SECTION 6

STRUCTURE OF THE PLAN

The Adult Plan relates to all adults over 18 years old, and those approaching adult life, and to all citizen groups (including carers). It will not only focus on shaping services which The Royal Borough will purchase, but on all adult residents. It will guide and shape commissioning activity giving agreement for service development, innovation and good practice. It will also stimulate the formation of new policy and revision of existing policy.

The focus of the Plan is on the delivery of adult social care services and it is therefore owned by and relates to The Royal Borough Adult Services. However, the nature of commissioning in a strategic manner to achieve outcomes associated with the well-being of the community cannot be achieved alone, therefore there is a need for this strategy to align with and influence the commissioning activity of the Primary Care Trust and regional and sub-regional bodies.

Primary responsibility for the development and delivery of the strategy will rest with the Commissioning Unit of Adult Services in partnership with operational and provider groups.

Although the general direction of travel for strategic commissioning will be defined in this plan, the strategy will be refreshed in three–year cycles. This will ensure the strategy to remain focused and to adjust with the growing body of evidence as it emerges, and in line with the current financial frame. Each iteration of the 3-year joint local delivery plans will provide the specific detail that cannot be shown within this long-range plan.

The initial 3-year joint delivery plans will sit alongside this Plan, identifying commissioning activity where there is:

- Need for urgent action, particularly regarding difficulty securing care
- Opportunities to test an approach to service delivery
- Partners seeking the chance to work together to achieve synergies
- Opportunities to test hypotheses that appear to have the potential to make a significant impact.

As well as setting medium term service objectives, the strategy will need to assist in financial planning timescales and processes. It is proposed and recommended that Learning & Care Directorate develops a Medium Term Financial Strategy (MTFS) that is reviewed each year as part of the budget cycle to create a rolling three-year revenue budget plan.

A Capital Plan may also need to be developed in detail using the same rolling three-year approach. This work on Strategic Commissioning will assist in reviewing and as necessary revising these longer-term financial plans.

The Government is committed to moving towards a three-year planning cycle for local government. So far this has been linked to the Comprehensive Spending Review (CSR) process. The Comprehensive Spending Review was

completed in 2007 and announcements have been made regarding funding over a three-year planning framework for 2008/09 to 2010/11.

The same Government planning process will address funding streams to our other partners including Health. It is anticipated that changes may be made as part of the CSR that might assist in better financial planning for partnership or integrated working.

The Commission for Social Care Inspection's new performance regime set out in 'A New Outcomes Framework for Performance Assessment of Adult Social Care' [2] seeks to test the viability of the strategy and inform the proposed detailed 3-year joint delivery plans necessary to achieve the outcomes.

There are a number of cross cutting themes identified within this Plan that will need to be addressed in each of the three year joint delivery plans. The following have been identified but this is not seen as an exclusive list:

- Advocacy
- Assistive technology/Telecare & Telemedicine
- Care Breaks/Respite
- Day Opportunities
- Dignity in care
- End of life care
- Health & Well-being
- Housing and Accommodation
- In-control – Individual Budgets
- Safeguarding adults
- Single Assessment Process/Common Assessment Framework
- Transition Services (16-25 year olds)
- Workforce Development

SECTION 7

THE ASSUMPTIONS AND CONTEXT FOR FUTURE COMMISSIONING

In order to take a long-term perspective, it has been necessary to state a number of working assumptions to underpin the strategy. Over such a long period a range of unknown variables are likely to impact on the social care market. These could include unexpected central government policy changes, significant changes in the patterns of private sector investment or a change in the expectations of the public. These assumptions and context can be grouped into six main headings:

- Demand and Demographics
- Health Profile
- Financial
- Commissioning and Procurement Approaches
- Policy and Legislation
- Promoting Community Well-being and Sustainability

Demand and Demographics

The introduction to Section 8 deals with the population needs of The Royal Borough. However, the demand for care services will continue to grow due to the demographic trends affecting The Royal Borough. There will be particular growth in the number of older people and, within that, the numbers of older people with more complex needs.

There will also be growth in the number of adults with complex long-term conditions including those with a learning disability.

Expectations relating to the quality of services are increasing and people are already beginning to demand choice and control over their services.

Services will increasingly deliver to outcomes that are defined by citizens.

We know there will be many more older carers and we are already beginning to see the emergence of younger carers who are either caring for siblings or adult relatives. We can anticipate that there will be further legislation that will seek to continue to enhance their rights and give consideration to their needs.

There will be an increasing number of older people with mental health problems and their needs will be met predominantly through mainstream services where possible, rather than through discrete/specialist services.

Health Profile

Windsor & Maidenhead at a glance

- The health of people in Windsor and Maidenhead is better than the England average. Most indicators are better than the average with the exception of binge drinking, adult physical activity, drug misuse, hip fractures and infant deaths, which are similar to the England average.

- Although relatively affluent by national standards, there are health inequalities with the borough by location, gender, income and ethnicity. For example, Boyn Hill and Furze Platt wards are relatively deprived, an men from the most deprived areas have a 3.5 years shorter life expectancy than those in the least deprived areas.

- Over the last ten years, all age all cause mortality has decreased for both men and women and is better than the England average. Early deaths from cancer and from heart disease and stroke have decreased in this period and remain better then the England average.

- Although the death rate for smoking is lower than the England average, smoking continues to account for 200 adult deaths per year. There are also an estimated 410 drug users living within the borough.

- The Annual Public Health reports will provide further details of the health of the borough and will be used to inform the Joint Local Delivery Plans.

Financial Assumptions

The financial impact on the Council will depend on a range of factors set out in the section above and decisions taken about the care models put in place to meet these needs and the way in which services are funded when someone has a right to publicly funded services. How much they will contribute towards these services will also affect the net cost.

The Wanless Review [28] attempted to project the future costs of social care for older people up to 2026. Using current service provision models, this projects an increase of 139% in the gross cost of provision. Of this increase, 50% is accounted for by an assumed 2% per annum real increase in the unit cost of care compounded over the period. The Review looks at other more generous service models which could increase costs further and different approaches to the way the country could fund such models, including the share between public subsidy and private means.

The challenge set out in the Review is whether the country can afford these increases which would represent a significant rise in the proportion of Gross Domestic Product (GDP) committed to care, and how it should be funded. If the outcomes of the latest (Sept 2007) Comprehensive Spending Review are anything to go by then times are going to be tough for those local authorities who have responsibility for social care services.

Whatever the uncertainties in the projections, the messages are clear – numbers, unit costs and service expectations will all lead to significant increases in overall costs. The indications are that there is unlikely to be significant change in the expectation that individuals with means will continue to fund some or all of their social care needs.

Assumptions about Purchasing and Procurement Approaches

The current purchasing and procurement arrangements will not remain fit for purpose in the context of this long term Adult Plan. The model of block contracting whilst supporting the development of capacity and stability in the social care market does not fit easily with Individual Budgets and more people having the cash to pay for their care.

The market will be more fully understood following completion of our planned comprehensive market analysis, as set out in Section 8.

There will be greater efficiency to be gained by better contracting and procurement practices and this will be tested early within the first joint local delivery plans.

Commissioning will need to be undertaken jointly with a range of partners and in particular with the Primary Care Trust and collaboratively with other Local Authorities

Whilst our current relationships with service providers are generally strong and positive we will need to take a further long term look at how we work together and collaboratively, and by looking at how those relationships may have changed in those authorities involved in the In Control pilot sites.

The council has already started to involve citizens and carers in the commissioning and tendering process as this offers them a significant opportunity to influence service design and help commissioners to get it right. Initial progress has been made in Learning Disability services where citizens and carers have been more fully involved in service redesign, particularly around changes to day services and independent living.

Policy and Legislation Assumptions

The White Paper '**Our health, our care, our say**' [23] is a statement of policy that is likely to remain in place for a number of years. It appears to have a broad consensus amongst the political, academic and professional communities, and the support of citizens and representative organisations.

It is likely that the Green Paper on Adult Services announced by the Government in October 2007 and promised for late 2008 will strengthen the local authority's role as a commissioner of services rather than being a provider. This would have little impact upon The Royal Borough as we already commission more than 90% of care with the independent and private sector.

The present legal framework for community care appears unlikely to change except for specific legislation to support moves towards more Direct Payments and Individual Budgets.

The Wanless Report supports the view that the present ‘mixed economy’ of funding patterns between the state, the private individual and local government are likely to continue.

The regulatory framework, as well the market, will increasingly favour those organisations who can demonstrate they can deliver improved outcomes to individuals. This will include organisations that commission services as well as those who provide them.

Promoting Community Well-being and Sustainability

The Council will continue to develop its role as community leader and ‘place shaper’ as envisaged in the Local Government White Paper ‘Strong and Prosperous Communities’ [29]. This approach requires the securing of effective strategic partnership arrangements to support and sustain community wellbeing.

The Council is also required to promote sustainable development, working with the private and third sector to achieve this by supporting, promoting and developing the boroughs economy, skills and infrastructure. The care industry in The Royal Borough is yet to engage in this and we need to persuade them that they have a major role to play in achieving this both as investors and employers.

Adult Services, in fulfilling the new statutory role of the Director of Adult Social Services, will have extended responsibilities to secure the care, support and well-being for all adults regardless of their eligibility for direct service provision. The planned Joint Strategic Needs Assessment will both support and enable this as it begins to shape the commissioning of services over the next few years.

Commissioning for inclusion will contribute to the sustainability of local communities by maintaining and supporting their natural diversity. Older people, people with physical and sensory impairments, people with learning disabilities, those with mental health problems and people involved in caring will be able to access ordinary community facilities as well as the health and social care support they need, tailored to their personal outcomes.

SECTION 8

MARKET ANALYSIS (SUPPLY AND DEMAND)

This section describes in some detail the nature of the care market in The Royal Borough – this is defined as both the available supply of care provision and support, and the demand placed on this by the needs of the population. It includes a section on the expectations of citizens and carers, as we anticipate that the structure of the market will be increasingly determined by the citizen and not only those whose needs are assessed by the local authority. It is becoming clear that people will also expect to have their needs and wishes met as equal citizens, exerting choice and control over the way they wish to live their lives. We also need to provide an overview of the workforce available to meet citizens' needs.

There are six main sub-sections in the analysis:

- Population needs analysis for older people, learning disabilities, autism, aspergers, mental health problems, physical disabilities, and sensory impairments.
- Citizen expectations
- Carers expectations
- An analysis of the provider market
- Workforce
- Information from current commissioning strategies and consultation events

A wide range of data has been accessed in shaping this plan, including District-level Public Health Observatory information along with partner organisations strategies and other data sets to inform this analysis.

It is recognised that ongoing analysis and interpretation is required of this data. It is proposed that this will be undertaken as the implementation programme emerges.

Royal Borough Profile

The Royal Borough of Windsor and Maidenhead is a dynamic and diverse area, with much to offer residents, visitors and those who work here. Although 83% of The Royal Borough is designated Green Belt, it is relatively densely populated with 687 people per square kilometre compared to 424 for the South-East Region. Most people live in the two urban centres of Windsor and Maidenhead, with Maidenhead being twice the size of Windsor. There are fourteen rural parishes, one of which includes Ascot, The Royal Borough's third town, and Eton Town Council, with similar status to a parish council.

The Community Strategy is based upon a clear vision for The Royal Borough, **"We want The Royal Borough to be a place where everyone can thrive in a safe and healthy environment, take an active part in decisions and continue to learn and develop throughout their lives".** This was developed through extensive consultation with partner organisations, stakeholders and local residents.

8.1 Introduction to The Royal Borough Population Needs Analysis

Population figures are often considered as mundane and simple. In reality, they are usually complicated and controversial and have a wide range of implications, not least in relation to funding issues. They are fundamental for many purposes including: resource allocations, epidemiological analysis, planning, and equity audits. The simple question of what is our current population will legitimately yield a range of different answers from circa 134,000 to 138,800 which is a 3.5% variance between these different sources, therefore future projections pose similar difficulties. Defining the number of people in a population is a technical process which is quite complex. For the purpose of this analysis in the Plan we have used two official data sources - Office for National Statistics (ONS) and Projecting of Older People Population Information (POPPI), which is operated through the Department of Health.

Revised figures have been issued nationally on estimates of in-migration from accession countries joining Europe since May 2004, with estimates of 150,000 extra in the first three years into the United Kingdom. Some figures derive from registrations for work or allowances. This has led to an increase by ONS of the total national population, but this has not yet been attributed at lower levels. The fundamental problem is differentiating between those who come and go and those who stay.

The total population has fallen within The Royal Borough since 1991 and following the 2001 Census it was predicted that this trend was set to continue during the early years of this millennium due to the falling birth rate. However, mid term estimates published by the ONS for 2006 show that the population may have actually risen by around 3.8% between the years 2001 and 2006, and that by 2020 this would have increased by 11.13%.

The Royal Borough has the greatest proportion of people aged 65 years or over in Berkshire (circa 15.2% compared to 13.11% as an average across the four comparable neighbouring local authorities) and is predicted to grow by around 27.6% between 2001 and 2020. Also The Royal Borough has the greatest proportion of over 85 years in Berkshire (circa 2.08% compared to 1.75% as an average across the four comparable neighbouring local authorities), which is predicted to increase by over 24% by 2020.

This increase is bound to have significant implications for health and social care. This knowledge has led to a shared focus on the needs of older people by the council and its partners.

POPULATION PROFILE TABLE THE ROYAL BOROUGH - source ONS/POPPI				
Age Profile	2001 (actual)	Mid-year (estimated) 2006	2020 (estimated)	% change 2001 -2020
0 – 9	16,174	16,700	18,000	+11.3%
10 – 14	8,557	9,100	9,300	+8.7%
15 – 19	7,806	9,600	9,000	+15.3%
20 – 49	55,935	57,000	60,600	+8.3%
50 – 64	24,622	25,300	25,400	+3.2%
65 – 84	17,949	18,400	22,200	+23.7%
85+	2,583	2,700	4,000	+54.8%
Total population	133,626	138,800	148,500	+11.13%

Note- Figures for 2006 and 2020 may not sum due to rounding

The population is generally affluent, healthy and mobile. 55% of households are employed in either the professional or managerial/technical social classes compared to 38% in Great Britain. However, there are pockets of deprivation in some wards (Oldfield; Clewer's North and South; South Ascot; Horton and Wraysbury; Hurley and the Walthams; Datchet) and the general high standard of living can mask these. All partners work together to redress some of this imbalance through joint projects in the community.

Ethnicity

People from black and minority groups comprise 7.6% of the total population. This is the third highest proportion in Berkshire after the urban areas of Reading and Slough. About 4.6% of the total population have Asian or Asian British ethnic minority backgrounds, 1.7% Irish backgrounds and 0.5% Chinese backgrounds. There are three wards in Maidenhead where over 10% of the population are from BME groups. The proportion of pupils from ethnic minority backgrounds in The Royal Borough's schools is 15.6%. In some schools this figure is much higher - in one school 75% of pupils have a Pakistani ethnic minority background.

