AGENDA ITEM NO.

COMMITTEE: HEALTH SCRUTINY COMMITTEE

DATE: 20th FEBRUARY 2007

REPORT OF: ASSISTANT CHIEF EXECUTIVE (STRATEGY, PERFORMANCE AND GOVERNANCE)

REPORT TITLE: JOINT COMMISSIONING OF OLDER PEOPLE'S HEALTH AND SOCIAL CARE SERVICES SCRUTINY REVIEW

1.0 Background

1.1 The Health Scrutiny Committee selected this review at its away day at the beginning of the year. The Director of Public Health, the Director of Modernisation (Stockport Foundation Trust) and the Health Policy Manager (Stockport Council) assisted the Committee in their topic selection.

1.2 This review has been carried out at the same time as Stockport Primary Care Trust (PCT) has led a review of non-acute services for older people. This has been a major piece of work which has led to proposals for a new model of delivery which increases the level of care provided in the community, and replaces services currently provided from three wards at Cherry Tree Hospital.

1.3 The Panel recognised that the timing of the review created an additional demand on workload across the Council, PCT and Foundation Trust. Accordingly, the work of the Panel took the form of evidence-gathering about the existing structures and rationales for commissioning of older people's health and social care services, rather than a comprehensive attempt to redesign the whole system. Officers responsible for commissioning and representatives from the community and voluntary sector were questioned over a series of meetings.

1.4 The work will contribute to the parent committee's understanding of local health and social care services, and assist the committee in responding to the PCT's formal consultation and monitoring the modernisation of these services in the future.

1.5 This report addresses the following topics:

- Demographic changes and increased pressures upon social care and health systems.
- National policy context.
- Joint commissioning of older people's social care and health services in Stockport.
- Stockport PCT's proposals for Developing and Improving Non-Acute Services for Older People.
- Future challenges for joint commissioning.
- Conclusions made by the Panel.

1.6 This report will be considered by the Health Scrutiny Committee at its 20th February meeting. **The report does not make recommendations, but invites the Committee to discuss the report and identify any recommendations it wishes to make at the meeting**.

2.0 Increased pressures and demands upon older people's health and social care services

2.1 Derek Wanless' report, *Securing Our Future Health: Taking A Long-Term View* (DoH, 2002), was the first ever evidence-based assessment of the long-term resource requirements for the NHS. The Wanless report discussed the changing health care needs of the population as the age structure of the population alters over the next 20 years.

2.2 Health care needs are closely linked to age. The need for care is highest at the beginning and at the end of people's lives. The average annual cost to the NHS of a person aged over 85 is approximately six times the cost for a 16–44 year old and four times the cost for a 45–64 year old as a result of higher levels of utilisation of the NHS by elderly people. Estimating the numbers of elderly people in the population and is, therefore, important in considering how health and social care will be financed in future.

2.3 Wanless argues that it is possible to assess the impact of a growing and ageing population by estimating the change in health care utilisation that would be required if the future population used health services at the same rate as the current population in each age group. However, people's health care needs are higher as they approach death. Part of older age groups' higher cost will reflect the greater number of people close to death as well as age related health care needs. More than a quarter of all acute health care costs are incurred in the last year of life[1].

2.4 Although the cost of acute health care incurred in the last year of life actually decreases with age in the period immediately before death, the costs for survivors (people of the same age who were not in their last year of life in the year the data was collected) increase very steeply with very old age. The average cost of acute care for an 88 year old survivor was twice that of a 75 year old survivor. A different pattern exists for social care in which costs rise with age, but the additional costs for those close to death also increase with age.

2.5 The evidence on the compression or expansion of morbidity has been mixed. In Great Britain between 1981 and 1995 both life expectancy and healthy life expectancy at age 65 increased. Improvements in healthy life expectancy did not keep pace with improvements in life expectancy resulting in people living more years in self–reported poor health, which

[1] Wanless bases this figure on preliminary analysis of English Hospital Episodes statistics, weighted for decedents and survivors using the results from Scottish Record Linkage data.

includes relatively minor conditions. There are some signs that the health of older people is improving between generations, such as the falling prevalence of smoking, but the overall prevalence of long–standing illness has not declined and trends in other health–related behaviours such as drinking alcohol and not exercising are worsening.

2.6 The data Wanless examines suggests that while levels of very serious ill health are falling, older people are experiencing more minor health problems. This suggests that costs associated with long–term chronic conditions might rise while costs associated with severe disabilities might fall.

2.7 Wanless concludes that even if health status remains constant, current levels of service use by elderly people are likely to increase over the next 20 years as a resulting of efforts to combat age discrimination within the NHS. In order to meet people's expectations and to deliver the highest quality over the next 20 years, the UK will need to devote more resources to health care and that this must be matched by reform to ensure that these resources are used effectively.

2.8 The more recent report by Derek Wanless for the King's Fund, *Securing Good Care for Older People*, considered the costs of providing social care for older people in England in 20 years time.

2.9 Wanless points out that more than one million people aged 65 and over currently use publicly funded social care services in England. Local authorities spent £8 billion on personal social care services in 2004/05, £1.6 billion of which was recouped from users through means-tested charges.

2.10 Over the next 20 years, the number of people aged 85 and over in England is set to increase by two-thirds, compared with a 10% growth in the total population. Between 1981 and 2001, increases in healthy life expectancy did not keep pace improvements in total life expectancy. In future, the total number of people with disabilities, and potentially in need of care, will be higher.

2.11 In 2002, around 900,000 older people were considered to have high levels of need, and a further 1.4 million older people to have low levels of need. Over the 20 years to 2025 Wanless projects a rise in the number of older people who do not require care of 44%, a 53% increase in those with some need, and a 54% increase in those with a high level of need.

