

# Community Care Commissioning Strategy 2008 - 2013

Choice and control  
for Adults with  
Social Care needs

With Dignity, Value, Respect

Community Care Services





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Appendix 1: Tribal Consulting Needs Analysis

## Executive Summary

This strategy sets out how the Royal Borough of Kingston (RBK) Community Care Services will transform and improve Social Care Services to Adults over the next five years. The strategy has been developed jointly with key partner, including our main commissioning partners, Kingston Primary Care Trust. Whilst the focus of the strategy is Social Care, individuals do not and will not receive support in isolation. Every time we support people through commissioning or enabling Social Care, there is a wider context of family support, voluntary sector support, NHS services or individuals' own self-care and support.

The subtitle of the strategy is Dignity, Value and Respect. We will ensure that these three key values underpin the future of Adult Community Care. This strategy is an overarching strategy covering all Adult Community Care. In addition there are six component strategies, which deal with the following user groups and key issues.

- Older Peoples Services
- Physical Disability and Sensory Impairment Services
- Carers' Services
- Learning Disability Services
- Safeguarding Vulnerable Adults
- Mental Health Social Care

All the strategies set out the strategic direction for RBK over the next five years from 2008 to 2013. Each strategy includes an action plan. These will be updated annually.

### **A strategy for transformation**

Over the next five years RBK's adult Community Care services will be transformed. The progress will see a shift to more personalised models of support, building on longstanding areas of success, such as Direct Payments. There will also be a shift to greater partnership working, with NHS and third sector colleagues. We will work with others to improve commissioning and service delivery. The Council's focus will be to provide support and care to the most vulnerable, whilst also offering a wide range of lower level services, which promote independence and wellbeing.

These changes will be delivered in partnership with service users and citizens. Whilst the Council is keen to improve services as quickly as possible, it is recognised that people need to be involved in the change process. The strategies propose a number of changes, but there are no plans to remove services from any group or individual.

### **Key outcomes areas**

The overall strategy identifies eight key outcomes for Kingston:

- Targeting the most vulnerable
- Prevention, rehabilitation and recovery
- Resources and value for money
- Integration, seamlessness and partnership
- Independence, autonomy and personalisation
- Safeguarding vulnerable adults
- Dignity, respect and equalities
- Engagement and co-production

Set out below is an overview of each of these aims:

#### **Targeting the most vulnerable**

The Council will seek to ensure that those people in greatest need of support are targeted and receive the help they need. Access to services should be easy and straightforward - people should be able to know what is available and what they are entitled to.

#### **Prevention, rehabilitation and recovery**

Services should work to keep people well by supporting people and giving them information, which will help them stay well. They should also help people to maximise their potential to support and care for themselves.

#### **Resources and value for money**

RBK spends over £40 million on Adult Social care. This money will continue to be spent on services, which meet people's needs. There will be a good mixture of services, which offer people choice. The evidence from RBK and across the country is that people want to stay living in their own homes - resources should be directed to support this.

The Council should check that the money is well spent and that services are of high quality. The Council will also make sure that staff who work in the care field are properly trained and can provide a caring and efficient service.

### **Integration, seamlessness and partnership**

The Council will work with other bodies, like the NHS and voluntary sector organisations to make sure that all the services work well together and there are no gaps. The Council will work with other organisations to develop new ways of supporting people and helping them remain independent.

### **Independence, autonomy and personalisation**

This is one of the biggest challenges in the strategy. This is a key priority for the Government and for RBK. We will ensure that support to individuals is more personal to them, building support around individuals, rather than fitting them into existing models of service. We will also be working to ensure people have greater choice on how this support is organised, through giving people control over the way the money is spent.

### **Safeguarding vulnerable adults**

RBK will improve the way we protect vulnerable adults from abuse, whether this is physical, financial, emotions or sexual abuse. We will do this by improving staff training, supervision and working closely with other agencies.

We will also be working to make sure that there are processes to ensure that people can speak out about their care and support.

### **Dignity, respect and equalities**

RBK's population is changing and the Council will work to ensure that services meet the needs of all groups in the Borough. We will also be working with partners to ensure that everyone is treated with dignity and respect.

### **Engagement and co-production**

RBK is committed to develop services in partnership with local people. A key part of the strategy is to involve people who use services, their carers and other local people to develop services and help to improve things. This will range from developing plans for individuals on how they are supported to work through local groups and plan service changes.

### **Targets**

There are targets within each of the component strategies and each will have an action plan, which is reviewed and recast every year. The overarching Adult Community Care strategy has the following set of targets. These are set out in greater detail in the action plan attached to the strategy (see Action Plan).

- Information and advice provided in an accessible way, by informed providers in a format that can be understood by all

- Providing comprehensive information and advice is critical to improving people's choices and wellbeing. The Independence and Wellbeing strategy will help to plan this, to deliver the Council's commitment to undertake a review of information and advice systems within this financial year
- Build on the success of the self-assessment system for community equipment to enable self assessment for all services
- By July 2008 we will have revised our risk management guidance for all staff, to enable staff to support people to make choices and live independently
- To complete the evaluation of brokerage by September 2008
- By 2010, everyone using Community Care Services will have the option of using a support brokerage model, to help them achieve their planned outcomes
- RBK will continue to provide an in-house home care service for the next five years. Most Home Care will be provided in the independent sector. The in-house service will work on new and complex packages of support
- By 2011 RBK will have expanded the numbers of support/care providers by 25%
- By 2011 there will developed new models of community transport.
- By 2011 RBK will have worked with partners to develop new Social Enterprises in the care field
- RBK will have reviewed the impact of personalisation on current charging policies; any suggested changes will require consultation and a decision from the Council's Executive
- To work with local Housing providers:- RBK, Housing Associations and private landlords to provide a wider range of Housing options.
- RBK and Kingston Primary Care Trust will explore the possibilities for joint commissioning with a view to developing more joint commissioning

- Increase the number of people using either Direct Payments or Individual Budgets by 20% every year
- Enable all service users to have a virtual individual Budget
- Community Care will undertake a survey to measure the success of engagement with service users and carers

### **Consultation**

There has been extensive consultation on all of the strategies, each being produced following consultation with partners and the public.