Health

The overall state of health is better than the national average and continues to improve. Life expectancy from the age of 65 years continues to increase and was 79.3 from 1998 to 2002, the same as the figure for the south-east region. However, life expectancy differs between the different incomes groups, especially for men.

	RBWM	England Average
Life Expectancy at Birth Males	78.6 Years	77.3 Years
Life Expectancy at Birth Females	82.7 Years	81.6 Years

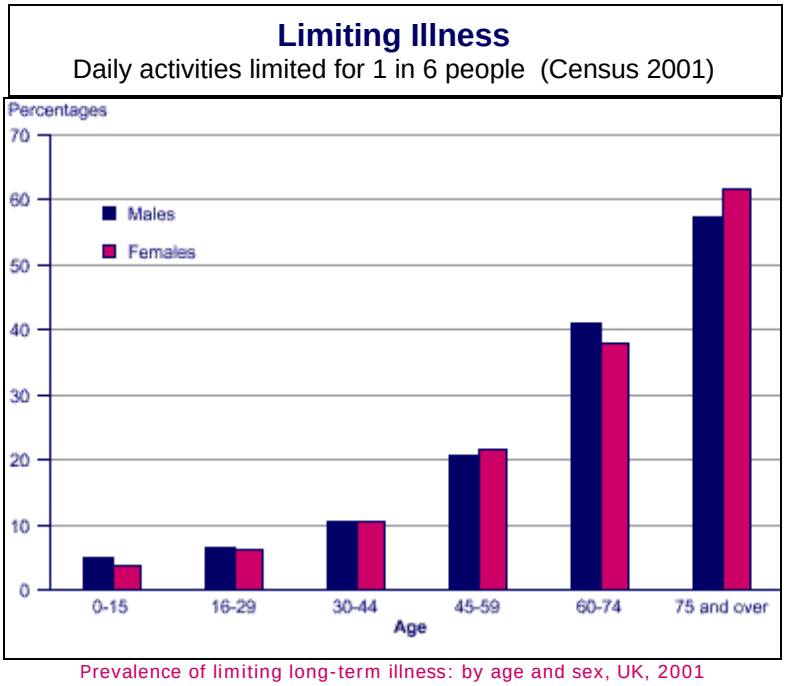
This data is from the November 2007 Health Profile for The Royal Borough, which is produced by the South East Public Health Observatory and facilitated by the NHS.

Whilst there is an increase in life expectancy not all of the 'extra' years are necessarily spent in good health. The difference between life expectancy and healthy life expectancy can be regarded as an estimate of the number of years a person may expect to live in poor health. In England in 1981 the expected time to live in poor health from the age of 65 years for a male was 6.5 years and females 10.1 years. By 2001 this had risen to 8.7 years for males and 11.6 years for females.

Whilst residents in The Royal Borough have much healthier lifestyles than in other areas of England only 1 in 8 adults take the recommended level of physical activity. A national study from Age Concern England (2006) found that only 17% of females and 25% of males aged over 65 partook in enough levels of activity to benefit their health.

Although death rates from heart disease, cancer and smoking are low compared to the England average, cancer still accounts for circa 300 deaths a year, heart attacks circa 250 and strokes around 150.

Long-term illness rates are lower in The Royal Borough than the national average as are hospitalisation rates.



Prevalence of limiting long-term illness: by age and sex, UK, 2001

In the 2001 Census, one in six people in the UK (10.3 million) living in a private household reported having a limiting long-term illness (LLTI). There was a steady increase in rates of LLTI with age for both males and females. Below age 30, rates were less than 10 per cent but were more than twice this for those aged 45 to 59. Rates virtually doubled again at ages 60 to 74, reaching 41 per cent for men and 38 per cent for women.

Neighbouring Authorities Comparison (ONS 2001)

	Population	With a Limiting Long-Term Illness	%	With a Limiting Long-Term Illness and Working Age	%
Bracknell Forest	109,617	12,864	11.74%	6152	8.63%
Reading	143,096	19,315	13.5%	8993	9.47%
Slough	119,067	17,013	14.29%	8244	10.77%
West Berkshire	144,483	17,911	12.4	7886	8.57%
Wokingham	150,229	16,426	10.93	7321	7.52%
Windsor and Maidenhead	133,626	16,803	12.57%	6584	7.9%
England	49138831	8809194	17.9%		
South East	8000645	1237399	15.5%		

Top ten causes of death, RBWM Unitary Authority, 2006

Disease by gender	Rank	South East rank
Ischaemic heart diseases - F	1	2
Ischaemic heart diseases - M	2	1
Pneumonia - F	3	7
Ischaemic heart diseases other than myocardial infarction - F	4	5
Cerebrovascular diseases - F	5	3
Malignant neoplasm's of digestive organs - M	6	6
Cerebrovascular diseases - M	7	8
Ischaemic heart diseases other than myocardial infarction - M	8	4
Stroke, not specified as haemorrhage or infarction - F	9	10
Pneumonia - M	10	15

(Source: Joint Strategic Needs Assessment 2008)

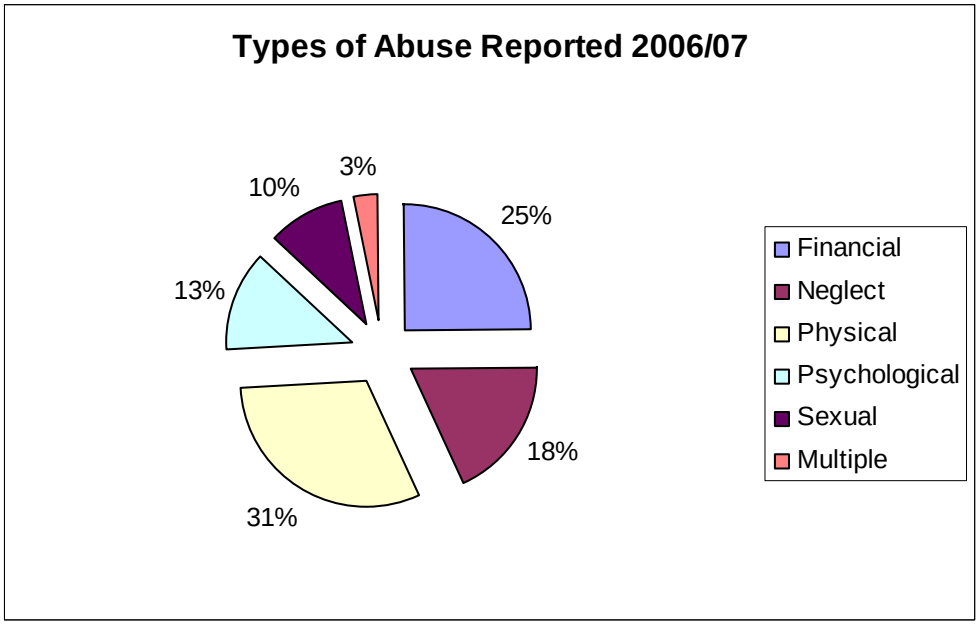
8.2 General Information

The Access Team is the first point of contact for people with an enquiry regarding older people, carers, sensory impairments and physical disabilities.

Access Team Data			
	2004 / 05	2005 / 06	2006 / 07
No of Calls In	15,314	16,837	15,131
Average Weekly	294	324	291

They are also the first contact for any adult protection concerns that are raised. When a vulnerable person is reported as being abused or at risk, The Royal Borough has the responsibility of coordinating the investigation with key partners who may need to be involved. All of the people who receive social care in The Royal Borough are entitled to this protection, whether they are a citizen of the Council or not**.**

Protection of Vulnerable Adults		
	2006 / 07	2005 / 06
Number of Vulnerable Adults Recorded	69	74



Assistive Technology

Assistive technology (also known as telecare or telemedicine) is as much about the philosophy of dignity and independence as it is about the equipment and services. Equipment is provided to support the individual in their own home and tailored to meet their needs. The different types of equipment that are covered by the term assistive technology can range from community alarms that can be used to summon help in an emergency to a fully wired “smart home” that can sense if someone has fallen, wandered, left the fridge door open or the gas on, and so on. An additional advantage is that telecare can be used as a preventative method, as it can provide early warnings of deterioration that prompts responses from family and friends.

With telecare / assistive technology being a relatively new development for social care the figures for use do not have the same historic data as other services. In 2006/07 the number of people in The Royal Borough who were aged 65 or over and had 1 or more items of telecare in their home was 1,116 people. This has been achieved through the work of the council and other agencies, such as housing associations. For private residents in the community (not attached to housing associations or other forms of supported tenure) 146 people are receiving this service. The Royal Borough has plans to actively encourage and support the use of assistive technology for all citizen groups throughout the duration of this Adult Plan.

8.3 Population Needs Analysis: Older People

This section provides a summary of the detailed population needs analysis of older people in The Royal Borough. From this analysis we can identify the key factors that need to be taken into account in planning future service provision.

Numbers in The Royal Borough

In 2006 the total population of The Royal Borough was 138,800 people, of which the ONS estimated 21,100 were aged over 65 years. The Royal Borough's own GIS Team (Geographical Information Systems) conducted their own population analysis and produced the figure of 20,253 people aged 65 and over. Using ONS data the over 65's make up 15.2% of the population, whilst the GIS Team's numbers equate to 14.6%, the contradictory figures allude to the earlier mention regarding the difficulty of obtaining accurate population data, However, both figures are approximately in line with the national figure of 16% of the English population being aged 65 years and over. Future projections and demographic changes for 2020 show that of a total forecasted population of 148,500, the number of people aged 65 and over in the year 2020 is 26,200, which is 17.64% of the population. Whilst this may seem like a small number, this actually represents a growth of 24.2% in the older population between 2006 and 2020.

By 2020 the number of people aged over 85 will represent approximately 2.69% of the population, an increase from 2.08% in 2008. It is people in this age range that are the most likely to require support of some kind to enable them to maintain a reasonable quality of life.

<u>Living Alone</u>

Older people who are living alone may be at risk of social isolation, particularly if they have difficulty with transport, few family or friends close by or live in a rural area. The problem of social isolation is very relevant to having a good quality of life and can be a trigger of depressive illnesses and other mental health concerns in older people. As a consequence, community based services that promote social inclusion and enhance wellbeing are just as vital to the older community as those services that deliver personal care needs.

In addition to social isolation, older people who are living alone may not have the social links that co-habiting older people do. This means that there may not be someone there to assist that person in a caring or practical support role. Informal or family carers often assist older people in day-to-day tasks. People who live alone are unlikely to have that support to hand and may need to have those care and support services provided.

Numbers of Older People Forecasted to be Living Alone

	2008	2010	2015	2020	2025
Males aged 65-74 living alone	884	901	1,003	1,003	986
Males aged 75 + living alone	1,120	1,176	1,288	1,400	1,624
Females aged 65-74 living alone	1,881	1,947	2,211	2,211	2,112
Females aged 75 + living alone	3,717	3,776	3,953	4,248	4,779
Total population aged 65-74 living alone	2,765	2,848	3,214	3,214	3,098
Total population aged 75 and over living alone	4,837	4,952	5,241	5,648	6,403
Total population aged 65 and over living alone	7,602	7,800	8,455	8,862	9,501
People aged 65 and over living alone as a percentage of the over 65 population	36.02%	35.77%	35.37%	35.73%	36.26%

Information from POPPI, based on Census Data and population forecasting

State Pension

The following table details the number of pensioners in The Royal Borough receiving state pension and other state benefit. The figure that is used as the population varies from the other population information as it is for pensionable age, being women aged 60 and over and men aged 65 and over. The other state benefits that are included for this analysis are for example, incapacity and disability, but does not include housing benefits. It was not felt that projecting these figures would be reliable, therefore this is a current picture without forecasting ahead.

Pension and Benefit	No. of Pensioners
Total population of a pensionable age	25,130
Total receiving state pension only	19,260
Proportion receiving state pension plus one other benefit	23.36%
Proportion receiving state pension only	76.64%

Note that the information regarding other personal income streams for the population is not widely available. This information shows that whilst there is a perception of the Borough being affluent in terms of buildings and residences, the actual income that older people have may be lower than people would expect. Thus, many older people may be considered capital rich, but cash poor.

Transport

Having the use of personal transport can greatly enhance peoples wellbeing and quality of life. From the Census 2001 data, the number of households (rather than people) where there is someone of a pensionable age and their access to personal transport is shown in the table below. The criteria for inclusion was being of a pensionable age, therefore it is 60 years for females

and 65 for males. This information is accurate as of the Census data, however the projection of this information into future years was not considered to be reliable due to the individual nature of the topic.

Transport	Pensioner Households
Living alone with transport	3,278
Living alone without transport	3,917
Not living alone with transport	4,558
Not living alone without transport	671

The Borough and its partners have a strong commitment to ensure that public transport facilities are suitable for all residents and their needs. For older people the free bus pass service is supplemented by a concessionary fares scheme, which gives additional financial support to those who are not able to use bus services and do not have other means of accessing transport services.

Demand on Services (based on 2007 data)

Councils with Adult Social Services Responsibilities (CASSR's) have to report on the levels of activity that takes place each year. Based on historic data of previous performance, the table below shows how those figures have been projected to the year 2025. This information is from POPPI

Number of people helped to live at home supported by the Council

	2008	2010	2015	2020	2025
Number of People Helped to Live at Home	1,772	1,831	2,008	2,083	2,201
Of which Receiving Intensive Homecare*	186	192	210	218	231

**Intensive Homecare - having 10 hours or more of care and 6 or more visits per week*

Community Based Services

There is a range of services that take place in the community, and these vary from formal day services to social lunch clubs. Often being a member of one of these groups gives information to older people about services and other community information, whilst providing essential networks that promote friendships and reduce isolation. There are many different styles of day services that can be accessed, including those that have a particular focus to do with a condition or topic. Information regarding membership trends combined with population projections allows us to forecast the number of people that the council will be supporting to access community services.

	2008	2010	2015	2020	2025
No. of older people receiving community based services provided or commissioned by the Council	2,393	2,472	2,710	2,812	2,971

Residential Home Establishments

Sometimes people require a higher level of support and care than can be provided for in their own homes, often leading to entering residential services, either care or nursing homes. People who are eligible can receive financial support from The Royal Borough, however often people have enough capital to fund their stay in the residential home, these people are often referred to as 'self-funders'. The following data has been collated by POPPI and is from the Census data 2001 which asked about place of residence and projected to 2025.