Within Stockport

2.12 The 2001 census recorded 284,528 people resident in Stockport. According to the census, Stockport has a population of 47,011 people aged 65 and over.

Age	1991 Census	2001 Census	Difference
65-69	14050	13157	-6%
70-84	26530	28206	6%

85+	4190	5648	35%
Total	44770	47011	5%

2.13 The significant factor is the increase by 1,458 (35%) of people over 85 since the 1991 census. Evidence shows that this is the principle age range of older people known to Social Services although the numbers of those aged 70 and over are also increasing. The number of over 75's is predicted to rise from 22,315 in 2000, to a projected 23,276 by 2006 (Source: Census Database) and 32,200 by 2027. (ONS Population Projections).

2.14 The most recent population estimates and population projections produced by the Office of National Statistics for Stockport show a marked change in the increase of older age groups within the population. Between 1991 and 2001 the population in Stockport changed significantly.

- The number of people aged 65 and over rose by 3.6%, the number aged 75 and over by 9%, and the number aged 85 and over by 17.2%.
- Projections show that there will be 50,718 individuals aged 65 and over by 2011, a projected increase of 3,672. They will account for 18.3% of the population compared to 15.8% in 1991.
- Similarly, it is expected that the population aged over 85 years will increase by 53% over the 20 year period from 4,340 in 1991 to 6,640 in 2011.
- Projections suggest that from the 1991 baseline to 2011 the population aged 45-49 will decrease by 9.4%, whilst the population aged 50-54 and 55-59 will increase by 12.6% and 20.6% respectively.
- Overall then there is a cohort moving through the population who will significantly contribute to the increase in the over 65 age groups within Stockport over the next decade.

2.15 In 2001 there were in the region of 50,000 people in Stockport who classed themselves as having a long-term limiting illness (nearly 18% of the population). Further analysis by age shows that there were 28,413 people with a long term limiting illness aged over 60 in Stockport.

2.16 Despite general improving health within ageing population (and longer life expectancy) there has been a year on year trend of increased hospital utilisation both for elective and non-elective admissions.

Year	Elective admissions 65+	Emergency spells 65+
02/03	11,788	9,844
03/04	12,048	10,522
04/05	12,331	11,305
05/06	13,484	12,236

2.18 Meanwhile, both the Council and PCT are operating under substantial financial pressures. The settlement for the Council in 2006/07 was the worst for a decade, resulting in efficiency targets in 06/07 for adult social care of £3.544 million to balance budgets at year end, including £2.3

million for older people's services. Further pressures totalling £750k have been identified within the year. Stockport PCT, at the beginning of the year, identified a deficit of over £10 million due to the loss of purchaser parity adjustment funding and instructions to lodge £5.9m reserves with the Strategic Health Authority.

3.0 National policy context.

3.1 In summary, national guidance for older people's services has in recent years emphasised joint planning, a greater degree of integration of services, a shift in resource from acute to community care and services genuinely centred around the needs of older people. The key themes are:

- Modernising services through promoting independence, prevention, and improving social services for older people;
- A clear strategy for the development of primary and community care, including ambitious goals for the shift of resources rooted in the vision of the White Paper.
- A more integrated approach to delivering health and social care with an emphasis on whole systems working in areas such as hospital admissions and discharges, and community based services; hip fractures; stroke; rehabilitation; intermediate care; mental health; equipment; and adaptations;
- Greater choice and contestability in the provision of services.
- *A National Service Framework for Older People* (NSF) covering health and social care, focussed on rooting out ageism and promoting wellbeing;
- *An Information Strategy for Older People* to support the implementation of the NSF;
- Developing an overarching approach to the older population as a whole which reflects all aspects of the lives of older people, tackles age discrimination and promotes social inclusion.

3.2 A more detailed discussion of the policy context is set out at Appendix One.

3.3 The Panel focused in particular upon joint commissioning of older people's health and social care services. The Audit Commission defines commissioning as *"the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the private and voluntary sectors."* Increasingly, the local authority and its partners are encouraged to commission together in order to achieve better outcomes.

3.4 The Panel considered the policy context for joint commissioning of older people's services. In summary:

- The 1990 *NHS and Community Care Act* significantly changed the way health and social care services for adults were organised. The Act split the role of authorities to that of assessing the needs of the local population and then purchasing the necessary services from providers – whether from their own in-house departments or other organisations. This change was usually referred to as the 'purchaser/provider split'.

- The *Health Act* 1999 placed a duty of partnership on the NHS and local authorities, along with powers to develop lead commissioning arrangements, integrated provision and pooled budgets.
- In addition to the context set out at the last meeting, the next phase of health and social care reform will focus more on commissioning and contestability, i.e. ensuring that markets are open to competition from alternative providers if required; and patient choice. *Creating a Patient-Led NHS*, published in 2005, set out the arrangements intended to deliver the objectives of the *NHS Improvement Plan* (2004). It focused on supply side reforms such as greater consumer choice, competition between providers and greater use of non NHS providers. The Department of Health has increasingly promoted commissioning as a tool to improve services and support the wider reforms.

3.5 In particular, the concepts of choice and individual budgets were considered. The concept of choice in public care services is considered by government as the main element that will ensure service development is responsive to needs. Service users will have greater independence, choice and control over the way their needs are met by expanding the use of direct payments and individual budgets.

3.6 Individual budgets are a particular example of how choice will be placed at the heart of commissioning. Individual budgets are currently being piloted in 13 local authority areas. Key features are:

- A transparent allocation of resources, giving individuals a clear cash or notional sum for them to use on their care or support package
- A streamlined assessment process across agencies, meaning less time spent giving information
- Bringing together a variety of streams of support and/or funding, from more than one agency.
- Giving individuals the ability to use the budget in a way that best suits their own particular requirements
- Support from a broker or advocate, family or friends, as the individual desires.