## 1. INTRODUCTION

This strategy sets out how the Royal Borough of Kingston upon Thames (RBK) will transform and improve Community Care Services to Adults over the next five years. The strategy has been developed jointly with key partners, including our main commissioning partner, Kingston Primary Care Trust. Whilst the focus of the strategy is Social Care, individuals do not and will not receive support in isolation. Every time Kingston supports people through commissioning or enabling Social Care services, there is a wider context. This may be family support, voluntary sector support, NHS services or individuals' own self-care and support. The strategy sets out the role the Council plays in developing the fabric of support in partnership with other organisations and, most crucially, with local peoples themselves. The aim is to enable all adult residents in RBK to enjoy the full benefits of living in the Borough and to take part in, and contribute to community life.

There are a number of definitions of 'commissioning'. Perhaps the most relevant definition is that provided by the Department of Health (DH) in its document 'Commissioning framework for Health and Wellbeing', March 2007:

### Key outcomes of, and requirements for, good local commissioning

Commissioning is the means to secure the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services for users which:

- Deliver the best possible health and wellbeing outcomes, including promoting equality
- Provide the best possible health and social care provision
- Achieve this within the best use of available resources

Commissioning for the health and wellbeing of individuals means helping local citizens to:

- Look after themselves, and stay healthy and independent.
- Participate fully as active members of their communities.
- Choose and easily access the type of help they need, when they need it

Commissioning for the health and wellbeing of a local population means:

- Understanding and anticipating future need
- Promoting health and inclusion and supporting independence
- Identifying the groups or areas that are getting a raw deal and giving them a voice to influence improvements
- Delivering the best and safest possible quality of care

This definition and much of the best practice guidance on commissioning has been prepared by the Care Services Improvement Partnership (CSIP).

At a national level the goals have also been expressed as the four priorities from the Government's White Paper 'Our health, our care, our say':

- Better services and earlier prevention
- More choice and a louder voice
- More on tackling inequalities and improving access to services
- More support for people with long term needs

These are key aims both for Local Authorities and for the NHS.

These aims have a good fit with the shaping principles that underpin the Royal Borough of Kingston's vision, 'Changing Kingston, Choosing our Future':

- **Prevention** – we will invest now in those services which will reduce the need for more intensive and expensive services later
- **Personalisation, choice and control** – we will tailor our services to meet individuals' and communities' needs and aspirations and allow them greater control over the services they receive and how they receive them
- **Local settings** – we will deliver services as close to the users as we can, at home or in local neighbourhoods will be our preferred approach
- **Customer focus** – we will put the customer first in all we do and align our organisation to our customers rather than to our services
- **Working with partners** – we will work closely with a full range of partners, voluntary, public and private, in order to ensure that the most effective and efficient services are provided

As the national policy context has developed there has been increasing emphasis on offering people greater choice and control. In the Government's pre-budget statement in October 2007 there was the following announcement:

"In addition, today the Government is announcing its intention to produce a Green Paper on reform to the system of adult care and support, in order to ensure that an affordable system is in place for the 21st century. These reforms will ensure that state resources are targeted effectively, and enable people to have choice and control over the ways they live their lives".

Whilst this Green Paper and any subsequent legislation will inevitably bring a range of changes to Adult Social Care, it is clear that the policy direction of a shift to greater personalisation, choice and control is irreversible and accelerating. RBK has an excellent track record in developing more personalised models of care and support.

The Borough, working with local users and carers, was one of the first to develop and promote Direct Payments and is now actively developing Individual Budgets. This strategy sets out the route to even more personalisation.

In January 2008 the DH issued a circular, 'Transforming Social Care', which emphasised this direction of change. This strategy seeks to ensure that RBK can deliver that transformation. Personalisation is key to this.

"In the future, all individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and wellbeing."

and, further that

"Personalisation is about whole system change, not about change at the margins."

There is also emphasis on developing information and brokerage (support brokerage is about helping people to plan and organise the support they need to be independent – they make it happen!), so that people can find their way through the systems and achieve the outcomes they want.

This document sets the strategic framework for commissioning outcomes. The emphasis on personalisation makes the focus on outcomes for residents even more important as the traditional model of commissioning blocks or volumes of service for people will be reduced by the growth of personalisation. The key outcomes set out below are responses to both the policy directions set locally and nationally and the needs of the community identified in the needs analysis at Appendix 1.

Our key principal outcomes are:

- Targeting the most vulnerable
- Prevention, rehabilitation and recovery
- Resources and value for money
- Integration, seamlessness and partnership
- Independence, autonomy and personalisation
- Safeguarding vulnerable adults
- Dignity, respect and equalities
- Engagement and co-production

These principal outcomes will include individual outcomes. The aim of the Strategy is to set a context which improves the delivery of the crucial outcomes for individuals. These range from: choosing what to eat and when, acquiring and recovering life skills, choosing where one lives, to how one's daily life is conducted and much more.