Residential Care (Nursing and Residential) Places in RBWM, for the over 65 year's

	2008	2010	2015	2020	2025
Total People Aged 65 and over in a residential care establishment	706	742	820	897	1,023
Of which, number of places provided or purchased by RBWM	314	325	356	370	390
Number of *new admissions to residential services* per year provided or purchased by RBWM	66	69	75	78	83

Everyone is entitled to have an assessment of their care needs, and this involves a Care Manager completing an assessment of a person in their own environment to see how they manage. Below are the numbers of completed new assessments that have taken place for the last three years for people aged over 65 and by their primary diagnosis of need (Ref POPPI)

Number of Assessments for Older People, by primary need

	2004/05	2005/06	2006/07
Physical Frailty / Disability	1,452	1,127	1,348
Sensory Impairments	Data unknown	100	57
Mental Health	69	40	36
Dementia	33	27	50
Learning Disability	2	0	1
TOTAL	1,556	1,294	1,492

The increase between 2005/6 and 2006/7 is 15.3% or 198 more people in the year. Whilst not everyone who has an assessment goes on to receive care that is provided by the Local Authority, this does show that there is a resource pressure in the time spent on assessments that is not reflected elsewhere.

Whilst the number of people in the future who may need assessments has not been projected from an authoritative source, the 2006/07 figure of 1,492 older people who are new to services and have been assessed represents 7.1% of the older population based on the 2006 information above sourced from the ONS

Applying this percentage to the future population forecasts from officially recognised sources gives the following data trend as an approximation for the number of referrals likely to occur in future years.

Future Forecast for Number of Referrals for Social Care (Over 65's Only)

	2008	2010	2015	2020	2025
Population aged 65 +	21,100	21,800	23,900	24,800	26,200
Number of New Referrals	1,498	1,548	1,697	1,761	1,860

This shows that there could be an estimated increase of 17.56% in the number of referrals between the years of 2008 and 2020.

Policy Implications

- Increased investment into preventative services in order to prolong independent living for older people as far as possible
- More investment into services in the community that address a social inclusion demand, in order to prevent isolation and related depression
- Further development of the joint Health and Social Care rehabilitation services in order to facilitate timely discharges from hospital and to prevent hospital admissions and avoid or reduce premature reliance on long-term social care
- Encourage the take up of Direct Payments and Individual Budgets by older people to increase the choice and control older people have over their care packages
- To have a joint day services strategy that encompasses the needs of the community
- Need to invest in temporary low level intervention support for people who have had a life changing event (i.e. bereavement)
- Increase the use of minor aids & adaptations
- Increased use of assistive technological equipment that promotes independent living
- Work with the providers of all services in order to maximize the value and quality of services
- Increase the awareness of services in the Borough and target resources effectively for those who are eligible, including hard to reach and minority communities
- Commission services that are reflective of central government guidance, local needs and support the care services markets accordingly

8.4 Population Needs Analysis: Older People's Mental Health

Older people's mental health is an increasingly important area of public policy that does not get the attention it deserves. Three million older people in the UK experience symptoms of mental health problems that significantly impact on the quality of life and this number is set to rise by a third over the next 15 years. This represents an enormous cost to society and the economy, in direct costs to public services and indirect costs in lost contributions from older people who boost the economy by over £250 billion each year as workers, volunteers, unpaid carers and grandparents.

Providing services for people with mental health needs can be complex, as they cut across health and social care, physical and mental health and mainstream and specialist services. Making sure that people's needs are met in a co-ordinated way, and that they don't fall between gaps in the system. The range of mental health problems experienced in later life is very wide. It includes depression, anxiety, delirium (acute confusion), dementia, schizophrenia and other severe mental problems.

Depression

Depression is the largest mental health condition in older people and is much more common in the years after, retirement, when people may struggle to adjust to a new role and routine in life.

Number of older people predicted to have depression / severe depression

	2008	2010	2015	2020
65+ predicted to have depression: lowest estimate	2,170	2240	2490	2620
65+ predicted to have depression: highest estimate	3,255	3360	3735	3930
65+ predicted to have severe depression: lowest estimate	651	672	747	786
65+ predicted to have severe depression: highest estimate	1085	1120	1245	1310

- Depression affects over 1 in 4 people over the age of 65 and is severe enough to warrant intervention and is largely a neglected area (www.careandhealth.com)
- Depression is also the leading risk factor for suicide. Older men and women have some of the highest suicide rates of all ages in the UK.(www.careandhealth.com)
- By 2051 there could be as many as 5 million older people with depression
- Depression affects three times as many older people as dementia (Mental Health and Older People Forum)
- A third of people who provide unpaid care for an older person with dementia have depression.
  (Age Concern – Improving Services and Support for Older People with Mental Health Problems)

Dementia

In 2007 it was predicted that around 1 in 4 people aged over 85 will have a significant degree of dementia. This means of the circa 1000 new to the 85+ age group in the year 2020, around 250 will have a dementia or memory related problem.

Number of older people forecasted by year to have dementia, by age and gender

	2008	2010	2015	2020	2025
Males Aged 65-69	42	44	51	44	48
Males Aged 70-74	74	74	78	93	81
Males Aged 75-79	97	97	102	107	128
Males Aged 80-84	122	133	143	153	163
Males Aged 85+	177	197	235	276	335
Total Males 65+	513	544	610	672	754
Females Aged 65-69	30	32	38	33	34
Females Aged 70-74	65	65	70	82	72
Females Aged 75-79	156	156	156	169	202
Females Aged 80-84	253	253	266	279	293
Females Aged 85+	504	529	580	633	706
Total Females 65+	1.008	1,035	1.109	1,193	1,306
Total Population 65+	1521	1,579	1,719	1,865	2,060

- The above table from POPPI demonstrates that we can estimate a 35% increase in the total number of people with this condition between 2008 and 2025 in The Royal Borough.
- Dementia costs the health and social care economy more than cancer, heart disease and stroke combined.
- Fewer than half of older people with dementia ever receive a diagnosis.
- Delirium or acute confusion affects up to 50 per cent of older people who have operations.

  (Age Concern – Improving Services and Support for Older People with Mental Health Problems)
- Older people with a learning disability have an increased vulnerability to early onset dementia

Dementia is an illness that mainly affects older people and is a progressive in nature. The Alzheimer's Society state that generally one quarter of people aged 85 and over will have the condition, and that increases to one third of all people aged 90 and over. Statistics from the Medical Research Council's Cognitive Function and Ageing Study in 2002 are considered one of the most reliable sources of UK data, and have been applied to the projection of the populations from POPPI to identify the forecasted number of people aged 65 and over who are predicted to have this condition.

Demand on service (based on 2007 data)

Mental Health (not including Dementia)

- In 2006/7, 160 older people (65+) received social care provision. This is 0.76% of the over 65's.
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will increase by circa 24% for the 65+ age group.

Dementia only

- In 2006/7, 89 older people (65+) received social care provision. This is 0.42% of the over 65's.
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will increase by circa 23% for the 65+ age group.

Total

- In 2006/7, 249 older people (65+) received social care provision. This is 0.12% of the over 65's.
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will increase by circa 26% for the 65+ age group.

Policy Implications

- Provision of home treatment and crisis service, to prevent admission, reduce re-admission and support early discharge, thereby offering more choice and control.
- To expand direct payments schemes where appropriate to enable more choice for older people who use mental health services.
- Maintain provision of specialist residential nursing care, home care, respite care and long term placements for those with enhanced need, such as dementia
- Accommodation provision for the MHTOP to operate from one site
- Increase the provision of specialist day care services for older people with mental health problems and dementia
- Increase the provision of specialist day care services for Young People with dementia
- Provision for recruitment to deliver strategic priorities
- Expansion of extra care and help with housing related support (for example helping people to maintain their independence to stay safely in their own home).
- Offer more respite care and carers assessments to support carers and their families
- Access to mental health services should be based on need not age.

8.5 Population Needs Analysis: Learning Disabilities

This section provides a summary of the detailed population needs analysis of people with a learning disability in The Royal Borough. From this analysis we can identify the key factors that need to be taken into account in planning future service provision.

Numbers in The Royal Borough

- Around 330 people with a learning disability receive social care services through the community team
- National statistics indicate that there are many more people with mild to moderate learning disabilities who live in the borough who do not need to access social care services
- By 2020, in the UK there will be around 2.5% more people with mild learning disabilities. This will total approximately 1.8m people
- This will mean that within The Royal Borough there could be as many as 3,700 residents who have a mild learning disability (using 2.5% prevalence assumptions) an increase of 300 (circa 9%) based on 2006 estimates

Population with mild/moderate learning disabilities	2006	2020
	3470	3710

Valuing People 2001 suggests a prevalence rate of 2.5% of the population have a mild to moderate learning disability

- By 2020, using the Valuing People projection of 1% increase per annum, there will be around 638 people with severe learning disabilities living in The Royal Borough, an increase of 83 (15%) based on 2006 estimates.

Population with severe learning disabilities	2006	2020
	555	638

Valuing People 2001 suggests a rate of 0.42% of the population have a severe to profound disability

Older people with a learning disability

Those who live beyond 50:

- Have an increased vulnerability to early onset dementia
- Are at greater risk of cancer and circulatory diseases
- Are at greater risk of clinical depression
- Are at greater risk of respiratory disease

Demography

- People with a learning disability are living longer
- More children with a learning disability are living into adulthood
- There is evidence to support that there are increasingly more people with a learning disability from South Asian, black and minority ethnic communities. However the numbers accessing services are very low.

Demand on service (based on 2007 data)

- In 2006/7, 317 adults 18-64 years with a learning disability received social care support. This is 0.4% of the total current adult population mid year figure 2006 (82,300 total aged 20-64).
- In 2006/7, 13 adults 65+ years with a learning disability received social care support.
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will:
    - Increase by 7% for the 18-64 age group
    - Increase by 30% for the 65+ age group.

Note: For the 65+ the population forecasts of 21,100 for 2006 and 24,800 for 2020 taken from the chart at the beginning of this chapter have been used to predict future demand. There are currently 13 people known in 2006 and this is estimated to increase by 17 at current prevalence which gives rise to 30% increase by 2020

Policy Implications

- Focus on a supported living model so as to maximise independence and choice with a particular emphasis on home ownership and tenancies.
- Work to decommission local residential provision where either buildings or provision are no longer ‘fit for purpose’.
- Examine the whole of the local residential provision in terms of planning for future needs and efficiency to live within our means.

- Increase local provision for those people with complex, often challenging needs and for those people on the Autistic Spectrum who meet eligibility criteria
- Continuous health improvement by ensuring through effective partnerships, that the NHS provides full and equal access to good quality healthcare for people with a learning disability.
- Personalisation of services in order that people having real choice and control over their lives and services
- Ensure social inclusion with day opportunities enabling people to be properly included in their communities, with a particular focus on paid work
- Implement the 'Independence and Choice' agenda by pursuing a policy of offering Individual Budgets and Self Directed Care for people with a learning disability as part of choice options
- Ensure equality of access to services and be responsive to local needs for service creation for all communities in The Royal Borough including BME communities
- There may be additional policy implications that will need to be considered following the 'Valuing People Now' consultation taking place in early 2008.

8.6 Population Needs Analysis - People on the Autistic Spectrum and those Adults with Asperger's Syndrome

Autistic spectrum disorder is one of the many conditions that cross service boundaries. As a consequence adults with autism currently in The Royal Borough, receive services through the Community Team for People with a Learning Disability. Aspergers tends to be diagnosed as a higher I.Q functioning condition on the autistic spectrum. However in reality there are no sharp boundaries separating 'typical' autism from other autistic disorders, including Aspergers syndrome.

National data on the numbers of people on the Autistic Spectrum is variable partly due to variations in diagnosis and also lack of national collection systems. Valuing People estimates there are 535,000 people in the UK with an ASD. There are no national prevalence rates as such for the adult ASD population according to some sources (Medical Research Council, Review 2001). However, the National Autistic Society has carried out its own research and believe they can estimate prevalence

This underlies the importance of collecting local data to inform needs.

- Currently around 44 adults and young people on the autism spectrum are known to receive services through the Community Team. Few of these people will have a single diagnosis i.e. there will be a diagnosis of learning disability and/or challenging behaviour as well as autism
- Data from the transition database 15 to 21 years shows there are 29 young people in this category known to different agencies who may well need social care services in the near future
- The majority of those 44 people known to learning disability services receive their support in residential care settings, many of the placements being commissioned out of borough due to the lack of local provision
- Nationally the numbers of children diagnosed with ASD is rising. Most reviews agree nationally that autistic spectrum disorders affect 60 per 10,000 children under the age of 8.
- In an audit of adults with an autistic spectrum disorder in Windsor and Maidenhead in 2007 by the Berkshire Autistic Society, 96 adults with an ASD identified themselves for the survey. Of this number 54 had some form of learning disability (LD), 8 had mental health issues (MH), and 4 had both LD and MH issues. 30 people had neither LD nor MH issues. Given the sampling this figure is atypical and reflects under reporting
- The National Autistic Society (NAS) despite the lack of consensus nationally re any prevalence rates have estimated 91 per 10,000 for all autistic spectrum disorders including Aspergers Syndrome

Asperger's Syndrome

Asperger's Syndrome is a condition within the Autistic Spectrum and is the term most commonly used to describe people with autism who have average or above average intelligence. It affects four times more males than females.

Many adults with an Autistic Spectrum Disorder (ASD), particularly those at the more able end of the autistic spectrum (i.e. having Asperger's Syndrome (AS) or High Functioning Autism), do not receive appropriate support services because they do not meet the strict eligibility criteria which would enable them to qualify for learning disability or for mental health services – even though their lives may be severely affected by their condition. Within The Royal Borough almost 30% of all adults identified do not therefore, qualify for support services.

A survey was initiated to determine the number of adults affected, gaps in provision and then to work with local service providers to fill these gaps. Of the adults interviewed so far in the project:

- 90% of adults interviewed live in the family home with their parents
- 90% said that they did not have friends and found it difficult to make friends
- 25% worked, but only part time
- 25% stayed at home all day and it was felt that at least 75% of these, without intervention, were more likely to have health problems in the near future

The adults interviewed clearly had needs in the areas of: Advocacy, Social Groups, Employment and Housing. Adults in The Royal Borough with Aspergers Syndrome currently receive their services through The Community Mental Health Team.

Prevalence Rates

Recent figures circulated by the National Autistic Society estimate that the prevalence of all autistic spectrum disorders is 91 per 10,000. For people with average or higher ability (IQ>70) the rate is 71 per 10,000, and of these 36 per 10,000 have Aspergers Syndrome and 35 per 10,000 have other spectrum disorders (Ehlers and Gillberg, 1993). The table below illustrates the effect of the estimated prevalence on UK populations.

People with IQ under 70	Rates per 10,000
Kanner Syndrome	5
Other spectrum disorders	15
People with above IQ over 70	
Aspergers Syndrome	36
Other spectrum disorders	35
Total estimated prevalence rate all autistic spectrum disorders per 10,000 all age population	**91**

Using this NAS estimate 91 per 10,000 (all ages) illustrates the following:

Estimated prevalence all people with ASD in RBWM	2006 pop 138,800	2020 pop 148,500
	1,263	1, 351

Source: NAS website (Ehlers and Gillberg 1993)

This increase represents an estimated increase in the ASD population of 7% within The Royal Borough.