3.7 *Independence, Well-being and Choice* (DH, March 05) and *Our Health, Our Care, Our Say* (DH, January 06) make clear the commitment to develop and extend choice and control.

4.0 Joint commissioning of health and social care services in Stockport

4.1 In November 2003 the Social Services Inspectorate published *Improving Older People's Services: an Overview of Performance*, which included Stockport as a case study example. Stockport Social Services was noted as an example of good practice in having some elements of a comprehensive commissioning strategy. The long term aim at this point was to produce a Joint Commissioning Strategy that fully included partners for health, housing, the independent sector and users and carers.

4.2 Since 2003 this aim was explored by a multi-agency steering group. The primary focus was to develop a cohesive vision for older people's services regardless of organisational boundaries. This led in 2004 to the *Background Paper in Preparation for Development of a Stockport Older People's Strategy*, which set out aims and missions, identified best practice, reported a needs analysis, analysed the local care market, identified gaps and priorities and made recommendations for next steps.

4.3 Under the Stockport Partnership a structure developed to facilitate joint working and planning. Representatives from the Council, Stockport PCT and Age Concern met and established an Older People's Partnership Board (now the All Our Tomorrows Board), which was launched on 27th September 2004.

4.4 Under the Older People's Partnership sit two groups – the Independence and Prevention Group and the Health and Well-Being Modernisation Group. These groups, which have been created from pre-existing Local Implementation Teams, now have the responsibility of identifying new workstreams and priorities in their relevant areas.

4.5 In order to take forward the work of the *Background Paper* and the creation of the Older People's Partnership two Change Event Days were held in December 2004 and April 2005. These brought together stakeholders from the Council, PCT, NHS Foundation Trust, private and voluntary sectors to assess Stockport's current position in relation to partnerships, innovation, commissioning and contracting and understanding and influencing markets in older people's services.

4.6 The following statement of purpose and vision were agreed:

- *Statement of Purpose.* To develop a 'whole systems' approach for health, social services and housing which maximises the potential for older people in Stockport to live independently and provides ease of access and seamless care pathways whilst plotting solutions that will meet our diverse population's needs until 2015.
- *Vision for Older People's Services.* To enable older people to maintain their preferred lifestyle; to increase their overall level of choice, independence, quality of life and social inclusion.

4.7 The following principles were agreed:

- To promote good health and well-being, not just treat people when they are ill.
- A commitment to building the capacity for services to be delivered in community settings, where appropriate, according to the type and level of need.
- Services which explicitly cater to the diverse needs of our older people; recognising that one size does not fit all.
- A simplified approach, which enables people to access the services they need. To offer people streamlined and integrated services based on the needs of older people as identified by older people themselves.
- To invest strategically in developing systems and services which uphold people's rights and support independence, choice and inclusion.

- To plan jointly across health, housing and social services using a person-centred approach.
- A commitment to working in partnership, pooling resources, and breaking down barriers between the National Health Service, council, voluntary and private organisations in order to achieve this.

4.7 Stakeholders agreed that while the agreement of a shared vision and principles was a key step towards successful joint commissioning, these needed to be developed into meaningful actions and shared measures of success.

4.8 At the Follow-up Change Event Day stakeholders agreed to "review and restructure joint planning and commissioning systems for older peoples' services to achieve a more streamlined whole systems approach, and to ensure user and carer involvement." The new system would incorporate both:

- The broader independence and health promotion remit as outlined in "All Our Tomorrows" and Public Health White Paper.
- The change agenda across health, social care and housing being developed through the joint commissioning strategy.

4.9 These strategies come together under Stockport Older People's Partnership Board and also report to the Stockport Health Improvement Programme.

4.10 Priorities for joint commissioning were summarised as:

1) Improving assessment and care management systems for older people through:

- Reviewing single-assessment implementation and embedding across the whole system, and continued efforts to secure the whole systems IT solution to the single-assessment procedure.
- Extending active case management to primary care, developing the role of assistant and advanced practitioners.
- Joint health and social care approaches to meeting the needs of people with long-term conditions including integrated care pathways.

2) Continue to work on a whole systems approach to reducing emergency hospital admissions and improving hospital discharge planning by:

- Developing a whole system falls strategy which includes prevention, treatment, rehabilitation and long term community support.
- A single point of access for intermediate care services.
- Developing broader, preventative approaches to keeping people out of hospital and/or long term care.

3) Developing a joint commissioning strategy for older people with mental health needs and redesigning service models in line with agreed priorities.

4.11 At this point the Social Care and Health Scrutiny Committee received a report on joint commissioning which identified key blockages. Blockages included:

- Identifying the information needed to inform joint commissioning.
- Collating and analysing this information.
- Developing shared measures of success and indicators of performance against these.

4.12 At the Follow-up Change Event Day it was agreed that officers with responsibility for joint commissioning for older people's services would develop options for a) identifying, collating and maintaining the evidence base for informing commissioning across local partners; and b) shared measures of success, included quantifiable indicators, for each agreed shared principle or priority as appropriate. This was reported to the Scrutiny Committee.

4.13 At the Social Care and Health Scrutiny Committee's February 2006 meeting a progress report on joint commissioning was given. Steady progress was reported, with workstreams established to address priorities identified by the All Our Tomorrow's Partnership Board overreaching older people strategy (which drew upon the outcomes of the Catalyst for Change Day). Key areas that had been prioritised included:

- The development of extra care housing (housing designed to meet the needs of frailer older people with varying levels of care and support available on-site.
- The further integration of intermediate care services.
- The reprovision of non-acute hospital services and agreement of an admissions policy.
- The development of community mental health services.

