement Agencies for major repairs or, alternatively, assistance with practical tasks provided by the Handy Van Network. Information about housing alternatives can also be provided by the Derbyshire Older Peoples Housing Options Service that supports people with impartial advice. Others need much more care and support and we have developed a number of Extra Care Housing facilities to meet their needs.

The availability of funding within older people's services has proved critical in a number of ways:

- It has ensured that basic running costs will be financed, enabling the commissioners and the developer to proceed with confidence;
- It has paid for core services, such as 24-hour cover, so that emergencies can be dealt with, in conjunction with the relevant agencies, at any time of day;
- It has enabled providers to offer more choice, without the concern that individual choices will undermine service viability.

Older People's Housing Options - Advice and Support

The Derbyshire Older People's Housing Options Service is a free service that provides information, advice, support and practical help for older people who are living in poor or unsuitable housing and / or are considering options for moving on or changing their home to a different type of accommodation. The service is available to anyone over the age of 50 who is vulnerable or to anybody of any age who is the main carer of an older person, and can offer support to 900+ people every year.

Advice provided includes:

- Housing choices – choice based lettings and housing options systems, how to access private landlords, other housing associations, and evidence needed to support applications.
- Additional Services – community alarm provision, warden services, cleaning and gardening services, handy van network.

- Benefits – which benefit clients may be entitled to, how to obtain the forms, who to contact, evidence needed to support applications.
- Signposting – additional specialist services e.g. Citizens Advice Bureau for debt/money advice, Home Improvement Agency for housing repairs/adaptations, Derbyshire Housing Aid for advice around tenancies, rent and mortgage arrears.

Support available includes:

- Completing forms for the clients if they are unable to do so themselves.
- Liaising with partner agencies to obtain additional services i.e. adult care, housing associations, other voluntary agencies.
- Negotiating on behalf of clients with suppliers/providers to manage bills/finances more efficiently.
- Bidding on the choice based lettings and home options systems.

iDecide, including P3 and Amber Trust, told us that during “the first six months of the service operating we have supported 33 individuals across four of the six districts to access additional benefits totalling £85,000 (Average of £2,577.82 per client).” The additional income has been used to:

- Cover the cost of minor adaptations allowing clients to remain in their homes.
- Purchase cleaning and gardening services helping clients maintain their tenancies and avoid action being taken against them.
- Pay fuels bills meaning clients aren’t worrying about heating their homes.
- Purchase white goods, aids and home furnishings.
- Pay for transport to social activities reducing social isolation.

Derbyshire Older People's Housing Options – Case Study

iDecide - Joyce is wheelchair dependent and cannot access her kitchen or reach surfaces in her bungalow without help. Initial contact identified that Joyce wanted to stay in her bungalow but felt work on adaptations had been halted due to the impression she wished to move. She was supported to access befriending and support services and to enrol on a computer course she could do from home. Her support worker engaged with the District and County Councils to progress her Disabled Facilities Grant and adaptation work. The worker also supported Joyce to identify benefit entitlements.

The Handy Van Network

The Derbyshire Handy Van Network is a service making it safer for older and vulnerable people to live in their own homes. A Derbyshire resident who is aged 60 or over or a vulnerable person who is referred into the network can access the service free of charge. However, any materials required for any small repairs or DIY tasks have to be purchased by the client.

The service provision includes the following:

- Home Fire Safety and Home Security checks.
- Installation of Telecare.
- Security equipment provided and installed.
- Installation of key safes and grab rails.
- Energy efficiency advice.
- Practical tasks − for example:
    - changing light bulbs.
    - securing carpets and rugs.
    - removing and hanging curtains.
    - checking stair rails are secure and appropriate.
    - path and door access clearance.
    - securing tap washers to reduce dripping taps.
    - and other tasks, as appropriate.

During 2011/12, the Handy Van Network completed over 25,000 tasks during 8,111 visits. Support was provided to a range of older and vulnerable people across the county, including the provision of specialist services for people at risk of domestic abuse and supporting the Derbyshire Fire and Rescue Service following fatal fires across the county.

A summary of the benefits delivered is detailed in the table below:

Measure	Number	Outcomes
Reduced falls	140	Falls prevented
Improved or maintained independent living - sheltered	16	People prevented moving into sheltered accommodation
Improved or maintained independent living - temporary	2	People prevented moving into homes
Reduced burglaries	4	Prevented burglaries
Reduced bed days	8	People prevented using an avg. number of bed days
Reduced use of social services	11	People prevented using social services
Reduced fuel poverty	2256	People with reduced bills

Handy Van Network – CASE STUDY

Hannah contacted the Handy Van Network for help with a broken and loose stair rail. Two of the operatives visited and removed the broken stair rail, repaired it and fixed it firmly back to the wall. In addition they noticed that Hannah did not have a smoke alarm so they carried out a Home Fire Safety and a full Home Security Check and fitted 2 smoke alarms, a door chain and a door alarm.

Hannah was given advice about ways of cutting energy costs by using various energy efficiency measures. She said she would be pursuing the option of free loft insulation which is also good for the environment.