#### **The structure of this document:**

The Community Care strategy provides an overarching framework for all adult services, identifies the keys goals and the key mechanisms for delivering them.

Linked to this strategy are component strategies, which cover specific areas, these are:

- Older People Services
- Mental Health Social Care
- Learning Disability Services

- Physical Disability and Sensory Impairment Services
- Carer's Services
- Safeguarding Vulnerable Adults

Two strategies are being jointly commissioned with NHS colleagues and will be completed later in 2008. These are:

- Mental Health strategy (the MH Social Care strategy is attached but this will extend beyond that and over the full range of partnership activity). Work will begin in autumn 2008 and be completed by Spring 2009
- Older Peoples' Mental Health Strategy. This will be complete by October 2008

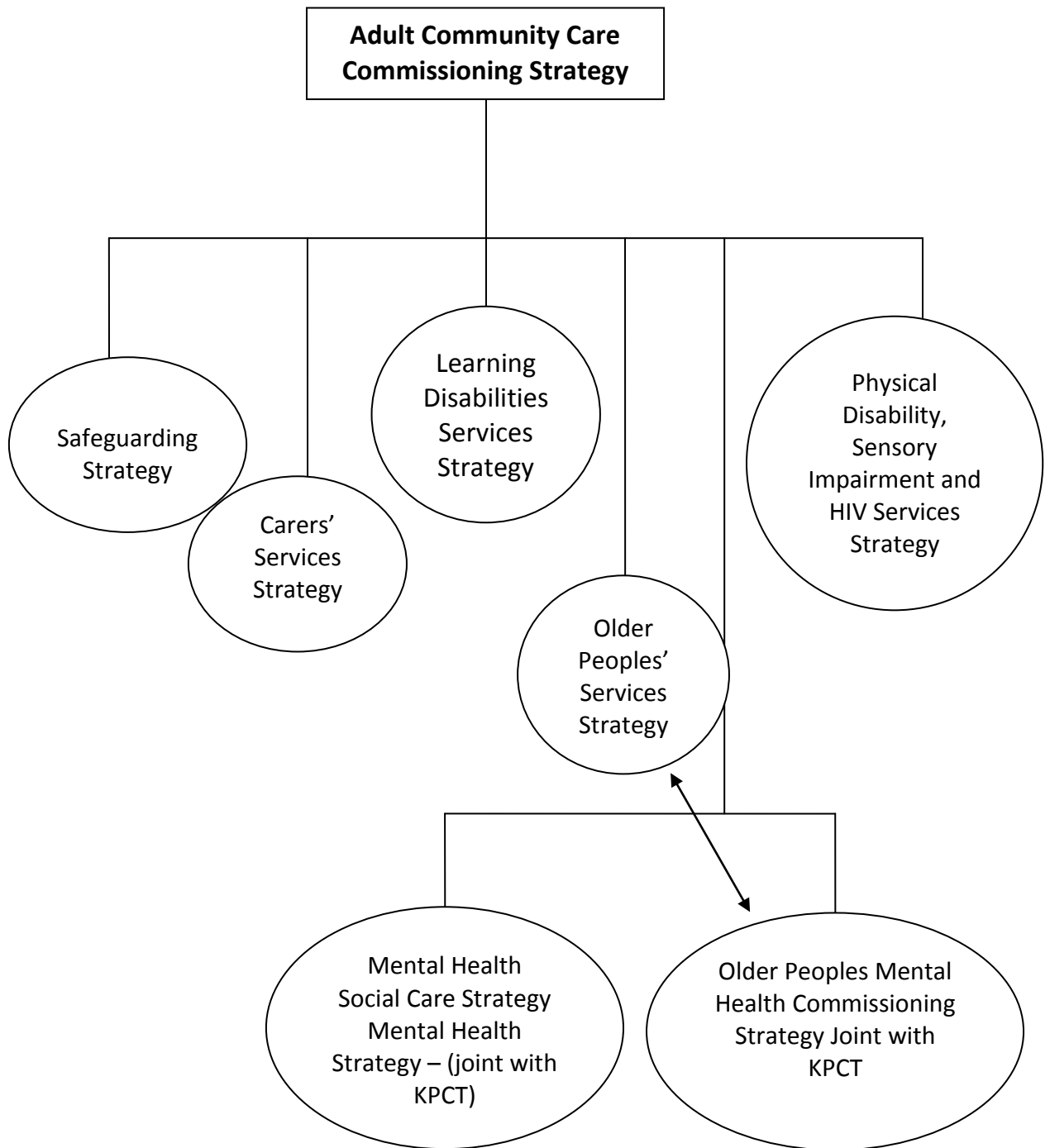
There is an existing Treatment Plan which sets out clear intentions and objectives for substance misuse services and there is a multi-agency Alcohol Strategy.

These component strategies focus on delivery for specific groups within the population, but each strategy helps to deliver the aims of the overarching strategy. All focus on detailed commissioning and delivery for these groups. Each strategy is slightly different as there are different national and local drivers.

A brief summary of each of these strategies is contained in this report and the full text of each strategy is available as an appendix.

The Independence and Wellbeing strategy, agreed by the Council's Executive on 22nd July 2008, is a 'sister' to this one and sets out the direction for prevention services to support people with lower levels of need, promote wellbeing, and covering a wide range of community support.