4.14 The re-provision of non-acute hospital services was a particular important aspect of the work programme, as it rested upon the more systematic appraisal of existing demand and provision which the committee had called for.

4.15 The Committee asked for more information about the information needs workstream and received a progress report at its April meeting. The Committee heard that an independent consultant had been commissioned by the PCT to undertake work on a whole systems older people's demand and capacity analysis. This work was accountable to and project managed by the recently established older people's project team (reporting to the Health and Well-Being Modernisation Group), and would in turn inform the reprovision of non-acute hospital services.

4.16 During the Scrutiny Review the Panel discussed the role and existing work programme of the Health and Well-Being Modernisation Group. The group meets bi-monthly and is chaired by the chief executive of the PCT and has senior representation from all stakeholder organisations. The terms of reference agreed for this group are set out below:

- To develop and implement a commissioning strategy that reflects the shared strategic vision for older people in Stockport as agreed by the AOTPB

- To build on the analysis of the health and well-being needs of various populations of older people and their carers as provided in the *Joint Commissioning Background Paper* (2004).
- To develop a range of commissioning processes in respect of older people and work towards integrated commissioning in accordance with the agreed strategy at the health and social care interface
- To ensure older people are meaningfully involved in service development and commissioning and consider appropriate mechanisms for how this could be funded
- To ensure clear and effective linkages to the IPG and with other partners in the "family" of partnerships, in order to mainstream a coherent approach to promoting the well-being of older people.
- To ensure that the aims of the *Older People's National Service Frameworks* and subsequent local priorities are/have been, and continue to be met.
- To ensure that consultation with users of older people's services and their carers is broad and inclusive.
- To ensure that the needs the BME communities are reflected in the Joint Commissioning strategy.

4.17 The current work programme is set out at Appendix Two. The Panel noted that for a number of these actions timescales and performance measures had not been developed.

4.18 Finally, the Panel also recognised the recent performance assessment for adult social care carried out by the Commission for Social Care Inspection. Stockport Council was judged to be "serving most people well with uncertain prospects". In relation to older people, CSCI drew the following conclusion:

The council continues to make progress in relation to the modernisation of older people's services. The restructuring of the service has enabled priority to be given to timely responses to service users. Improvements are noted in the monitoring of the ethnicity of older people who are assessed and in receipt of a service. The council continues to have systems in place to ensure that all older people have access to services to meet their needs. The range of services to promote independence for older people has increased. The council continues to invest in the Age Concern Placement team to ensure older people who access care independently get the support they need. The use of direct payments has increased with 33 exercising their right to purchase services of their choice during 2005/6.

4.19 CSCI focused upon the following areas for improvement for services for older people:

The council has continued to purchase the majority of its residential and home care services from private and independent sector providers on a spot contract basis. It recognises that on completion of the modernisation of its in-house services it must increase its use of block contracting. During 2006/7 the council should work with the independent sector to reduce the number of shared rooms it commissions in

residential and nursing care. There should also be continuing monitoring of the ethnicity of all people in receipt of services to ensure there is equality of access to service for all older people and their carers.

5.0 Non-acute review of older people's services

5.1 The Committee has received the PCT's consultation document, and will be invited to comment in more detail at its February meeting. In summary, the consultation document sets out the case for change, and a new service model.

5.2 The case for change is summarised as:

- In response to the ageing population within Stockport we need to be able to provide more services in the future in order to better meet the needs of the increasing numbers of older people. We need to make best use of our resources to ensure as many people as possible can access services in the future.
- Most of the services currently provided in Stockport are either hospital or Intermediate Care beds. In fact, 82% of all places are provided in this way and this means we do not give enough choice to patients who prefer to be cared for in their own home and we do not do enough to promote people's ongoing independent living.
- Current services work well in many areas, but we do have problems in meeting demand for services which means that some change in necessary. Analysis has shown that up to 25% of intermediate care beds across hospital and community services could be blocked at any one time with people who could be discharged to their home or a community setting. However, community-based services are not always available to enable this.
- Many patients end up being admitted to a hospital bed in a short-term crisis due to a lack of alternative services. If alternatives such as more community support staff could be provided then a large number of inappropriate hospital admissions could be avoided.
- Voluntary organisations provide a large number of services to Stockport's older people. These services are popular but cannot be provided as widely as required due to resource constraints, and many of these services currently have long waiting lists.

5.3 Key aspects of the new model are to increase the level of support that will be available to enable people to be cared for in their own homes and reduce the number of services provided at Cherry Tree Hospital. Key components of the new model include:

- Developing an Enhanced Intermediate Care Rapid Assessment Service to provide speedy assessments for people who require access to Intermediate Care services.
- Increasing the number of places providing rehabilitation at home.
- Increasing the level of support for people who require rehabilitation/intermediate care within bed-based services. This includes the provision of Rapid Assessment Beds which will provide short term (maximum 72 hours) assessment and support people in crisis.
- Provide additional support to care homes to enable people to continue to be cared for in their normal place of residency.

- Increase the investment made with the voluntary sector to provide a range of preventative services.
- Closure of non-acute older people's wards at Cherry Tree Hospital.

5.4 The PCT is currently consulting on the new model, including with the Health Scrutiny Committee.

6.0 Future challenges for joint commissioners

6.1 On behalf of the review panel the Scrutiny Officer attended an LGC conference, *Joint Commissioning for Adult Services* in November 2006.

6.2 The Scrutiny Officer was asked to summarise the presentations made at the conference with a view to discussing current practice in Stockport and challenges for the future. The two presentations of most relevance are attached at Appendix Three for information.