Floating Support (Warden Service)

The Accommodation and Support Team carried out a strategic review of Older People's Services which included the "warden services." The review considered amongst other matters the projected increase in the number of older people living in Derbyshire, the need to provide and deliver effective, high quality, value for money services, which are accessible throughout the County, areas of deprivation and Derbyshire's rural communities where service provision may be lacking.

The recommendations from the review were used to shape the new Service:

- Services are tenure neutral. This facilitates the removal of barriers to support for minority groups.
- A menu of options is available across the County in order to target support where it is needed.
- The availability of increased support for short term needs only.
- Reduces unnecessary hospital admissions and prevents the need for moves into residential care.
- Includes a "falls recovery service," only for instances where no other medical intervention is needed.
- The option of a warden service that is not linked to the community alarm service.
- Service delivery allows for greater choice and control.

Falls Alert Service – Telecare and Falls Recovery Service

Derbyshire's Falls Alert Service – Telecare provides a 24 hour home safety system which incorporates a range of Telecare sensors. The service enables people to live independently within their own homes; with an instant response should a sensor be activated, providing valuable peace of mind. **Housing Related Support** is currently funding 500+ free packs of equipment to fallers or potential fallers. The only cost to the client is a £2.50 per week monitoring charge, plus call charges only when the alarm is activated.

The Falls Recovery Service (FRS) delivers a timely response and safe lift from the floor for clients who have fallen in their own homes, who are not knowingly injured and who are unable to get up off the floor without some level of assistance. FRS staff will carry out a pre-lift risk assessment on the faller and employ recognised safe moving and handling techniques with the use of specialist lifting equipment. The service has been established in partnership with the NHS.

Category 2 Sheltered Housing Services

Category 2 Sheltered Housing provides supported accommodation for older people who choose to live in the community but also to live in a more secure setting that offers communal facilities, on-site support staff during part of the day and access to a community alarm that offers 24/7 reassurance. This type of supported accommodation has a door entry system to the facility providing added security and peace of mind.

Learning Disabilities (LD)

In Derbyshire around 370 People with a Learning Disability receive housing related support. Many of these individuals have moved into independent living and maintained their tenancies with a mixture of both social care and housing related support.

Housing choices in Derbyshire include:

- Private Rented Accommodation.
- Home Ownership.
- Social Housing.
- Shared Housing.
- Living with Family.

Housing Related Support Provision for People with a Learning Disability

As part of future and on-going work the Derbyshire Accommodation and Support Team are working to ensure that our services are innovative and support individuals to achieve their identified outcomes. We are undertaking a review of services for People with a Learning Disability which includes supported living, floating support, shared lives and housing choices.

In Derbyshire there are different types of support available to ensure that service user needs are met. Examples are: some People with a Learning Disability can receive a small amount of housing related support per week within their own home (floating support), while others receive support within a family placement. Alternatively, some individuals live with other People with a Learning Disability in shared accommodation.

- The previous strategic review identified the need for more flexible support options to be available to People with a Learning Disability, this led to the procurement of a Floating Support and Housing Choices service which has now been in operation for over a year and is proving a success.

LD Floating Support - Case Study

David was not managing very well and his family were very worried about him. His Social Worker made the referral and it was identified that his flat was in poor condition. David admitted that he does not like to do domestic duties and was struggling to manage his finances; including getting overdrawn and being charged account fees. David was at risk of getting into debt, he was not going out often and there was a concern that he was becoming isolated. David said he was miserable and wanted some help.

An assessment indicated David would need 2 hours support a week. He wanted to manage his money effectively and responded well to a budgeting plan, set up direct debits and managed to clear his debts.

The support worker identified a benefit that had not been applied for and David received a sum of money. He was able to replace his very noisy fridge freezer, buy some household items and expand his leisure opportunities.

David has been supported to join in with the local pub pool tournaments and to get involved in a community pottery class. He takes pride in showing the support worker and his family his creations. At first his support worker attended with him until David felt confident enough to go independently, and he was also introduced to an organic farm where he has become a volunteer. He brings home the produce, which has had a positive impact on his healthy eating.

With support David set up a time table for cleaning duties. He stuck to this and managed to maintain his flat independently. He told his support worker that he feels more confident now and enjoys his life.

LD Housing Options - Case Study

Angela was in temporary accommodation but wanted a permanent home. Barbara had been living in a shared flat but was unsettled and needed to share with someone more compatible.

Social workers arranged for the two ladies to spend some time each week out together, with carers, to see how they got on. They both enjoyed this and felt they would be able to share a house.

The support worker discussed their housing needs with Social Workers i.e. suitable area, close proximity to families, local facilities, links to public transport and any mobility issues. The property search commenced with talking to housing providers and private landlords in the area to find somewhere suitable.

A property became vacant in a quiet residential area which was only a short bus ride from the local town. The house has a small garden that they can both enjoy.

The support worker arranged for Housing Benefit payments through the District Council. A care provider has also been chosen to provide the one to one care and for someone to sleep in at night.

All photographs used are for illustrative purposes only.