Policy Implications

- Focus on a supported living model so as to maximise independence and choice with a particular emphasis on home ownership and tenancies
- Examine the whole of the local residential provision in terms of planning for future needs and efficiency to live within our means
- Increase local provision for those people with complex, often challenging needs on the Autistic Spectrum who meet eligibility criteria
- Continuous health improvement by ensuring through effective partnerships, that the NHS provides full and equal access to good quality healthcare
- Personalisation of services in order that people having real choice and control over their lives and services
- Ensure social inclusion with day opportunities enabling people to be properly included in their communities, with a particular focus on paid work
- Implement the 'Independence and Choice' agenda by pursuing a policy of offering Individual Budgets and Self Directed Care as part of choice options
- Ensure equality of access to services and be responsive to local needs for service creation for all communities in The Royal Borough including BME communities

8.7 Population Needs Analysis: Mental Health (18-64 years)

At this stage of developing the strategy, only high level information has been included. This reflects the difficulties separating out the health and social care implications of the needs analysis activity within the integrated mental health services currently operating in The Royal Borough. Agreeing a joint approach to the commissioning of mental health services with the Primary Care Trust will be an early priority within the joint delivery plan. Developing a common approach to understanding the population needs analysis will be necessary once the overall structure of the new service is determined and for this reason a comprehensive population needs analysis is not currently available. From this initial analysis we can identify the key factors that need to be taken into account in planning future service provision.

Numbers in The Royal Borough

The following table provides an estimate of the prevalence of mental illness within the general population (16-74) within The Royal Borough.

Disorder	Rates per 1000	Estimated for 2004-10
Mixed anxiety and depression	88	7,876
Generalized anxiety	44	3,938
Depression	26	2,327
Phobias	18	1,611
Obsessive-compulsive disorder	11	985
Panic	7	627
All neurosis	164	14,678
Personality disorder	44	3,938
Psychosis	5	448

Source: Singleton et al (2000) Morbidity among Adults ONS

It is not possible to give accurate figures of the total incidence of mental illness occurring in the adult population of The Royal Borough. This is in part due to the fact that episodes or number of admissions are recorded, as opposed to individuals.

Statistics

- Depression is now the most common reason for claiming Incapacity Benefit (having taken over back pain). Data from the Department of Work and Pensions suggests that around 35% of people claiming Incapacity Benefit in 2002 had mental or behavioural disorders, compared to 22% with musculoskeletal conditions. The King's College London team have also reported that these benefits cost over £13bn a year

- If an individual is off work for more than 12 months with a mental health condition they are unlikely to return to work for another seven years (National Institute for Mental Health in England, January 2008)
- The World Health Organisation (WHO) predicts that depression will be the leading cause of disability internationally by 2020

Demand on service (based on 2007 data)

- In 2006/7, 352 adults (18-64) received social care support. This is 0.43% of the adult population.
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will increase by circa 4% for the 18-64 age group

Policy Implications

- Extend home treatment service to all age groups, which offers more choice and control
- To expand direct payments scheme to enable more choice for people who use mental health services
- Expansion of extra care and help with housing related support (for example helping people to stay in their own home) and appropriate housing in general, which offers a range of tenures to meet a wide range of need, including accommodation and support needs of vulnerable adults
- Extend the length of stay as an in-patient beyond 10 days
- Offer more respite care to support carers and their families
- Need to develop more opportunities to return to training and employment

8.8 Population Needs Analysis: Physical Disabilities

This section provides a summary of the detailed population needs analysis of people with physical impairments in The Royal Borough. These figures are mostly based on national census data, local information, prevalence and projection data. There are some reservations and the figures should be treated with caution. Some surveys are based on, or include, health status where disability and ill health are sometimes confused, or generic figures are provided about 'disability'.

Numbers in The Royal Borough

Because of the factors described above, it is difficult to predict changes in prevalence of physical impairments amongst people aged 18-64. Demographic changes, available prevalence data, social life style trends, medical advances, etc, make modelling over the next 20 years extremely problematic. National evidence supports an increase in the number of children with complex conditions surviving into adulthood. Further data analysis and development work is required to more accurately predict the impact of this on adult services.

Demand on service (based on 2007 data)

- In 2007 219 adults with a physical disability received social care support. This is 0.27% of the adult population.
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will increase by 5%

Policy Implications

- Increase in respite provision
- Expansion of self assessment
- Access to technical aids reduces future needs and in some cases delays the need for high level equipment / support
- Accessible housing / transport (improved funding for specialist transport services / environment)
- Equal access to employment
- Advocacy
- Increase capacity for preventative intervention (to reduce crisis involvement and plan towards known disease development stages)
- Timely provision of equipment & adaptations prevent physical health problems
- Access to appropriate local health care
- Long term conditions team
- Increase in self operated care
- Supporting people – (floating support / house clearance assistance when moving into residential care)

8.9 Population Needs Analysis: Sensory Impairment

This section provides a summary of the detailed population needs analysis of people with sensory impairments in The Royal Borough. These figures are mostly based on national census data, local information, prevalence and projection data. There are some reservations and the figures should be treated with caution. Some surveys are based on, or include, health status where disability and ill health are sometimes confused, or generic figures are provided about 'disability'.

Many older people experience a reduction in hearing and sight due to the ageing process, but may not define themselves as having a physical or sensory impairment. A literature review (commissioned by the Royal National Institute for the Blind) of all visual impairment studies, revealed a disagreement in the estimate of the population of people aged 16-64 with a visual impairment (0.8% compared with 2%). The disparity will have a significant impact on any projection of this population.

Not all children with a sensory impairment will be in receipt of social care services, even if they are currently accessing educational support to assist their learning in school. Information from the Disabled Children's Team shows us that there are only a few children in the transitional age range that are receiving social care support for either a visual, audio or combined sensory impairment, with a total number being 12 children.

Demand on service (based on 2007 data)

- In 2007, 121 adults with a sensory impairment (hearing - 40; visual - 81) received social care support. This is 0.12% (hearing 0.04%; visual 0.08%) of the adult population
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will increase by on average around 12% (hearing - 13%; visual – 11%)

Hearing impairment

By 2020 there will likely be:

- An increase in the number of profoundly deaf people +70 yrs by 49%
- An increase in the number of people with a hearing impairment amongst all age groups except the under 45s

		2008	2020	Inc	% inc
Some Hearing Loss	71.1%	8887	13225	4338	48%
severe hearing loss	6.3%	787	1172	385	48%

Visual Impairment

By 2020 there will likely to be:

- A significant increase in the number of people with a visual impairment aged 65+ who live at home
- A significant increase in the number of people with a visual impairment aged 65+ who are likely to live in residential or nursing accommodation.

Dual Sensory Impairment

According to national data approximately 0.04% of the population have a dual sensory loss. By 2020 there is likely to be an increase in the number of people aged over 60 with dual sensory impairment from 8 people in 2006 to 11 people in 2020.

Policy Implications

Development of a shared Strategy with neighbouring Local Authorities

Hearing Impairment

- Improved citizen recording
- Increased need for local services
- Increased need for equipment to ensure confidence in citizen
- Training – skill building and confidence building for citizen
- Training for staff – communication / understanding needs
- Accessible information
- Increase level of specialist help
- Training providers and staff
- Training employers (Social Model of care)

Visual Impairment

- Improved citizen recording
- Visual Impairment often leads to falls – preventing falls / access to equipment
- Training – skill building and confidence building for citizen
- Training for providers and staff – understanding needs
- Training employers (Social Model of care)
- 5% of people with a visual impairment are from Black & Ethnic groups

- Assessment guidelines can deny help to visually impaired as they are not always high risk – but access to services could prevent greater needs in the future
- Need to increase level of specialist help

Dual Sensory Loss

- Improved citizen recording to include dual sensory loss
- Provision of communication support
- Training – skill building and confidence building for citizen
- Training for providers and staff – understanding needs
- High level of support needs – communicator guides (prevents isolation, depression ensures inclusiveness)

8.10 HIV/AIDS

The Royal Borough currently contracts out its HIV/AIDS services to organisations outside of the Borough. Currently the Borough funds support services, employment options, respite and palliative care for children through the HIV/AIDS budget. Training for Borough staff is also funded from the budget.

There have been issues in The Royal Borough for people with a positive diagnosis not wishing to seek treatment and support in the Borough because of the 'stigma' that is attached to a positive diagnosis, and people's need to maintain their confidentiality. This has been evidenced in the low number of people reported to access services in previous years, however this trend is changing.

Historically, those from The Royal Borough with a positive diagnosis were reported to attend other clinics, for example, in London, for services, treatment and support. This assumption was correct until recently, where there has been a considerable increase in people accessing local services. For example, one support service has reported an increase from four citizens (being active and current) to 18 in the last year. In recent years, changes to funding requirements has meant that those seeking services in London are now subject to 'postcode' selection, meaning that London services cannot support people that live outside prescribed postcodes. This may provide one explanation for the increase in people accessing services.

There are no targeted services to people caring for people with HIV/AIDS. However, Upton Hospital does have a respite suite supported by the HIV team and there are well established links for respite care with a respite facility in Bodmin, Cornwall. This carer group does not have a voice, yet has high needs for support. This group is difficult to identify because of the stigmatisation attached to HIV/AIDS, and the need and want for people with a positive diagnosis to keep that diagnosis private. Further, there have been concerns raised that home care staff may not be adequately trained to sensitively deal with the issues that arise with a positive diagnosis.

Specialist Social Worker - Garden Clinic, Slough.

- Walk in clinic, self, GP and health referrals providing holistic approach to health and social care needs. Garden Clinic is a sexual health clinic including medical support and counsellors.

Thames Valley Positive Support (TVPS)

- Support, referral, holistic therapies, safe place, network, link to Garden Clinic. Link with other geographical areas, also out of area work to our citizens. TVPS have reported a significant increase in borough citizens accessing services. TVPS are well recognised in the community, and

also provides support through their up to date web site and their link with other volunteer organisations.

Ways into work

- Part funding for a Ways Into Work post to provide and support employment opportunities for people with a positive diagnosis. Referrals are either from service providers, or self referrals. The worker has an active caseload of citizens from the Borough. Case work with this group is intense and complex, and requires sensitivity. Case load has increased in the last year, possibly due to promotion and support of this post, but also due to increase in infection rate. The worker reports that there has been limited or no work done to support people in this target group in the past, and as such there is a lot of work to be done to assist people with a positive diagnosis.

Policy Implications

- HIV operational work to be reviewed
- Strategic / action plan for HIV/AIDS to be developed
- With partners review funding arrangements for HIV services
- Specific HIV service actions to be identified within the LTC plan
- Processes for HIV citizens to be reviewed and clearly mapped pathways agreed and communicated
- Partnership work to be further developed to include health, service providers and all RBWM Directorates
- Plan for training for community based workers

8.11 Drugs and Alcohol

Treatment mapping

All residents who need support, advice or information about drugs or alcohol have access to treatment when they need it. The service caters for families and friends as well as the misusers themselves.

Staff in generic services, such as housing, social care, have access to basic drug awareness training to ensure that whenever the service user first discloses they have a problem with substances the staff know where to refer on to.

T2 is located in Grove Road and is the main treatment centre for the residents of The Royal Borough. The services available at T2 include the following:

- Drop-in
- Key working
- Triage
- Assessment
- Needle exchange
- Parents/carers group
- BBV (Blood Borne Virus) clinic
- Prescribing clinic

For those clients who need more structured interventions there is CASCADE in Slough. Referrals are taken from T2 and the criminal justice clinic. Services available include:

- Specialist prescribing
- Psycho-social counseling

During 2007/08 the DAAT commissioned 10 residential placements, outside the Borough, for those userss who were most at need.

GPs and pharmacies are also part of the treatment system offering holistic health support including supervised consumption of substitute medication.

Key facts about drug misusers in The Royal Borough

- 385 users in treatment at the end of March 2008
- 190 individuals presented for treatment during 2007/08
- 78% of userss were retained in treatment for longer than 12 weeks
- The main drug of choice for adults is heroin
- 50% of those in treatment are aged between 20 and 29 years old

- 81% of those in treatment are white British
- 71% of users are male
- It is estimated that there were 412 problem drug users in The Royal Borough during 2007.

Criminal Justice including Prolific and Priority Offenders

The DAAT commission an arrest referral scheme from SMART (Substance Misuse Arrest Referral Team). The drugs workers work closely with users referred through the criminal justice system. There is access to a worker for all drugs users whilst in the police cells at Maidenhead and testing is available for those who have committed a trigger offence (acquisitive crime such as burglary). The results of the tests can be used to apply restrictions on bail in the following court proceedings.

The Royal Borough has 24 prolific and priority offenders who are individually case managed on a monthly basis. A multi-agency committee meets and takes responsibility for all aspects of treatment and social care including housing and child protection issues. Criminal justice clients have rapid access to specialist prescribing and key working.

Priorities for 2008 – 2011

- Consultation on and publication of the commissioning framework
- Increase the numbers of heroin and crack cocaine mis-users into treatment by 5% in 2008/09 and a further 1% for the following 2 years
- Continue effective commissioning ensuring that services are commissioned to meet the needs of the users
- Commission effective treatment services with measurable outcomes, using the TOPS (Treatment Outline Profile) forms
- Increase retention in the treatment system including an increase in appropriate referrals between the Tiers
- Increase planned exits through robust care planning including meaningful and regular consultation with the clients
- Ensure an efficient and effective tendering process for local services
- Increase the numbers of criminal justice clients entering treatment
- Implement an effective DIP (Drug Intervention Programme) steering group to monitor criminal justice issues and to ensure alignment between DIP and the PPO (Prolific Priority Offenders) scheme

8.12 Carers

People who provide unpaid care

Some key facts provided by Carers UK about carers:

- 1 in 8 adults is currently a carer. This would mean that within The Royal Borough there could be around 17,000 people who are unpaid carers.
- 3 in 5 people will become a carer at some point in their life – this will mean that in The Royal Borough of the current population circa 82,000 residents will become a carer at some point in their life.
- 1 in 5 female and 1 in 6 male carers aged 25-44 provide more than 50 hours care per week.
- Of those carers providing 50 hours care per week 20% are suffering from poor health, double the proportion for the non-carer population.
- Each carer will on average save the economy around £15,000 per year
- In 2008/09 the main carer's benefit was £50.55 per week - therefore for an average of 35 hours this would be equivalent to £1.44 an hour.
- People providing high levels of care are twice as likely to be permanently sick or disabled
- Around 1 in 6 carers may be caring for more than one person
- 58% of carers are women and 42% are men

The 2001 census reports that there are over 11,500 people acting as carers in The Royal Borough. Of these nearly 8,900 say they provide up to 19 hours of care per week, a further 915 provide between 20 and 49 hours of care per week and nearly 1700 reported they are providing more than 50 hours of care per week. Carers UK state that 1 in 8 adults are carers. It is likely that 80% of these people are of working age and will have to juggle care and work (figures extrapolated from a national survey).