7.0 Conclusions

7.1 Roundtable discussion with joint commissioners and representatives of the community voluntary sector assisted the Panel in drawing the following conclusions:

- The Panel is pleased that the evidence base for older people's services has been revisited since the *Background Paper* (2004) in order to support whole-systems analysis of non-acute health and social care services. The Panel recognised the important role of heath-needs analysis in supporting joint commissioning. The Panel was pleased to hear that the PCT recognises the much localised nature of deprivation in Stockport, and agreed that Practice-based Commissioning offers an opportunity to ensure that services meet the needs of local populations.

- The Panel heard that the Council and PCT do not share common data sets, but was satisfied that officers work closely to ensure joint commissioners have a shared understanding of local need.

- The Panel was pleased that an assessment tool for commissioning cycles had been used by partners to assess existing working practices, and that officers were aware of a new commissioning tool-book published by the Department of Health.

- The Panel questioned whether formal pooled budgets for joint commissioning (as in a model that was discussed in Barnsley Council) were necessary. The Panel heard that some pooled budgets do exist, for example for learning disability and equipment services, but that there was no current desire to pool budgets for older people's services. The Panel felt that it is possible to have a joint commissioning strategy without pooled budgets, as long as partner organisations are publicly signed up to a shared understanding of the local scenario, priorities and objectives.

- However, the Panel was concerned that shared baselines and targets had not been agreed for the Health and Well-Being Modernisation Group's work programme, attached at Appendix Two.

- The Panel felt that the role of carers was crucial. Officers from Stockport Signpost for Carers suggested that in 2000 carers in Stockport have saved the health and social care economy £11.5 million. The Panel also heard that future CSCI inspections will focus upon carers' needs.

- The Panel concluded with joint commissioners that a remaining piece of work was to attempt to comprehensively map out to different pathways and patient journeys that could occur, in order to better understanding effectiveness.

- The Panel felt that increasing choice creates dilemmas for joint commissioners. Within health, choice does not mean totally free choice, but choice within the resource available. However, the Panel could see the need for testing NHS conclusions about these levels of choice, and a particular need to ensure local people are involved in this process.

- The Panel felt that the public needs to be confident that choices offered are between providers of at least a minimum level of quality. The Panel agreed that there will always be variability of quality between different services, but was pleased to hear that from January 2007 the Council is receiving much more detailed information on domiciliary care and care homes in order to inform purchasing, and that the Council will not be able to purchase care from poor providers.

- The Panel felt that individual budgets were a potentially innovative way of providing choice and empowering service users. The local authority role would then be to ensure service quality and manage risk. However, the Panel recognised that many service users and carers may have anxieties about becoming employers and employees, and this needs to be managed sensitively. The Panel also recognised that this could create additional cost pressures, as many carers who currently provide care free of charge begin to be paid for their services.

- With regards to the non-acute review of older people's health and social care services, the Panel concluded that choice of residential and nursing homes was a major issue, especially if people do not want to be placed in certain homes. The full Committee had previously received information stating that:
  "A major system constraint lies in the lack of independent sector nursing home places… and residential home places. Available capacity is also skewed heavily towards residential places. Questions can be raised around the suitability of many homes following CSCI inspections. Home of choice is also a notable system constraint with many delayed transfers due to awaiting home of choice."

- The Panel was pleased that there was a clear aspiration within the proposals to re-develop services to invest in prevention, and in particular in the support provided by the voluntary sector. The Panel noted that

while local authorities increasingly provide services solely to people with critical and substantial needs, there is a need to ensure that people are supported in order to ensure they do not deteriorate into those categories.

Appendix One: Policy context for the provision of older people's health and social care services

Key developments over the last 50 years
Modern social care emerged from the 1948 *National Assistance Act*. This set out local authorities' responsibilities in broad terms, largely concerned with residential provision for persons who "by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them". Significantly, while health provision under the newly established NHS was free, the local authority was free to charge for social care services, which would be subject to means-testing.

From the late 1940s the idea of 'community care' emerged as a concept. By the 1950s a consensus had began to emerge about the preference of supporting older people in their own homes as long as possible, and a general shift envisaged from long-term hospital care to community-based alternatives.

By the 1970s the need to expand services for 'priority groups' in health and social care was an indication of how little development of community-based services had been achieved. A consultation document in 1976 set out objectives for achieving the redistribution of resources away from the acute hospital sector and into community services for older people.

From the 1960s onwards attempts to co-ordinate health and social care became evident and by the 1970s it was increasingly evident that the separation of health and social care services was problematic.

In 1989 the White Paper, *Caring for People*, led to major changes in the way social care was conceived. The White Paper declared that local authorities should be the brokers of social care, but not necessarily the providers. This led to huge growth in the independent sector.

The 1998 White Paper, *Modernising Social Services*, placed a new emphasis on prevention and rehabilitation, noting that existing policies had removed support from those receiving 'lower levels' of help. Targeting resources on people in greatest need inevitably led to a withdrawal of support at lower levels of need and raised the threshold for access to help and support. The White Paper acknowledged "This increases the risk that they in turn become more likely to need much more complicated levels of support as their independence is compromised." Additionally, achieving timely hospital discharges of older patients became a key goal.

The *Health Act* 1999 focused upon increased partnership working. New 'Health Act flexibilities' made possible pooled budgets, lead commissioning and integrated provision. These raised fundamental issues about the different basis for health and social care services. When services are developed through pooled resources it becomes increasingly artificial to maintain a distinction over which services are 'free' at the point of use.

The *NHS Plan* (2000) emphasised the development of intermediate care as a bridge between hospital and home. Intermediate care can look after people,

either in designated beds, or at home, to enable patients in hospital to get home sooner, or to prevent hospital admission in the first place.

The *National Service Framework for Older People* (March 2001) set out standards and a 10 year programme for health and social care.