The relationships between the overarching Community Care Services Strategy and the individual component (service area) strategies can be demonstrated by the diagram on page 14. The diagram shows that the overarching Community Care Services Strategy is the 'parent' to the individual service area strategies which are its 'children', so to speak. In other words, the overarching Strategy sets the national and local context, direction and developmental path for the individual strategies.



This strategy will run from 2008 to 2013. Each year an action plan for each service area strategy will be produced, detailing plans for the next year and looking forward to the following year in outline.

It is proposed that each year these action plans will be generated through the partnership structure, such as the Learning Disability Partnership Board, Older People's Partnership Board etc. and will be available on the Council's website.

## 2. NEEDS ANALYSIS

A detailed Needs Analysis was commissioned from Tribal Consulting to inform this and linked strategies. As the strategies evolve over the coming years, the needs analysis underpinning the strategies will be updated. The full analysis is attached at Appendix 1.

## 3. ELIGIBILITY AND ACCESS

All Local Councils operate under national guidance in determining eligibility for services. This guidance is based on an assessment of an individual's risk to independence. This is the Fair Access to Services guidance (FACS). Following extensive public consultation RBK moved from meeting all four bands:

- Critical
- Substantial
- Moderate
- Low

to meeting only the top two bands for new users from 1st August 2007. In making this move, RBK is in line with over two thirds of all councils in England and Wales.

This change has led us to examine the lower level and preventative services, previously only provided through adult social care services, but are now only provided to people whose risks to independence are judged to be critical and substantial. These preventative services include a wide range of services, such as parts of the Sensory Impairment service, some lower level day services, services to people with Aspergers Syndrome etc.

Part of the change to the criteria was the commitment from the Council to develop an Independence and Wellbeing Plan (I&WP), which sets out how the Council enables and supports services and activities for the whole community to promote independence and wellbeing.

The development of this Plan has been done in partnership with KPCT, (with particular assistance from the Joint Director of Public Health) and a number of voluntary and community organisations, RBK's Voluntary Sector Unit and RBK's Housing and Community Care Services.

This strategy was consulted on between February and April 2008. The relationship between this strategy and the I&WP is a close one, with the clear aim of ensuring that the fabric of support for people is robust, covers all citizens and offers information, choice and control.

Critical for the success of the changes proposed in the IWB Plan is the development of improved models of information and advice. Those people who meet the Council's criteria for services can receive support from assessment staff within the Council, but with the growth of individual budgets and preventative services, it is necessary that there is a wider, more universal system, which provides information and advice in a variety of settings. The development of this will be part of the development of the I&WP.

### **Target**

**Information and advice provided in an accessible way, by informed providers in a format that can be understood by all.**

Providing comprehensive information and advice is critical to improving people's choices and wellbeing. The Independence and Wellbeing Plan will help to develop this. We intend to deliver the Council's commitment to undertake a review of information and advice systems within this financial year (to be completed by March 2009).

Improved and comprehensive information and advice, the top priority to emerge from our I&WP consultation, will enable people who meet the Council's criteria, and those who do not, to find out what is available in the community or through other statutory agencies. Furthermore, this system will facilitate maximum welfare benefit take-up and help people to contribute to life in RBK.

### **What's out there for those with substantial and critical needs?**

Assessment and care management teams, which are able to provide information and advice, are as local as possible.

All of the teams are joint teams with local NHS partners.

There are single teams covering the whole borough for:-

- People with a physical disability and those affected by HIV (joint with Kingston Primary Care Trust)

- People with a learning disability (joint with Kingston Primary Care Trust)
- Older people with mental health problems (joint with South West London & St Georges Trust)
- People with a sensory impairment

For working age adults there are four area based Community Mental Health teams, staffed jointly with South West London and St George's Mental Health Trust.

For Older people there are three area-based joint teams with KPCT.

There is a self-assessment system for community equipment, which is available on-line, with supported assessments for those who want it.

RBK and its local partners, especially the NHS, the Police and the third sector are exploring the development of 'community hubs'. These will support the delivery of the strategic aim of 'promoting easy local access to services', offering rapid and seamless responses.

#### **Opening times for assessment and care management services:**

##### **Services run by RBK**

- Monday to Friday 8.45am to 5pm, 4.45pm close on Fridays.

##### **Services run by South West London and St Georges Mental Health Trust, i.e. Mental Health Teams**

- 9am to 5pm Monday to Friday.
- There are also out of hours assertive outreach and crisis services.

##### **Out of hours services for Adults (in partnership with Merton, Sutton and hosted by London Borough of Richmond)**

- provides emergency duty Social Work service outside normal working hours, 365 days per year

#### **Assessment and Care Management**

RBK puts people at the centre of assessment and will continue to deliver high quality person centred assessment to all users groups. Assessments always involve the person being assessed as much as possible and almost always involve others, whether that be family carers, NHS colleagues or a wide range of others.

To support the assessment process, a range of assessment tools is used. Where people meet the Council's criteria for services, the assessments result in what might be called micro-commissioning.

Amongst these tools is an already existing project, which enables people to complete an online self assessment for daily living equipment. There is also support available from voluntary sector partners, Age Concern, Kingston and Kingston Centre for Independent Living, and Council staff to help people to complete this assessment. It is a strategic aim of RBK to expand self assessment over the next five years.

### **Target**

Build on the success of the Self-assessment system for daily living equipment to enable self assessment for all services by April 2009.

### **Self Funders**

Assessment is offered to all those who might have a need for community care. For residential services, the financial assessment may mean that some people are responsible for paying for their own care. It is not always clear whether people will be responsible for paying for their own care until a financial assessment is completed. People who seem likely to have a community care need will be offered an assessment, regardless of their financial position. Support is offered to self-funders by the Kingston Hospital social Work team and the Placements team.