There is a clear discrepancy between these figures and this reflects different definitions of ‘carer’ and whether people choose to define themselves as carers in self-reporting surveys. Nonetheless, the number of informal carers is likely to increase significantly in line with the upward population trend of older people in particular.

Key facts about Young Carers

Around 3 million children in the UK have a family member with a disability. Not all take on a caring role that is appropriate to their age. Few parents want their children to be carers but it can happen for many reasons, such as families being isolated, afraid of outside interference or unsupported.

The 2001 Census identified 331 young carers in The Royal Borough. This figure is widely acknowledged to be an underestimate, firstly because census forms are normally completed by adults, and secondly, as they exclude young carers of those who misuse alcohol and/or drugs and those who have a mental health condition .

Young carers are at risk of social isolation and bullying, under-achievement, absenteeism from school, and physical and mental ill health.

Many young carers are also responsible for looking after younger brothers and sisters and all or most of the household chores in addition to caring for an adult.

Carers and Employment

Some key facts about carers and employment :

- 80% of carers are of working age, this means that according to Carers UK estimates (1 in 8 adults are caring) there would be circa 12,800 residents who are carers, so 10,250 (12.5%) are of working age
- Peak age range for caring is 45-64 years
- Carers are 12% of the UK workforce
- Around half of all carers combine work and caring
- 1 in 3 carers, currently not working, want to return to work
- Carers lose £11,050 a year on average through having to reduce their working hours

New statistics, published to coincide with Carers UK's Carers Rights Day, in December 2007, show that the average loss in earnings last year by a carer who had either to give up their job, reduce their hours or take a more junior position in order to care for sick, frail or disabled relatives or partners, was £11,050.

Currently around one in five of the nation's 4.4 million carers of working age have to give up their employment in order to care. Men lose out on an average of £13,681 per annum compared to an average of £10,083 per annum for women. Nearly 45 per cent of working age carers say that they would like to work, but more than a third (38%) say they cannot work unless they have the right care services.

The same research study for Carers UK finds that a third of carers are in debt and one in ten cannot afford their rent or mortgage. The main reasons that carers are often forced to give up work or reduce their hours are:

Lack of appropriate support services

- Between 40 and 50 per cent of working carers say that a lack of flexibility and sensitivity in the delivery of services hampers them in obtaining support. Only 25 per cent say that they have adequate support from formal services for them to be able to combine work and care.

Lack of flexibility at work, or unsupportive colleagues

- More than half those surveyed said that their employers are 'carer-friendly' and the Confederation of British Industry (CBI) recently found that employers had accepted 93 per cent of requests – either in full or with an agreed compromise. However, anecdotally, calls to the Carers UK's helpline indicate that awareness is low among some managers, proving the importance of training and designing policies for carers.

Benefit rules which stop carers from working

- The fact that carers can only earn £95 a week to receive the Carer's Allowance which traps them in low-wage jobs.

A refusal by the person they care for to accept formal care services

- This highlights the need for flexible and appropriate services, including technology solutions such as telecare, which look at the support the family requires as a whole – and possibly a service to help the carer.

Demand on service (based on 2007 data)

- In 2007, 1,421 carers were known to adult services. This is 1.41% of the adult population
- During 2006/7, 279 carers had received an individual assessment or review of need with a further 1083 having had their needs assessed or reviewed jointly
- During 2007, 330 adult carers were receiving services in support of their caring
- If the general model of social care service provision and eligibility for services remains the same, by 2020 demand on service will increase by around 11% (this is a very rough estimate)

Policy Implications

- Decrease in number of people working in the caring profession as population ages will increase role of informal carers
- Increase in numbers and types of service offering increased choice, access and control to enable work, leisure, emotional support and training – need to be appropriate and sensitive to needs e.g. support groups
- Identification of young carers and service provision for young carers
- Support for working carers (once carers leave work to care they don't go back to work – impacts on reduction in workforce overall)
- Extended home services to increase choice and control
- Increase in assessment
- Accessible information for self help
- Health of carers – heavy long term care = risk of injury, anxiety, depression, withdrawal from work
- Adaptations for carers prevent back injuries, reduce stress, lessen health care costs – supported carers = reduced need for residential care for citizen
- Demand for carers will increase over the next 10 years as population ages, (by 2040 the need for carers will be 30-50% above current levels)
- Train staff to understand the resources and support which might benefit the carer best and how to encourage carers to agree to the support.
- Increase provision for different types of carer breaks and respite
- Individual budgets for carers

8.13 Provider Market Analysis

8.13.1 Introduction

This section sets into context the future plans for adult social care in the borough, by providing an overview of the scale and geographical disposition of the services currently being delivered.

Finely detailed statistical analysis at sub-district level does present some challenges, partly because Census data lags several years behind our knowledge of the current state of local care provision, and also because only those categories of care that require registration (with the Commission for Social Care Inspection) are susceptible to reliable data capture. It is, nevertheless, instructive to look at the overall capacity offered in registered residential, nursing and home care provision, how this is distributed between the borough's main population centres and, where relevant, beyond the borough's boundaries.

The bulk of services in both residential and home care sectors are delivered by external providers, although the borough does retain a sizeable in-house home care team whose caseload is weighted towards the more challenging or complex citizens.

8.13.2 Financial Information

The table below summarises the 2008/09 revenue budget for adult care services. A 3 year medium term financial plan will be developed to reflect a tight resource situation resulting from limited increases in Government funding – the Council received less than 2% increase in Government funding for 2008/09. This is less than the expected costs that will arise through inflation pressures.

Summary Budget 2008-09 budget for adult services

	2008/09		
	Gross budget	Income	Net Budget
	£'000	£'000	£'000
Community Care Management	529	(36)	493
Elderly & Physical Disability	21,532	(5,627)	15,905
Joint Commissioning Team	906	(41)	865
Concessionary Fares	1,419	(342)	1,077
Learning Disability	14,400	(4,510)	9,890
Mental Health	2,665	(166)	2,499
Drug Action Team	241	(278)	(37)
	41,692	(11,000)	30,692

8.13.3 Types of Agreements

Externally purchased services can be categorised into one of three main types:

The first is Block Purchase contracts. In these, the borough commits to purchasing a fixed number of units of care (for example a number of beds in a care home, or a number of hours of home care service) over a pre-determined period, typically between three and ten years. The benefits of such an arrangement are a relatively attractive price, continuity of supply, easier quality control, and the ability to develop constructive, long-term relationship with providers, which helps to ensure that services are tailored to the needs of our citizens.

The second type is Spot Purchasing. These arrangements are made on an ad hoc basis according to demand, and afford a degree of flexibility which effectively “tops up” the block purchased capacity. Spot purchase unit prices tend to be higher than block purchased services, but cost exactly matches actual need, and so there is no risk of excess capacity being paid for. Spot providers are required to maintain the same levels of registration and are subject to the same level of quality monitoring as block providers.

The third type is Supported Living. This is a mode of support specifically intended for those who have the capacity to live independently, but who require support with some aspects of their daily life, and who, in some cases, also need some personal care services. This could for example be a purpose-designed sheltered housing scheme, in which each resident has his or her own tenancy agreement and all of the rights that this implies, but where a support worker is on site and available to help with difficult tasks or problems that may arise. In some cases the residents may also receive regular visits from a trained care worker who will assist with some aspects of personal care.

In addition to these three main categories, the borough supports or facilitates the delivery of a variety of other modes of care service. For example, financial support is provided in the form of grants to a number of local charitable and other benevolent organisations. In other cases facilities for day care services are provided, and consultative forums representing the interests of a number of vulnerable groups are held regularly at locations around the borough.

The following statistical analysis focuses firstly on the residential care market, and then on home care. More in-depth analysis will be needed in order to support this Adult Plan and the 3-year joint delivery plans that will be derived from it. Some of this has already been carried out, but much remains to be done.

8.13.4 Residential and Nursing Care Services in The Royal Borough

Table 1 shows placements funded by the borough (all types of need), 59% are placed within the borough itself. 13% are placed in neighbouring areas, defined as those sharing a border with Windsor and Maidenhead, and including Bracknell, Wokingham, Slough and South Bucks.

Table 1

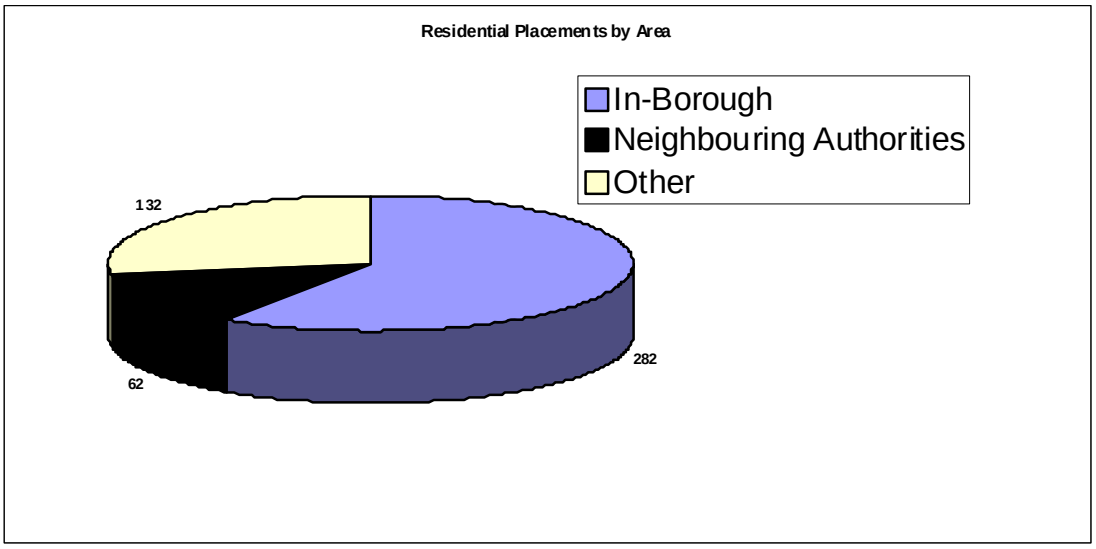


Table 2 shows that the majority of residential placements are for older people (including those with dementia), who represent 69% of all council-funded residential places.

Table 2

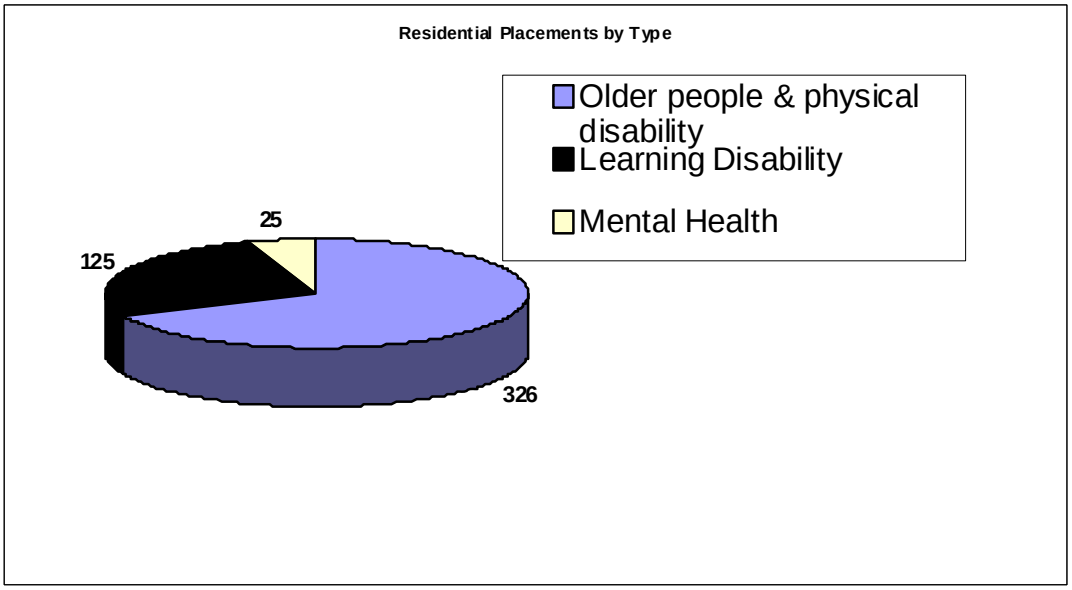


Table 3 shows there are 47 registered care homes in the borough with the geographical distribution between the main population centres.

Table 3

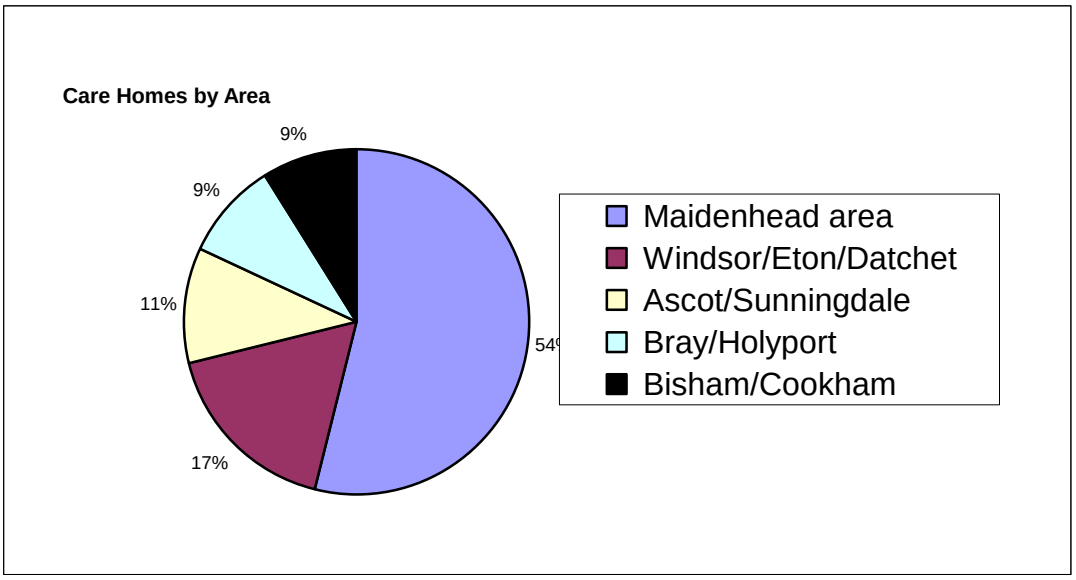


Table 4 shows the distribution of 18 homes provide nursing care.