Securing Better Mental Health for Adults (DoH, 2001) marked the beginning of a new initiative for mental health services. The report noted that mental health problems in older adults are common: present in perhaps 40% of GP attendees, 50% of general hospital patients, and 60% of care home residents. The key priorities in mainstream services are to change attitudes and improve skills in detection and assessment of mental illness, and equip staff with guidance on initial management and referral pathways to appropriate other services. The report also stresses the importance of specialist mental health services, and ensuring relations with the full range of partners, including working age mental health services (but also housing, the community and voluntary sector, etc).

Public Service Agreements (PSAs), implemented by the Government from 2001, included a specific aim to increase the number of people supported intensively to live at home to 34% of the total number of those being supported by social services at home or in residential care. Council's can access 'pump priming' money to meet PSA targets and, if successful, additional grants.

All Our Tomorrows, published by the Association of Directors of Social Services (2003), introduced the concept of 're-inverting the triangle of care' in order to make significant and sustainable improvements in the quality of life for older people. By 're-inverting the triangle of care' the ADSS meant that, historically, planning for services has focused on the acute tip of the triangle. Resources have been focused on those with the most severe needs. Future services need to reverse this trend by inverting the triangle so that the community strategy and promotion of the well-being of older people is at the top of the triangle and the extension of universal services for all older people is seen as crucial to all agencies.

The report stated that alongside recognising the vital role that older people play in our society and encouraging healthy lifestyles for older people, a joined up partnership approach to how services are delivered is needed to ensure integration of key services such as health, housing, social services, transport, leisure and lifelong learning, planning, regeneration and the environment.

In March 2005 the government set out, in a Green Paper (DoH 2005), its vision for the future of social care for adults in England (of all ages). This emphasised empowering people to 'choose' and improving people's well-being. The Department of Health announced that it would take forward the Green Paper by developing an integrated White Paper across social care and health.

Our Health, Our Care, Our Say (DoH 2006)
The White Paper *Our Health, Our Care, Our Say* (DoH 2006) set out a central tenet for older people's health and social care services: *'To move towards fitting services round people not people round services.'*

Four main goals were set out:

- Better prevention with earlier intervention.
- More choice and a louder voice for patients and service users.
- Tackle inequalities and improve access to community services.
- More support for people with long term needs.

Key issues raised by White Paper relevant to this report include:

Partnership working
- The development of outcome measures to apply to both health and social care, reinforced through consistent performance assessment and inspection.
- Aligning budgetary and planning cycles, including Local Area Agreements and Local Strategic Partnerships as a means of jointly agreeing priorities.
- Ensuring greater coterminosity (shared boundaries) for PCTs and local authorities.
- Greater integrated care (i.e. multi-disciplinary teams between PCTs and local authorities) and more extensive joint commissioning.

Better access to community services
- Direct payments will be increased and extended to other groups.
- Improving urgent access.
- The development of detailed plans for ensuring dignity in all care settings and particularly at the end of life; improved services for people with strokes, falls, dementia, multiple conditions and complex needs; and information technology for personalised care and promoting health active life, independence and well-being.

Support for people with long-term needs
Changing demography is increasing the number of people with long-term conditions. It is estimated that every decade the number of people with long-term conditions will increase by over a million. Proposals to address the implications are a key component of the White Paper.
- Helping people take control through Expert Patients Programmes, and encourage PCTs to place a stronger focus on commissioning self-care programmes.
- Better assessment and care planning. By 2010 the Government will ensure that patients and service users have integrated health and social care records with an integrated health and social care plan.
- A new deal for carers, and an Expert Carers Programme.

Care Closer to Home
The transition from hospital-based to community-based services is central to the White Paper.
- Increased investment in primary care is necessary to achieve this. The percentage of each PCT's budget spent outside the current secondary (hospital) sector will be expected to rise.
- For the 2008 planning round, PCT Local Delivery Plans will not be agreed unless there is a clear strategy for the development of primary and community care, including ambitious goals for the shift of resources rooted in the vision of the White Paper.
- The White Paper suggests the potential to replace acute bed days with less intensive beds in considerable. Acute beds could be released if better use is made of intermediate care.

- Accessible community facilities – a new generation of community hospitals defined as "a service which offers integrated health and social care and is supported by community-based professionals" will be established.

Patients and carers' priorities

Major consultation was carried out to support the White Paper which identified users and carers' priorities as:

- Helping people to make choices and take control of their own health and well-being and giving them more support to prevent ill-health and maintain independence and well-being.
- Easy access to services, information and advice which focus on health promotion, and not just sickness.
- Taking a holistic approach to well-being and health, rather than focusing on sickness.
- Cost effective and safe services closer to home.

Appendix Two: Current Health and Well-Being Modernisation Group work programme

OBJECTIVE: To continue to facilitate the delivery of services closer to home where appropriate and where possible.

ACTION & OUTCOMES

Task/Action	Outcome/indicator	Timescale	Performance Measure	Status
Intermediate care Address key issues facing intermediate care services	Future funding configurations agreed including specific access to services for older people with mental health problems Whole system plan for sustainable provision agreed and implemented *Reduction in bed days*	March 2006 2006/7	**Baseline:** **Target :**	IC Steering group working to establish a basket of indicators for IC
Continuing Care Review and clarify the governance arrangements for decisions affecting continuing care	Processes in place regarding; • Clarity over roles • Clarity over decision making processes • Consistent application of decision making processes	Nov 06	**Baseline: N/A** **Target: N/A**	Continuing Care Steering group convened. Action plan for project to be agreed at first meeting