Some people require ongoing support and care management for extended periods. These tend to be more complex cases, often where there are significant health problems. For some years now Mental Health Services have used the Care Programme Approach (CPA) to support individuals with ongoing needs. This is a structured way of managing cases, which sees the appointment of a Care Coordinator, who is the lead caseworker.

There are similar models for people with long term conditions. RBK and KPCT have a joint Long-Term Conditions Strategy, which sees GP's community health staff and social care staff working together to support people with long term health conditions. It should be added that in both the CPA and long-term conditions work the service user is central to the process, being encouraged to take on as much self management as possible.

Developing, extending and improving these mechanisms to support people in the longer term is a key aim for both RBK and KPCT. The benefits are that individuals are likely to have better health outcomes, avoid unplanned hospital admissions and are more involved in the management of their own care.

Following an assessment, reviews are undertaken after six weeks to ensure that the assessment and any services, or personalised budget, is meeting the expected outcomes. Thereafter all cases have an annual review, although this sometimes may be brought forward if there are specific issues that need to be addressed. These reviews are proportionate to the needs of the individuals. For some simple, stable packages of care, telephone or questionnaire type reviews may be used. For more complex and less stable packages a full review including face to face meetings and possibly professional's meetings will be required. All services have a face to face review at least every other year.

One of the key roles for Care Managers and brokers is to support people in managing risk. There is a range of guidance from Government on how to support people to live independent lives, protect themselves and the public. There was detailed guidance from the DH in relation to Mental Health in June 2007 following guidance issued in May 2007 by DH: "Independence, choice, and risk, a guide to supported decision making". RBK has always sought to enable people to live independently and to take appropriate risks. There are robust mechanisms to ensure public protection, such as the Multi Agency Public Protection Panel (MAPPA), but the shift to more community based care and personalised packages of care will require even more careful management of risk. Work is underway to change policies and procedures for staff to incorporate this guidance. This work will be completed by July 2008 and be shared with all stakeholders for comment.

### **Target**

By July 2008 RBK will have revised risk management guidance for all staff, to enable staff to support people to make choices and live independently. (This has been completed)

RBK is embracing new models of assessment and care management, in the push to develop individual budgets and self assessment (there is a separate section on personalisation below). A third component of this is the development of brokerage. Since 2007 there has been a brokerage pilot underway in Learning Disability services, which will be evaluated in the summer of 2008. By April 2010, all those using Community Care Services will have the option of using support brokerage.

Across the country there are a range of models of support brokerage and RBK will both contribute to and gain from the shared learning this will offer. The model pursued so far seeks to develop the ideas in the 2006 Commission for Social Care Inspection (CSCI) paper on Support Brokerage and follow Paradigm's 12 steps to brokerage. The service will work well, but it will not be exclusive to Individual/ Personal budgets.

### Target

To complete the evaluation of brokerage by September 2008

By 2010, all users of Community Care services will have the option of using a support brokerage model, to help them achieve their planned outcomes

One of the key tasks for adult social care is to continue to improve the transition process from children's services to adult community care. The Commission for Social Care Inspection (CSCI) produced a guide for better transition for young people with complex needs "Growing up matters" in January 2007.

RBK has already made good progress on transition. Care Management staff are already co-located with children's services to improve planning. Information about the number of young people coming through the system is much improved. However, national surveys consistently show that the transition from children's services to adult services is a particularly difficult time for young people and their parents and carers.

Therefore RBK needs to continue this work. To get this process right it is particularly important to engage with young people and their parents and carers as early as possible to support future planning. There are already groups of parents of young people with learning disabilities, but RBK will work to improve these links and make the transition smoother.

A key aim for RBK is to develop local commissioning models with partners. This will include working with partners in the NHS. There are key opportunities to develop new commissioning relationships with KPCT and particularly with local General Practitioners through Practice Based commissioning. Developing local services, which are effective at meeting local needs, is key.

The move to shift services from general hospitals and deliver local, preventative services will enable new models of integrated social care and NHS commissioning.

One of the key areas to improve is an area where RBK has already made good progress: recovery and rehabilitation. For all service user groups both commissioning and services should facilitate recovery and improvement. In terms of access and eligibility this means ensuring that everyone has the opportunity to maximise their independence.

Both community intermediate care services and Mental Health services have made progress in dissolving organisational boundaries at the point of access, in order to improve recovery and rehabilitation, but this is a key area for development. Critical too is to involve service users in this process. These models can both improve outcomes for service users and deliver better value for money, as they can reduce dependency.

In addition to targeting individuals with greatest need, there is also the task of targeting areas of the Borough where there is the greatest health need. There is detailed information available in the Joint Public Health Annual Report 2006 and the RBK Borough Profile, which indicates that some parts of RBK have worse health outcomes and lower life expectancy than others. Some work has already been done to target resources to these areas, through the Community Action Partnership (CAP). The Council is committed to work with partners in all sectors to continue to work to close the gaps in health outcomes and life expectancy that exist in RBK. This is not simply an Adult Social Care issue, but an issue for all partners in RBK, including Learning and Children's services, the NHS, other Council departments and third sector partners.

#### **4. RESOURCES AND HOW THEY ARE APPLIED**

The tables below show the high level of investment RBK makes in adult community care.