Table 4

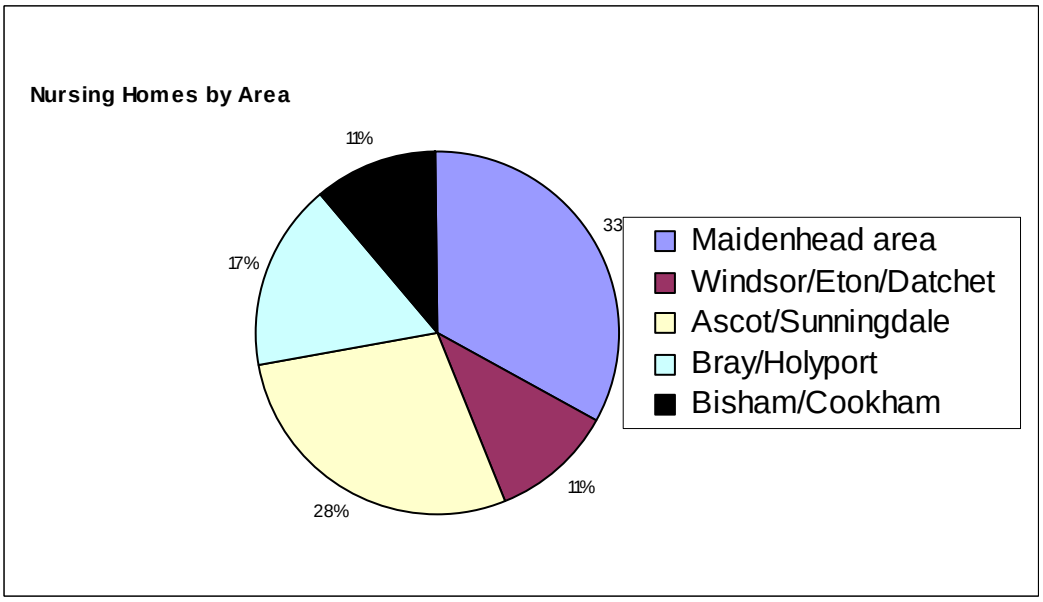
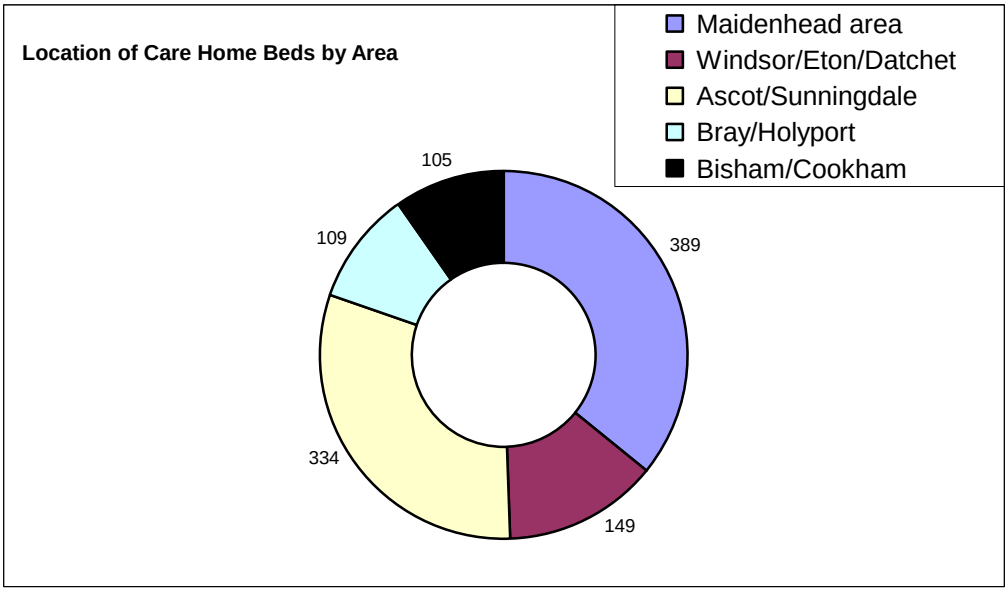


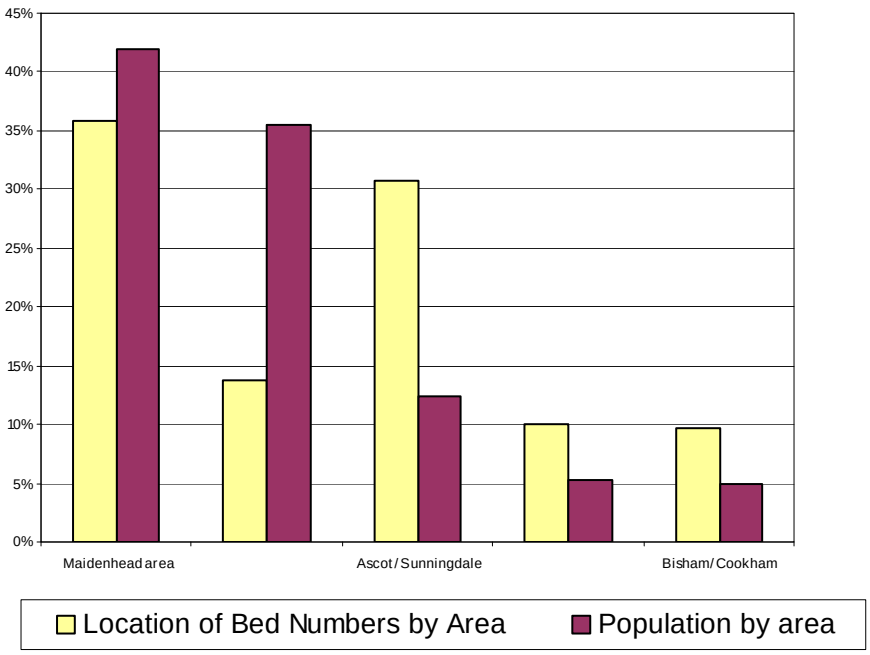
Table 5 shows the total number of care home beds in the borough. The most striking feature of this is the relatively high level of provision in the Ascot area, particularly when compared with the proportion of care homes here. The reason is that homes in Ascot are in general larger than those elsewhere in

the borough with an average capacity of 66 beds compared with the overall borough average of 23 beds per home.

Table 5



The following graph shows the location of beds by area in comparison with the population of each area. It shows that there is relatively low provision in Windsor (in spite of the opening in late 2007 of a new 62 bed facility in Dedworth) and, conversely, that Ascot and the Sunningdale/Sunninghill area are relatively over-provisioned. The latter is particularly rich in nursing care beds.



8.13.5 Care at Home

The commissioning, delivery and data recording of care at home services dramatically changed at the beginning of 2006. In 2006 block contracts were awarded to 3 external care providers. The 3 external providers cover 5 geographical areas in the borough. These geographical areas are referred to as zones. The 3 block providers are contracted to take up to 80% of the commissioned hours in their zone. The remainder of the packages are commissioned with spot providers. As a result of the implementation of 2 new electronic systems the ability to record and produce statistics is much improved. Prior to 2006 data collection was labour intensive and required considerable manual processes and calculations.

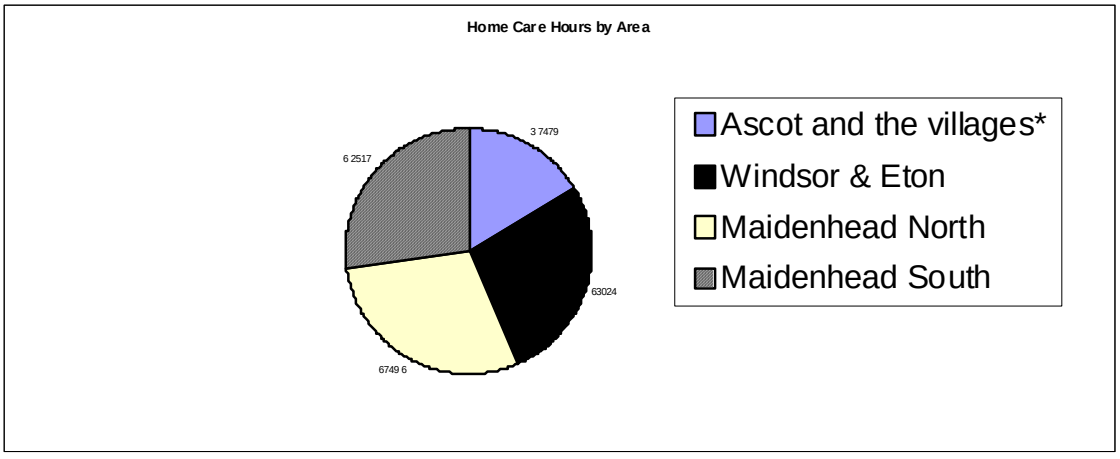
Staff Plan/Home Care Roster:

This was the first of the new electronic systems to be implemented. This system is a rostering system, and its primary use was for the management and delivery of the in-house care provision. However the Care Brokerage Team also use this to record accurate detail of external commissioned care packages detailing task, times of visits and duration of calls. All the details of the calls need to be kept up to date as this system interfaces with an electronic call monitoring system, CM2000. The statistics provided in this document were extracted from Staff Plan for a four week period starting 7th September 2007.

CM2000:

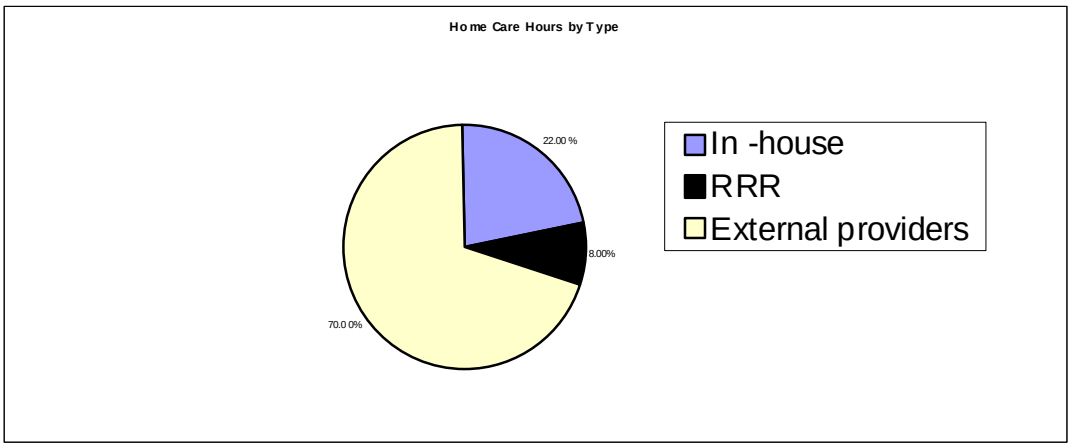
This is an electronic call monitoring system implemented in October 2006, firstly with the block providers and went live in January 2007. This system was subsequently used by the in-house service. CM2000 details care package visits; duration of those visits and gives details of 'actual' care delivery. The actual time of call, duration of call, and the care worker who attended are recorded. The quality of data has improved since the implementation of electronic call monitoring and further performance management information can be obtained for monitoring and quality assurance reasons

1. Home Care hours delivered,



* Sunninghill, Sunningdale, Horton, Wraysbury, Datchet

The following chart shows the proportions of care hours delivered by external providers, the in-house team, and the council's Short Term Support and Rehabilitation Team.



The provision of home care is divided into 4 geographical zones.

Zone 1/2 Ascot, Sunninghill, Sunningdale, Horton, Datchet and Wraysbury
Zone 3 Windsor
Zone 4 Maidenhead North
Zone 5 Maidenhead South

8.14 In-house Domiciliary Care Service

The In House Home Care Service operates from 7am until 11pm, 365 days of the year and covers the whole of The Royal Borough. The Overnight Service, operating from 11pm until 7am, 365 days of the year, supports both internal and external long-term home care citizens requiring assistance during the night who would otherwise be admitted to residential care. This Service comes under the management of the Short Term Support & Rehabilitation Service.

The In House Home Care Service supports people with one or more of the following conditions, to enable them to remain living in their own homes in the community:-

- complex medical and/or physical conditions
- dementia
- mental health problems
- self-neglect
- vulnerable adults at risk from themselves or others
- challenging behaviours
- problematic social circumstances
- at risk due to reluctance to accept the level of support to meet their assessed needs, and where trust has to be built up gradually over time in order to fully meet those needs.
- and people who 'bounce' between external providers as being too difficult to manage due to one or more of the conditions detailed above

There is a core of citizens who remain with the In House Home Care Service as their situations continue to be volatile, whilst others, once their situation/care package has stabilised, will be assessed as no longer meeting the Service criteria and can safely be transferred, or returned, to external provision.

To provide this type of service, the In House Home Care Managers deal with citizen related issues which arise on a daily basis, complete care management paperwork, attend case conferences and liaise with a wide range of agencies and health and social care professionals to achieve the best outcomes for the citizens. In effect, the Home Care Managers are case managing these cases, particularly if the citizen is classed as an 'open inactive case' i.e. not being actively managed by a care manager.

The In House Service has a very able and committed workforce, who receive comprehensive ongoing training to equip them for the job, can cope with very difficult and challenging circumstances and constantly feed back changes and issues that need resolving.

8.15 Short Term Support & Rehabilitation Service

Following the extensive Domiciliary Care Review, the management and provision of the First Response Service transferred to the RR&R Service in July 2006 and the merged Service was re-named as the Short Term Support & Rehabilitation Service. The two staff teams were merged into one for greater service efficiency and therapy input is now available should rehabilitation potential be identified in a First Response citizen to promote and maximise their independence thus reducing reliance on long term social care.

The Short Term Support & Rehabilitation Service is a 24 hour Royal Borough wide domiciliary intermediate care service as defined in Standard 3 of the National Service Framework for Older People.

- Prevention of inappropriate hospital admission
- Facilitation of safe, timely hospital discharge
- Prevention of premature admission to long term care

The Service provides social care crisis intervention, responding within 2 hours dependent on resources available at the time and the person's circumstances, and also individually tailored, goal driven rehabilitation. Referrals to this element of the Service are taken in person by a duty service coordinator 24 hours a day, seven days a week using Single Assessment Process documentation.

The First Response element is an intake service which, during a four week period, undertakes a practical assessment of commissioned tasks and right sizes the majority of new home care packages prior to allocation to a long term home care provider.

Referrals to this element of the Service are made by the Care Management Team following an assessment of each individual person's needs.

The single workforce is a multi-disciplinary team composed of physiotherapy and occupational therapy staff, care management and direct care staff who have been taught, or are being taught, low level rehabilitation and health care skills so that they can work generically and thus improve citizen experience by reducing the number of 'hand offs'. This will also release the valuable and scarce qualified therapy staff to undertake more appropriate tasks, again leading to an improved service. The Service also has access to Speech and Language Therapy, Dietetics, a Consultant Geriatrician and other health and social care professionals. Clinical governance is provided on a weekly basis by the staff grade St Marks Day Hospital doctor.

The following table shows the number of completed episodes of care that have taken place for each year.