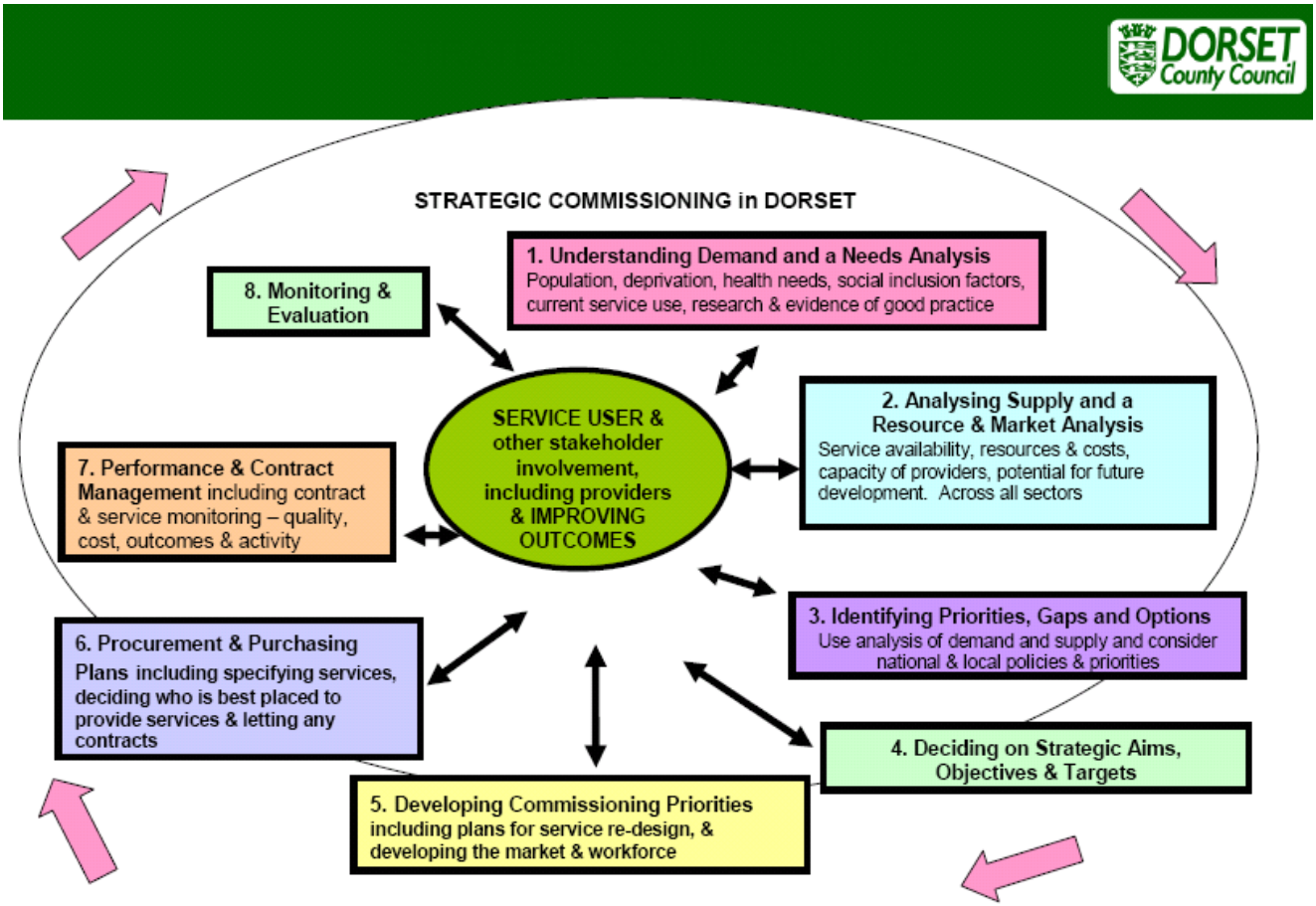
Task/Action	Outcome/indicator	Timescale	Performance Measure	Status
Mental health Implement the community model for mental health incorporating a liaison service in the hospital	New model will be operational and protocols for referral, assessment and treatment completed. *Reduction in bed days* *Reduction in emergency admissions*	Sept 2006	**Baseline:** **Target :**	Work is underway to: recruit staff to new posts in the CMHT, to incorporate the model into an over arching Commissioning Strategy, and to joint fund with the acute Trust a hospital liaison post. In patient bed days have already reduced as the beds are no longer available
Non-acute services Implement the outcomes from the review of non-acute services for older people	• intermediate care rapid assessment team established • re -provision of respite care agreed • rehab at home service transferred to community *Evidence of increased provision of, and access to, appropriate community based services.*	2008	**Baseline:** **Target :**	Targets and strategies identified and agreed in LDP as part of the Efficiency and Turnaround Plan.

Task/Action	Outcome/indicator	Timescale	Performance Measure	Status
Active case management Explore options to roll out Active Case Management to mainstream services (such as existing nursing teams)	Potential pilots for ACM to be delivered through mainstream services identified *Reduction in emergency admissions*		**Baseline:** **Target :**	
SAP Agree & implement protocols and pathways for Single Assessment Process	Protocols and pathways agreed and operational A training audit undertaken to establish training needs in relation to completing the overview assessment Adopt Best Practice Standards developed via representation on the multi agency NHS Connecting for Health - North West and West Midlands Cluster - Expert Reference Group for Older People		**Baseline:** **Target :**	The ESCR Programme has a supporting e-SAP Project underway. The second stage (development and planning 1) expects to be developed by June 2006 capturing data within a more flexible system.

Appendix Three – Summary of presentations

Data analysis and market assessment: Evaluating your community to ensure commissioned services meet their needs – Andrew Archibald, Dorset County Council.