##### **RBK Budget 2008/09**

	£
Community Care (38% of total)	43,686,800
Other Community Services	5,080,100
Environmental Services	23,082,700
Learning & Children's Services	30,891,900
Neighbourhoods	6,559,800
Central Services	4,257,700
Total	113,559,000

### Community Care 2008/09 Draft Budget

	£
Care Management	9,094,100
Residential	18,303,900
Day Services	4,956,600
Home Care	5,122,500
Concessionary Travel	4,494,000
Other Services	1,715,700
Total	43,686,800

### Community Care spend on client groups

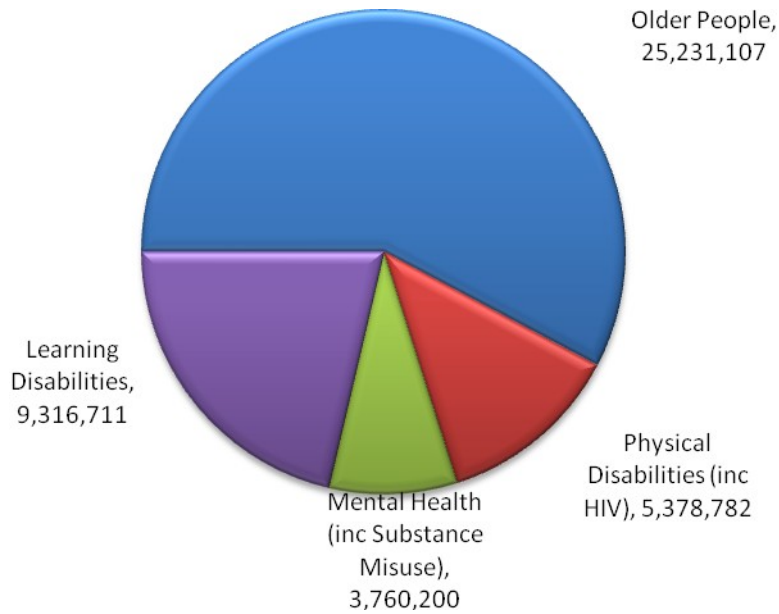
	£
Older People	25,231,107
Physical Disabilities (incl HIV)	5,378,782
Mental Health (incl Drug & Alcohol)	3,760,200
Learning Disabilities	9,316,711
Total	43,686,800

### Community Care Gross Expenditure and Income

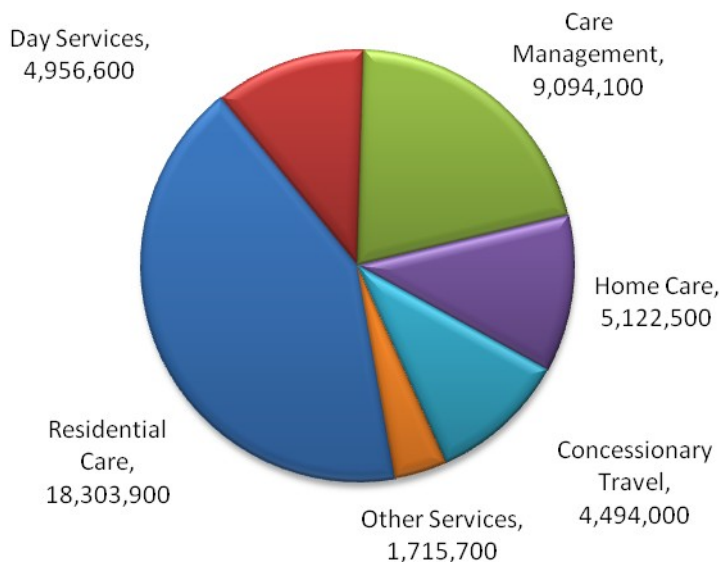
	£
<b>EXPENDITURE</b>	
Staff costs	17,700,200
Buildings costs	1,778,200
Transport	769,700
Supplies & Services	1,616,000
External Contracts	28,261,000
Concessionary Travel	4,407,400
Management and Support Services	4,166,800
	<u>58,699,300</u>
<b>INCOME</b>	
Government Grants	-1,990,600
Contributions from Health	-5,348,800
Fees and Charges	-7,673,100
	<u>-15,012,500</u>
<b>NET EXPENDITURE</b>	<u><u>43,686,800</u></u>

This can be summarised by the following charts:

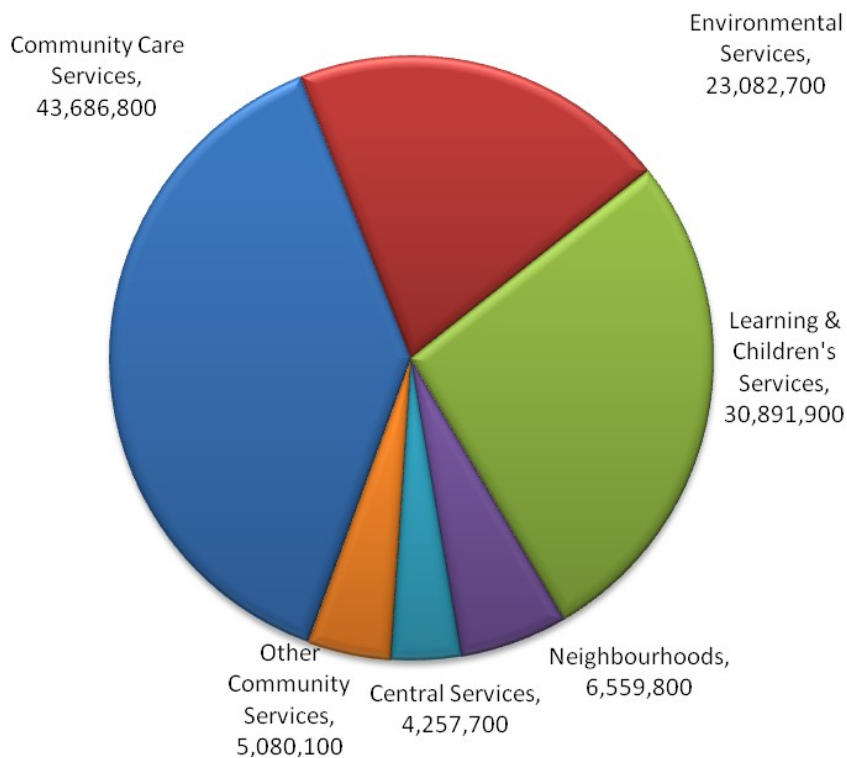
### Community Care spend on client groups (£)