	2004/5	2005/6	2006/7
Prevent Hospital Admission	**322**	**355**	**285**
Facilitate Discharge from Hospital	**312**	**405**	**369**
TOTAL	**634**	**760**	**654**

There has been a rise in the number of citizens not requiring long term social care support following their RR&R episode of care during the previous 2 years, and this is also a continuing trend for 2007-8.

	2002-3 %	2003-4 %	2004-5 %	2005-6 %	2006-7 %
Independent	*46*	*47*	*42*	*50*	*63*
Resumed Care Package	*11*	*12*	*12*	*8*	*4*
Allocated for LTC	*15*	*14*	*16*	*17*	*12*
Acute Hospital Admission	*12*	*14*	*12*	*9*	*5*
Non-Acute Hospital Admission	*8*	*4*	*5*	*6*	*9*
Nursing Home Admission	*0*	*1*	*3*	*4*	*2*
Hospice Admission	*2*	*2*	*2*	*3*	*1*
Passed Away	*6*	*6*	*8*	*3*	*4*
Total	***100***	***100***	***100***	***100***	***100***

8.16 Day Services/Day Opportunities

Day Opportunities supports adults and older people to continue to live an independent life within the community. A wide range of fulfilling opportunities can be offered on an individual needs led basis ranging from occupational, educational and therapeutic classes. Day Opportunities are designed for people who need support with one or more of the following:

- Social isolation
- Skills development
- Practical or emotional support with social care problems
- Risks associated with specific circumstances
- Respite for carers

Services are provided by either the council or a range of independent voluntary organisations.

Ways Into Work

Ways into Work is an in-house employment and training service funded by the council's adult services and staffed by full and part time staff. It is based at the community team office at Abell Gardens, Maidenhead and is a referral based service as opposed to an open access service.

Ways into Work supports people who have a disability to access sustainable employment and training opportunities. It provides the advice, guidance and support individuals need to make informed choices and reach their full potential within the work place. It covers four areas: physical disability, sensory impairment, HIV and learning disability services.

The service provides support into:

- Paid employment
- Voluntary work
- Work experience
- CV writing
- Interview skills
- Advice on employment benefits
- Support in the work place
- Information on college courses
- Sign-posting to other agencies

8.17 Accreditation and Monitoring of Care Providers

"Councils must make sure that the people they serve receive high quality social care services" (CSCI December 2007). In order to do so, The Royal Borough will ensure that it has suitable knowledge of the care providers from whom it commissions its services, safeguarding citizens and ensuring resources are used appropriately.

Accreditation will be an integral part of the contracting process, providing confidence in the services the council commissions. All registered care providers will be required to provide information that will assist in decision-making regarding suitable placements and ensure that they are a viable business from whom to purchase a service. The main objectives of an accreditation are:

- To ensure our citizens are receiving the highest possible quality of care
- To ensure the provision of care is the most appropriate to meet the needs of citizens
- To ensure continuity of supply from stable, well-managed businesses
- To develop and maintain constructive working relationships with care providers to support best practice.

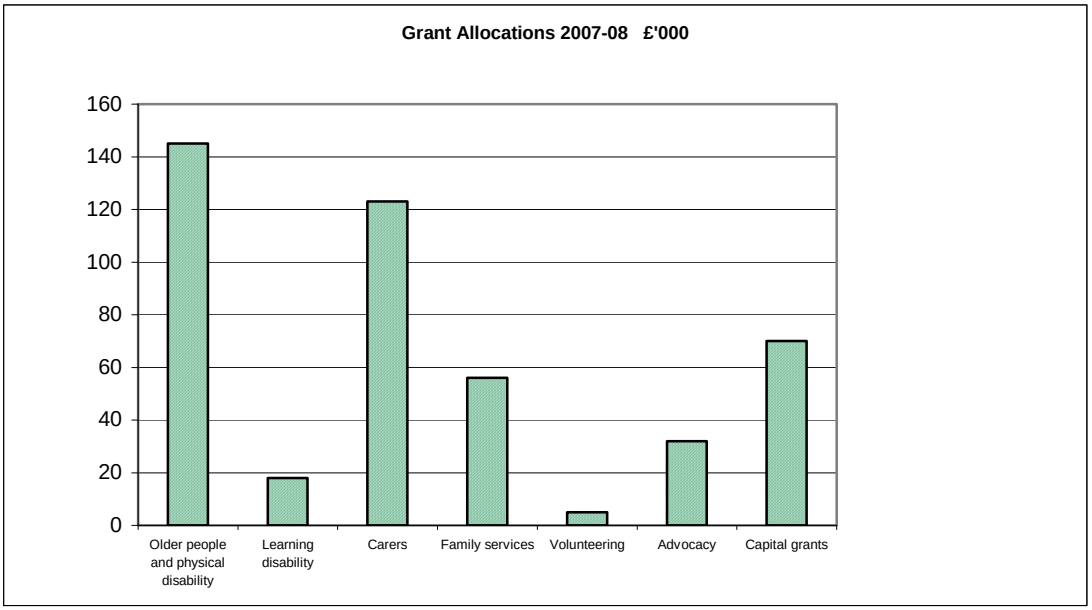
The six unitary authorities in Berkshire work together to share information via a shared website allowing information regarding care quality to be accessed. This will ensure care providers only complete this process annually, reducing replication of the role of CSCI, Care Quality Commission (or any such regulatory body which shall replace it).

Monitoring will begin once a signed contract is in place and a citizen is in-situ. This will take the form of on-site visits by the monitoring team and self-assessment by the providers. This information will be shared on the pan-Berkshire website and include citizens' opinions, contract compliance information and placement embargoes where applicable. The monitoring team will provide care providers with information regarding new legislation, promote the highest quality of care possible and assist providers to meet CSCI requirements and National Minimum Care Standards.

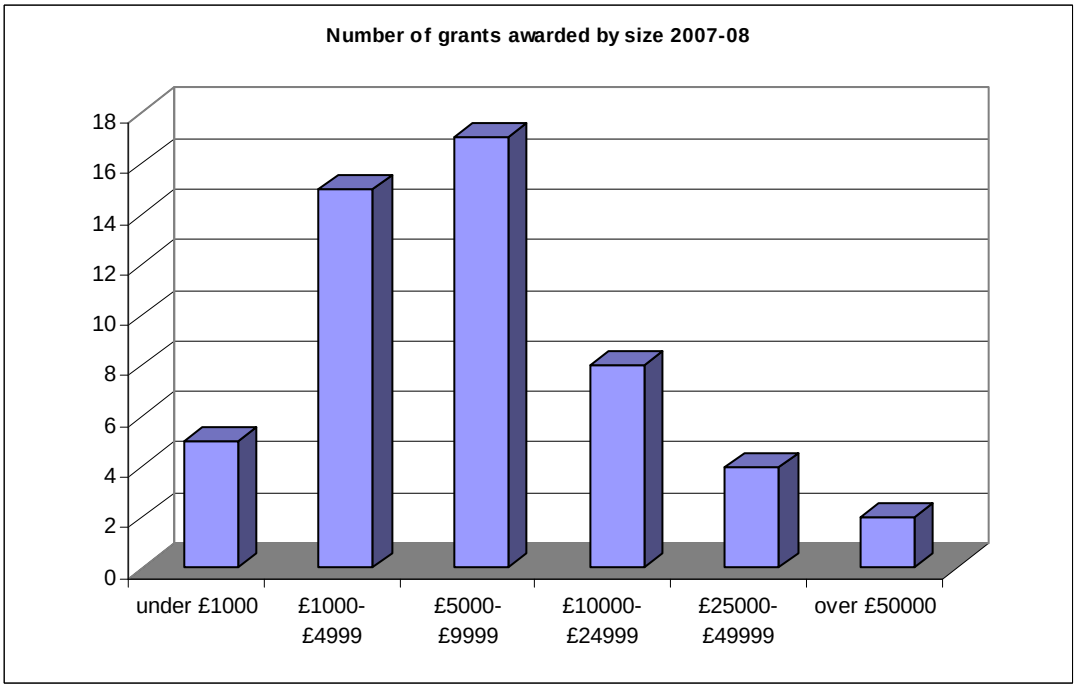
8.18 Grants to Voluntary Organisations

Grants

The council awards grants to locally based charities and other benevolent organisations providing services to adults and their families. Grant awards totalled over £400,000 in 2007-08. These grants support a wide range of community groups as shown in the following chart.



Grants range from a few hundred pounds to more than £50,000, with the majority of awards being in the range £1,000 - £10,000.



8.19 Direct Payments

A Direct Payment is a sum of money offered by the council in lieu of services. It can be made to a local person who has an assessed social care need and meets certain eligibility criteria. That person can then use their Direct Payment to arrange their own services. Direct Payments have been possible since the government introduced the 'Direct Payments Act' in 1996.

The council offers a Direct Payment that can be delivered in the form of several different products that can be differentiated as follows:

1) Scheme A - is for people who want to use their money to employ their own carers/support workers, purchase care from a local care provider of their choice, or any other product/service that is in their agreed care plan.

   48 recipients of Scheme A Direct Payment in 2007/8 financial year at an average cost of £292.14 per week.

2) Scheme B - is for people who want to use their money to purchase care from a local care provider of their choice.

   67 recipients of a Scheme B Direct Payment in 2007/8 financial year at an average cost of £129.01 per week.

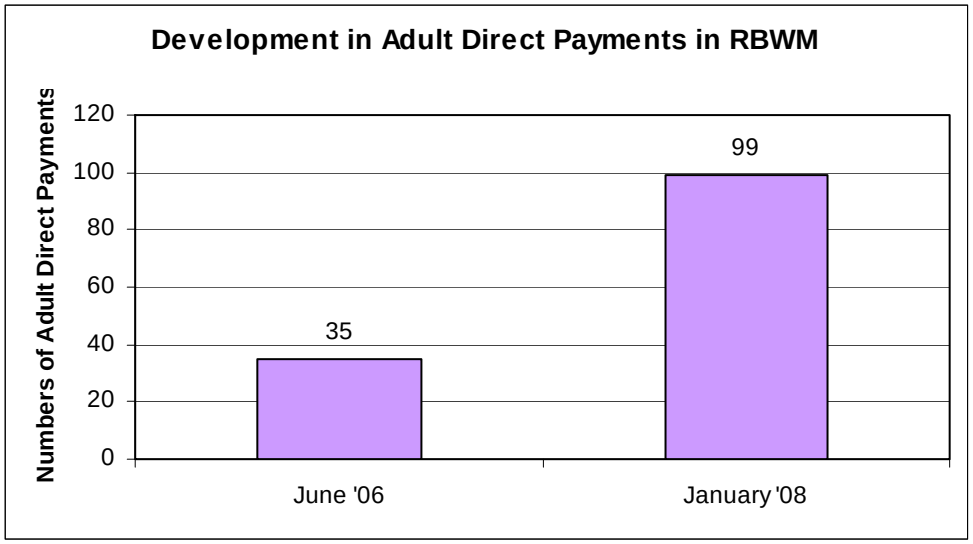
3) Scheme C - is made as a one-off payment to fund a specific one-off intervention for a specific time period as specified in an individual's care plan.

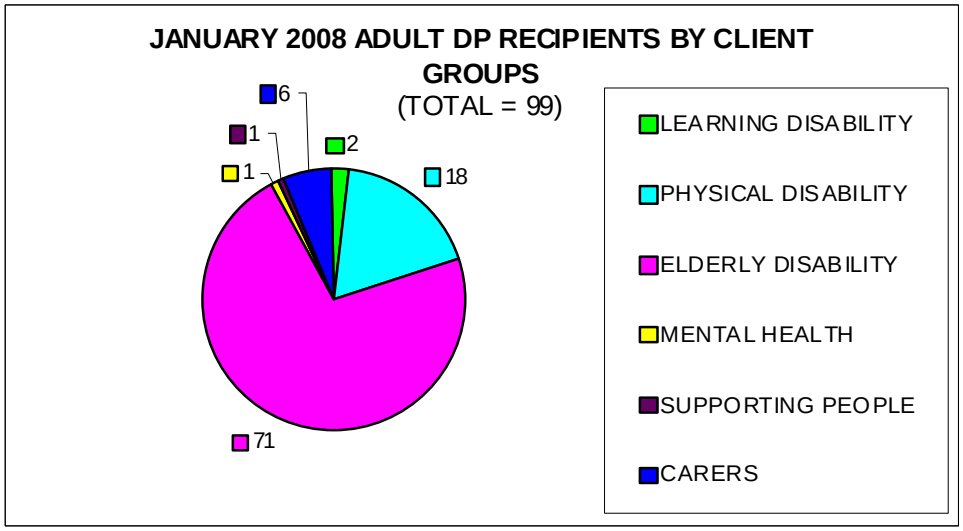
   11 recipients of a Scheme C Direct Payment in 2007/8 financial year.

4) A Concessionary Fare - is currently (2008) a one-off £100 payment made to people who are unable to use Public Transport. It is intended to be a contribution towards their travel expenses.

   There were 1,549 recipients of a Concessionary Fare Direct Payment in 2007/8 financial year.

24 of the people who receive either a Scheme A, B or C Direct Payment are children. Because this report is aimed at Adult Services, Figure 2 describes the other 99 people who receive a Scheme A, B, or C Direct Payment. It splits these 99 people in to different client groups.





Since June 2006 the council has had an in-house Direct Payments Team. This Team has responsibilities for providing a support service to Direct Payments recipients and for developing effective processes and policies within the organisation.

The government intends for as many people as possible that have an assessed social care need to benefit from Direct Payments. Even though we have seen a sharp increase in the last 18 months as Figure 1 above shows, 99 adults is still a small proportion of the adult population in the borough who could use Direct Payments. In the next 10-15 years the numbers are set to grow further. From Figure 2 we can see that the majority of adult DP recipients in the borough are from the older people group. It is common elsewhere in the country to see that the people with learning disabilities or a mental health condition outnumber those older people. Therefore, we will be aiming to reach those currently under-represented groups in the borough.

The 99 current Direct Payments (Schemes A, B and C) in the borough are made to adults with an assessed social care need. The 1,549 Concessionary Fare recipients are people who have completed a 'Well Being Assessment'. This is a self-assessment and has been devised as an innovative way to find out about the well being of the local community. Previous to the establishment of the Concessionary Fare Direct Payment, people who were unable to use public transport were given taxi vouchers. These were found to be restrictive. Some, but not all, taxi drivers would accept them and they could only be used for taxi journeys. The Direct Payment now allows people to use their allocation of funds in a much more flexible way. Indeed, it has enabled a large group of people to benefit from Direct Payments and gain more independence.

The government wants local authorities to change the way in which any need for social care services is assessed. It wants all citizens to be given a new type of self-assessment. This self-assessment will mean that 'Citizens' will be more involved in assessing and setting their required level of support. 'Citizens' will have more choice over how to meet their needs in a way that is correct individually for them, instead of having to settle for what might be right for most other people. Citizens will be given an 'Individual Budget'. This may include a Direct Payment, but it may also include other Services, which are commissioned by the council. This is a major change in the cultural make up of social care. It puts the 'Citizen' firmly in control of their allocated resources. Direct Payments are the ideal products to enable people to take this control and they are set to grow.