Andrew's presentation set out the detailed commissioning cycle that has been developed for use in Dorset:



Andrew focused upon the first four steps of the Dorset model. Andrew stated that without such a cycle the risk is that commissioners make decisions on a reactive basis and pursue short-term financial objectives.

In carrying out needs analysis Andrew stressed:

- Drawing upon literature review and national guidance to establish existing information about which interventions work well and which do not.
- Carrying out population analysis to understand prevalence, deprivation, and social inclusion information.
- Drawing upon service activity, resources and costs, and existing provider capacity.
- Gathering stakeholder views.

In carrying out analysis of supply and market analysis Andrew stressed:

- Carrying out market mapping, identifying regional and national providers and drawing upon benchmarking information. 'Export

costs' should be considered, i.e. can external placements be brought back into the borough?
- Mapping existing contractual arrangements considering capacity, value for money, contract risks and quality.
- Resource analysis, including identifying decommissioning options.

In developing the strategy Andrew stressed the importance of:
- Making absolutely clear what it is that partners want to achieve.
- Setting out a vision and strategic aims.
- Identifying proposed models.
- Carrying out service design.
- Setting out a timeframe. Andrew discussed the importance of long-term planning. The next 2-3 years will see a period of adjustment, after which a leap is required.
- Analysis and testing of suggested models.
- The importance of putting this strategy before Council executive and scrutiny committees and Primary Care Trust Professional Executive Committees.

Andrew discussed the current dilemma between the ageing population and reducing finances. In this environment commissioners will be continually faced with issues of resources. Commissioners will need to 'dispel the myth of the burden'. This current environment offers a number of opportunities to work with communities who have increasing expectations of service quality. Commissioners will uncover individual citizens who will be able to contribute to the solutions. By doing this commissioners can contribute to social capital and improve health and reduce health inequalities.

Using procurement to modernise health and social care services – Andy Rust, Cornwall County Council
Andy's presentation focused upon the latter section of the commissioning cycle, 'doing'; procuring and market management.

Andy characterised the changing landscape for commissioners:

Moving from…	Moving towards…
• Services purchased by Councils • Traditional approach – legacy services • Narrow range of choice • Special relationships • 'Cottage Industry' – "small, inexperienced providers" • Intensification leading to consolidation • Workforce problems • Short sighted and ineffective commissioning	• Services purchased directly by consumers • Individual budgets – self funding • 'Menu' of services with clear tariffs • Wider range of care and support – wider choice • Independent brokerage, navigation, advice and advocacy – shifts focus from inputs to outcomes • Strategic procurement - framework agreements • No special relationships • Smarter commissioning

Andy set out the drivers for this change as increasing pressures upon services due to demographic change; services that need to meet the needs of individual who have purchasing power; increased need to carry out good practice procurement and market testing; and the context of transfer of services from the statutory sector to the independent sector.

Andy stressed the importance of communicating the demographic changes across the organisation within a medium-term financial strategy, which sets up the extra investment needed year on year. In addition, this should demonstrate the real costs of care, both in terms of the 'free' provision provided by carers and the voluntary sector, and the importance of social care to the local economy.

Andy explored how individuals will be able to decide with their money what care they want to receive and who they want to receive it from. Andy saw individual budgets as central to the future of commissioning of health and social care services.

Andy discussed the role of procurement as individuals choose services for themselves:

- The role for commissioners lies in ensuring individuals choose services in the context of a strategic framework which absolutely ensure quality and diversity.
- Commissioners will need to follow a systematic procurement chain, from joint specification of services, to tender, follow OJEC regulations to minimise risks from anti-competitive behaviour and maximise contestability.

In arguing that strategic procurement can be balanced with individual choice Andy stated that:

- Advertising the specification opens up the market.
- Framework Agreements provide overarching accreditation.
- Tendering provides Value for Money – value based model.
- Consortium bids or sub-contracting preserves range of service providers.
- In Control and Reach Standards ensure individual choice.
- Individuals and their families are supported to 'call off' from accredited providers on approved lists.
- Traditional social services' role changes to navigation/brokerage/ advocacy.

Andy discussed the challenges resulting from the eligibility criteria. Fair Access to Care Services is a national framework from the Department of Health which helps decide eligibility criteria for adult social care services. Local authorities are increasingly solely providing services for people who meet the critical and substantial bands (like Stockport Council). Key points included:

- While not reducing budgets, consolidating on to higher levels of need will have an effect on providers.

- Partners will need to create headroom for commissioning of services that prevent deterioration to higher bands. This will large take place in the voluntary sector.
- Commissioners will therefore have a role in supporting small providers to ensure quality and diversity while managing risk.
- Improved value for money can be achieved by switching from regulated and care managed services to non-regulated and non-care managed services. However, partners will need to ensure accreditation to guarantee standards

Andy concluded that the position was as 'clear as day':

- We can't go on as we are. Demographic changes, and consumers who are increasingly choosing services from the independent sector (with their own money) will drive change.
- Commissioning needs to be done by the procurement book - no more special relationships – service survival according to consumer choice.
- Enormous changes for the social care workforce – from doing to, to doing for.
- We need smarter commissioning. A sophisticated approach which draws upon value for money principles. Procurement will provide accreditation and specification to identify approved providers, and carry out market testing.
- There needs to be a clear distinction between regulation of Council funded services targeting high level needs and non-regulated service targeting low level needs.
- The regulation (of the Council) process will move from services to commissioning – quality and outcomes become the key matters for commissioners.

Andy recommended the following next steps:

- Analysis of population needs and impact of resource shortfalls on market – medium term financial planning – 3 year indicative funding agreements.
- Vision and clear objectives for services
- Specification of services within and out-with Fair Access to Care Services.
- Procurement to identify accredited providers.
- Development of broader preventive services.
- Involving individuals using services and citizens.
- Workforce planning.