### Community Care 2008/09 draft budget (£)



### RBK 2008/09 draft budget (£)



As a Council, RBK faces a challenging financial outlook for at least the first three years of this strategy.

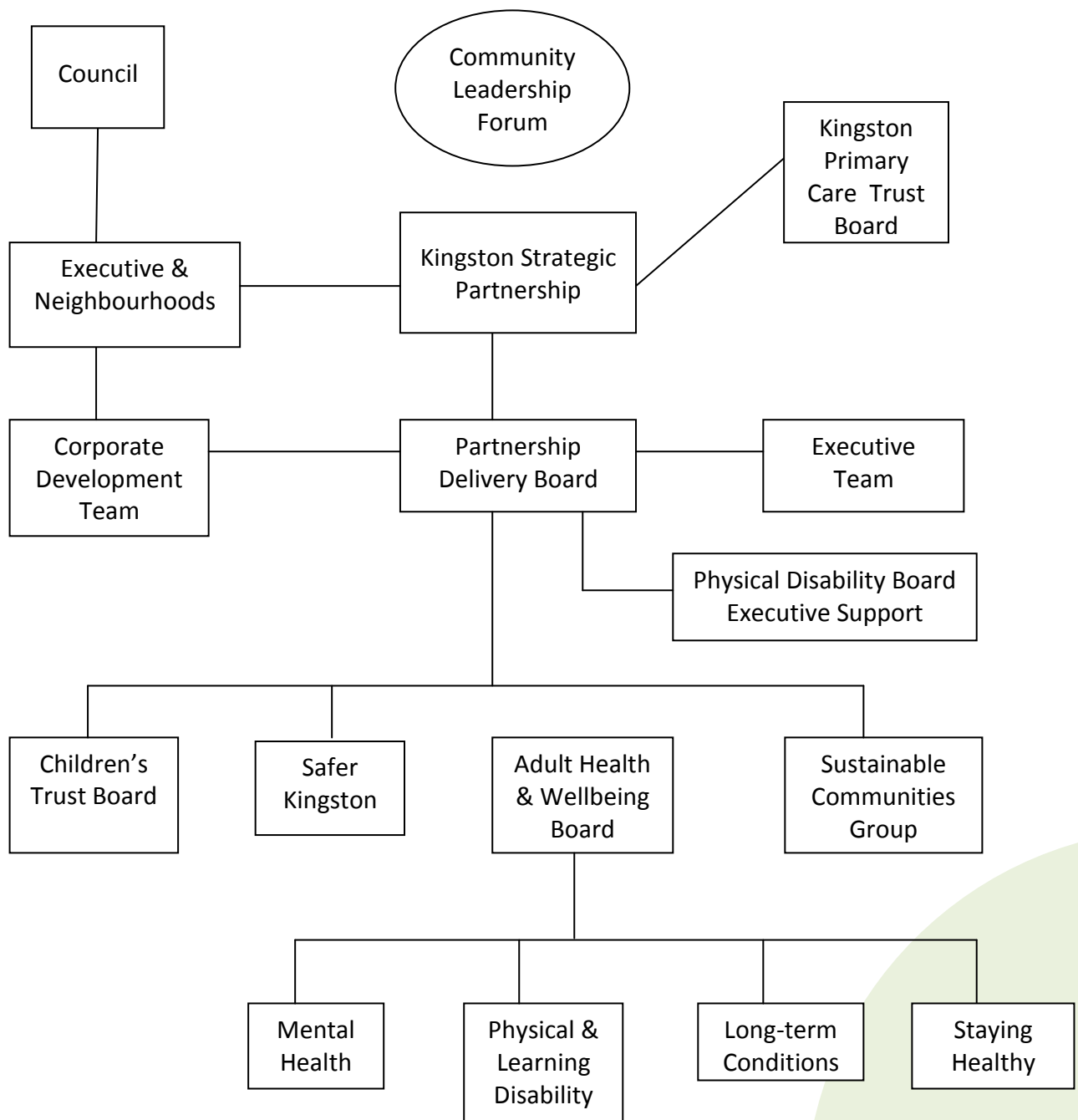
Details of RBK's strategic approach to managing resources and securing change are contained in 'Destination Kingston – 2011'. This sets out the objectives and principles for Kingston, as well as the financial outlook. Overall financial resources available to Kingston are diminishing until 2011.

Services provided to adults with community care needs and the preventative services, which are also provided, form a significant part of the Council's overall expenditure and therefore cannot be isolated from the challenges facing Kingston. The shaping principles referred to above will ensure that Kingston transforms services within available resources, retaining the strategic focus on improvement.