8.20 Workforce

We recognise that in order to deliver the vision of the Adult Plan we will require a coordinated multi-agency approach to developing the workforce. Improved outcomes for adults and older people can only be achieved if the workforce has the right skills, competencies, knowledge and capacity to deliver services within the resource available. For the purpose of this strategy the Workforce is defined as all employees and volunteers who work in the Adult social care sector:

Social Services
Private, Voluntary and Independent Sector
Health Services
Other partners

Some of the difficulties that most local authorities experience in adult care services are:

- Higher than national average figures for social care staff turnover, particularly in care homes and domiciliary care
- An increasing age profile of the workforce and in particular difficulties in attracting young people under the age of 25 to enter a caring profession
- Limited career development and opportunities in many areas of social care
- Competition between partners for scarce staff resources

Future staffing requirements will be influenced by two main factors; the requirements of the White Paper 'Our health, our care, our say' [23], and the changing demographics within the borough. The latter means that demands on services will increase, compromising the ability of staff to respond. In this context, we need to continue to explore new ways of delivering services that will make best use of staff resources. This will include the need for staff with different knowledge and skills.

It is predicted that, in terms of direct service delivery, staff skills around advocacy, communication, negotiation, brokerage, navigation, partnership and integration will be key for those staff who will be working to empower citizens to choose services that best meet their needs. A partnership approach will be key to this if, by integrating or merging current roles, there needs to be improved capacity to address the challenges of increasing numbers of older people in particular. The results of our pilot scheme using more generic workers carrying out a broader range of tasks in the community will be evaluated.

The White Paper will also impact the balance and type of skills required to deliver the care assessment process. The current mix of professional and non-professional staff and the processes in which they are involved will need

to be evaluated to respond to new roles and functions that will emerge as the national social work reform programme gains momentum.

The council also recognises that it has a significant role in promoting, supporting and developing the local economy by helping people to improve their skills and developing the borough's infrastructure to support appropriate worker mobility without having a negative effect on the environment. In relation to this the Community Strategy strongly endorses the development of projects for local residents with the aim of creating a sustained sense of economic well-being.

The community of the Royal Brough experiences low unemployment in comparison to the South East and UK overall. Due to current development projects it is estimated that 350 new jobs will be created in The Royal Borough over the next three years. The **Grow Our Own** project is a joint initiative between Bracknell Forest Borough Council and Royal Borough of Windsor and Maidenhead. The emphasis is to enable economically inactive people and those with low skills to acquire relevant skills or qualifications suited to the existing and new job opportunities being created in the local area by town centre redevelopments.

Work is currently being undertaken with a range of employers in the retail and service sectors to identify job opportunities and work with groups to prepare them for interview as well as to assist with on line applications. So far no work has been undertaken within the social care sector and this is an area which will need to be considered quite urgently.

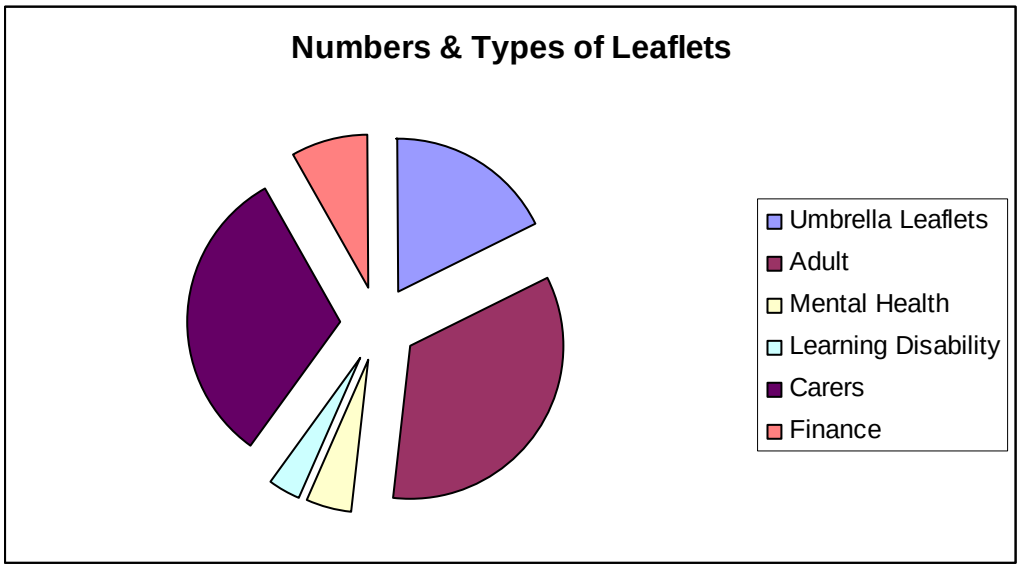
The total number of people that will benefit from the full project over the next 3 years is estimated to be 1,260 with 24% of those going into employment. Within Windsor and Maidenhead over the next year the emphasis is on those within the target group who are job ready and will to go into new employment. Skills development will be targeted at those with a further distance to travel, e.g. those on incapacity benefit and people with disabilities. It is possible that some of these people may be currently working within the care sector and we are already starting to see an exodus of workers leaving the sector.

Policy Implications

Adult Services will need to commission the Directorates Workforce Team to develop an Adults Workforce Strategy as part of this Adult Plan. The aim of that strategy will be to look at how the workforce needs to be developed to meet national policy, the proposed national reform of adult services and local requirements. The key themes this strategy will need to tackle are recruitment and retention, integrated working and the development of leaders and managers.

8.21 Information and leaflets

Adult Social Care produces 62 leaflets for use by staff and the community and these range from providing information relating to services such as homecare to advice about well-being.



The leaflets are printed as hard copies and are also held on the borough's website for easy access. All leaflets with financial information are reviewed on a yearly basis in line with changes to allowances and rules.

In a multi-lingual society, providing services by means of communicating in one language only is potentially discriminating.

Citizens and their carers cannot be offered dignity, respect and choice if there are difficulties in communication. The council is committed to providing a fair and equitable service to all citizens. This cannot be done unless the methods used to communicate are appropriate.

The Government is recognising the costs involved with translating documents and wishes to encourage people to learn the English language. Currently leaflets are translated upon request. However, consideration is being given to the use of interpreters as an alternative to translation so that specific needs can be addressed.

8.22 Citizens Expectations/Aspirations

What people think is important in itself, but even more so given what we already know of the changing needs and expectations over the next decade and beyond.

So in order to plan for better services, we have to fully understand what people want and need. When asked, most people are clear about what independence means for them and what factors help them to maintain it. More and more people are demanding choice and control over how they live their lives. Interdependence is a central component of people's well-being; to contribute to the life of the community and for that contribution to be valued and recognised. People rightly state that they require comfortable, secure homes, safe neighbourhoods, friendships and opportunities for learning and leisure, the ability to get out and about, an adequate income, good, relevant information and the ability to keep active and healthy.

Older people particularly want ageism to be tackled. They want to be involved in making decisions about the questions that affect their lives and the communities in which they live. They also want services to be delivered not as isolated elements, but as joined-up provision, which recognises the collective impact of public services on their lives.

Generally people expect:

- To be seen as a person
- To have friendships, relationships and fun
- To continue with normal life patterns of life
- To get out and about
- To feel safe
- To be as healthy as possible
- To be in control

There are a number of ways in which citizens and carers are able to contribute their views on service planning issues. The following list is not exhaustive but merely serves as an example of how people can be involved:

- During assessments, care planning and reviews
- Involvement in partnership boards
- Satisfaction surveys
- Stakeholder conferences/events
- Voluntary sector liaison meetings
- Contract monitoring
- Citizen and carer organisations

8.23 Information from current commissioning strategies and consultation events

8.23.1 From previous commissioning strategies

Older People

The previous Older Persons Joint Commissioning Strategy (JCS) was a shared document between the Primary Care Trust and The Royal Borough. Key themes were identified in the JCS for the development of services for older people, both from a Health and Social Care perspective. These themes are:

- To provide more multi-agency assessment
- That services will be developed that prevent deterioration of health and promote well-being
- To commission models of care targeted at supporting all older people to remain living in their home environment
- Carers will receive more flexible and responsive services that better support them in their caring role
- To promote and increase the range of appropriate housing
- There will be improvements in the quality and availability of long-term care

Learning Disabilities

The Government has decided that it is time to 'refresh' the Valuing People [37] policy. The document - Valuing People Now: From Progress to Transformation [36] is a draft of how government intends doing this from 2008 to 2011.

In February 2008 the consultation event on the draft objectives was held in Maidenhead. The objectives in *Valuing People Now* reflect those first set out in Valuing People in 2001 and represents those objectives that over this period have worked and also what people have found challenging to achieve.

These objectives reflect those priorities of Windsor and Maidenhead Partnership Board through their work plan and Learning Disability Commissioning Strategy 2004 as it had its basis in Valuing People.

The main priorities for 2008 to 2011 from Valuing People Now continue to be:

Personalisation – so that people having real choice and control over their lives and services. This will include Individual Budgets; Direct payments and Person Centred Planning approaches. A strategy for Self Directed Care will need to be in place to increase take up.

What people do during the day (and evenings and weekends) – helping people to be properly included in their communities, with a particular focus on entering paid work. This will mean continuing to increase the range of services and workforce skill on offer through our day opportunities staff. Our own employment work stream will be forging closer links with day opportunities staff and taking on some of those roles to facilitate e.g. job coaches

Better health - ensuring that the NHS provides full and equal access to good quality healthcare. This is to include annual health checks for all people with learning disabilities. This is happening through primary care and needs to continue. Health Action Plans and Person Centred plans are beginning to be combined.

Access to housing - housing that people want and need with a particular emphasis on home ownership and tenancies. The need of people with a learning disability to be included within the general housing needs strategy.

Making sure that change happens and the policy is delivered - including making Partnership Boards more effective.

The Wider agenda from Valuing People Now- places an emphasis on the following as priority:

Advocacy and rights: Action to ensure that people's voices are properly heard and their rights are respected. A renewed emphasis on creating a local voice.

Partnership with families: Family carers are essential long-term partners in achieving positive change for people with learning disabilities.

Including everyone: There is concern that changes so far have excluded some groups of people. *Valuing People* will only be a success once it is working for everyone. This includes members of BME communities; people on the autistic spectrum, those within the prison system and those people with complex and challenging needs

People as local citizens: People want to be full members in their local community and so access outside traditional learning disability services is important. Priority areas include combating hate crime, transport issues, personal relationships and supporting parents who have a learning disability.

Transition to adulthood: As young people with a learning disability move into adulthood, they should have access to the same life opportunities as everyone else. Good transition planning and multi agency approach is essential for transition planning.

Improving the workforce: New ways of working for staff that support people with learning disability have to underpin the changes from *Valuing People Now*.

Better commissioning: In order to help improve commissioning, some funding in 2008 for social care services, including learning disability services, is to be transferred from the NHS to local government, as a part of the transformation of Social Care.

Mental Health

- The introduction of Community Development Workers and the development of culturally sensitive services. (Awaiting funding from PCT for one more)
- To attain a full compliment and deployment of Graduate Workers. (Awaiting funding from PCT for one more)
- Increasing number of StaR Workers.
- To commission and provide gender sensitive services.
- To develop primary care psychology services with clarity and information.
- To develop a Housing Forum to develop wider range of housing options.
- To improve the mental health services for adults with a learning disability,
- To improve the social and vocational outcomes of people with mental health problems.

Physically & Sensory Impaired Adults

The key themes from the strategy for Physically & Sensory Impaired Adults:

Promoting Independence: Developing systems and processes that support independence and ensure effective use of resources, information and equipment

Access Arrangements: Develop access to services, public places and transport to enable social inclusion for all disabled residents

Advocacy: Develop advocacy services

Continuity of Care: Develop seamless links between statutory agencies and reduce the number of organisations / people that citizens need to communicate with and provide the same information to. Develop community based services.

Sensory Loss Services: Develop services and use of technology to improve support to people with sensory loss.

Accommodation: Develop housing policies to consider re-use of adapted housing, floating support and carer networks for disabled residents. Work with the main Housing providers in the review and development of stock.
Employment: Support people with disabilities to enter into employment.

Information: Improve the range, quality and accessibility of information for physical and sensory impaired adults.

The key themes from the Carers Support Strategy 2005:

Better information and signposting for carers: Improve the range, quality and accessibility of information for carers. Raise awareness of Caring role.

The right to a Carers Assessment: Ensure there is a system for Carers Assessments in line with Carers Acts. Need to increase the number of assessments and improve recording.

Partnership with other agencies: Work in partnership with Carers, Carers' groups & their representatives to develop timely & effective services.

Consultation and involvement with Carers: To involve carers in planning, shaping & providing feedback about services.

Practical & coordinated support for Carers: Ensure that services are as practical & coordinated as possible.

Breaks from Caring: Provision of breaks services to Carers. Improve the quality, range & accessibility of short term break opportunities.

Choice for Carers: As far as possible provide the Carer & the person they care for with choice of the services they receive.

Ensuring the quality of services that support Carers: Ensure that services to Carers are of high quality

Training and support to Carers: Training and support provided to support Carers in their caring role

Equal Opportunities: Recognise and value carer's diverse needs and backgrounds.

Minimising the cost of Caring: Minimise the cost of caring through partnership work

8.23.2 Information from Consultation Events

We set out to ensure that the proposals found in this plan truly reflected the views of the citizens of The Royal Borough and carried out citizen, public and staff consultations during September and October 2007. We committed ourselves to three public consultation events during this period designed to give people a genuine opportunity to influence this plan. These events were held in Ascot, Windsor and Maidenhead and around sixty people attended these. In addition each of the Partnership Boards – Older Persons, Learning Disabilities, Mental Health, Physical Disabilities and Sensory Impairment and Carers – all had the opportunity to contribute to the development of the plan. People were also able to let us have their views through the council's website and over 50 responses were received.

The messages throughout the consultation period were fairly consistent about the proposed strategic priorities. In particular people were pleased to see greater focus on preventative types of services and greater personalisation of care. People were also realistic and understanding about the resources available and acknowledged that finance is limited and that staff are hard-pressed. But this did not mean that services could only get better if there was more money available.

Generally people said they wanted services that are based around their needs and that help them to have greater choice and take control of their own lives. Many said they wanted to see improved and easier access to help them as and when they needed help and in a way that fitted with their life. Whilst many spoke encouragingly about the range of information in leaflet form some did say that we needed to do more in the way of different mediums such as Braille, large print and recorded on CD or DVDs. Many people also indicated that they would want services closer to where they live and that they didn't only focus on an immediate crisis.

People were generally clear about what improvements and developments they would like to see and some of these can been seen in Figure 1 on the next page.

Figure 1- Feedback from consultation events