Resources for local partners are also limited and under pressure. Kingston Primary Care Trust (KPCT) has been engaged in a financial recovery process, which has been managing down a deficit, which, in 2007-08, was £22 million. This is showing signs of success, but the financial position for K PCT remains tight with modernisation and transformation being critical to achieving financial balance. This strategy is congruent with KPCT plans to modernise and gain better value.

Other local NHS partners, Kingston Hospital Trust and South West London and St George’s Mental Health Trust also have financial challenges and have developed plans to achieve a sustainable financial position. In 2008 both of these Trusts will be working towards achieving Foundation Trust status, which will require the demonstration of financial viability.

The collective aim of improving services, outcome and value for money is one RBK shares with local NHS partners. Working together to achieve this is a key goal. These partnership arrangements are governed by a range of partnership arrangements, which also have the involvement of the third sector and service user representatives. These arrangements are evolving; the model RBK and its partners are working towards was agreed at the joint partnership Delivery board in February 2008 and is set out below:



Over recent years RBK and the NHS has worked very hard to ensure that changes made in the local Health and Social Care economy do not impact negatively on other organisations, this is sometimes called 'cost shunting'. This has been successful, with organisations working together to achieve change. This continued communication and cooperation has the commitment of all local partners.

The thrust of Government policy and of this strategy is to accelerate the shift to more personalised services, which deliver the outcomes individuals want. This shift has been happening in financial terms for some years. There has been significant growth in the development of Direct Payments over the last five years, with £1.5 million now being spent on Direct Payments. There has been rapid growth in the amount of resources committed through individual budgets, with £0.2 million now being spent on these. There has also been a shift away from spending on residential options. In older people's services the number of bed days purchased in residential services has reduced by 25% since 2001.

There has been reduced commissioning of residential placements for people with Learning Disabilities, with only 1 new placement being made in 2006-07. However, there has been some growth in residential services. Between 2001 and 2006/7 the number of bed days in older people's nursing care fell by just 2%. Within the overall reduction there has been steady growth in need and therefore commissioning of services for people with dementia type illnesses. In the Learning Disability Service, although numbers have fallen, costs have risen, with the average cost of a Learning Disability residential place rising from £879 per week in 2002 to £1,223 per week in 2007.

There has been a steady growth in the number of young people coming through the transition process from Children's to Adult services in recent years. The numbers of young people and their level of need vary from year to year. Numbers range from 10 to 20 per year, although not all are high cost placements. The Council has responded to this changing demand by making additional resources available to meet these needs. The Community Care budget has had growth of £300k per annum over the last three years (2006–2008) to reflect this change in demand. The aim has been and will continue to be to avoid residential placements for these young people where possible and offer them personalised care packages.

Overall the pattern is of reducing numbers of people accessing residential and nursing services, but the average costs are rising. This seems likely to be because of the relatively higher needs of those now accessing residential or nursing settings.

## Key Facts

- £1.5 million was spent on Direct Payments in 07/08
- 25% fewer beds were commissioned in residential homes for older people between 2001 and 2007
- Average cost of a Learning Disability residential placement rose from £879 per week in 2002 to £1,223 in 2007

This shift in the pattern of purchasing is likely to accelerate and will pose challenges for the pattern of RBK commissioning.

RBK has very limited use of block contracts for residential or nursing care. However RBK is a significant provider of residential and nursing services for both older people and people with a Learning disability.

In older peoples services RBK provides:

- 38 residential places at Murray House
- 38 residential places at Newent House
- 44 nursing beds (22 flexible) at Hobkirk House
- 44 Elderly Mentally infirm beds at Amy Woodgate House from summer 2008 (new development)

The development of nursing care at Hobkirk House and Elderly Mentally Infirm (EMI) care at Amy Woodgate was a response to changing needs. The details of population trends in the needs analysis suggests that, whilst the picture is not perfectly clear; there is no major demographic growth in the older population. This and the trend analysis suggests that the provision of a total of 76 older people's residential beds needs to be reviewed, during the lifetime of this strategy, to ensure that it meets the changing patterns of need and commissioning requirements. This review will look at all aspects of commissioning of older peoples residential and nursing services; including supply, quality, provision of single rooms and likely future needs. The review will be completed by the end of 2008

In Learning Disability Services RBK provides 14 residential beds at Woodbury. Whilst the numbers of placements of PLD are falling fast, there remain over 150 people placed in residential settings, many outside Kingston, so it is likely that Woodbury would continue to meet RBK's needs during the life of this strategy.

A range of other services are funded by RBK. These include services provided to people in their own homes, day services, respite care and support to carers. In addition, funds are provided to individuals to purchase their own care under the Direct Payments scheme. The pattern of spending in these services has been subject to change. Support to people at home covers a wide range of services and types of support. The emphasis has shifted in recent years from undertaking practical tasks, such as shopping and cleaning, to personal care tasks and support with daily living. The change in the Council's eligibility criteria has accelerated this change.

Services are increasingly specialised, with some services providing high quality services to support people with challenging behaviour in the community.

The distinction between these services and day services is becoming less clear. RBK continues to commission and provide significant day care services:

- For older people at Newent House, incorporating services for people with functional (non-dementia type) mental illness
- For people with Learning Disabilities at the Causeway Day Centre
- For people with Physical Disabilities at the Crescent Resource Centre
- For older people with dementia type illnesses at Amy Woodgate House

Day services are also commissioned for people with Learning Disabilities from Home Farm Trust. In Mental health and substance misuse services, there are models of outreach day support, as opposed to building-based day services.

These services have undergone major change in recent years and will continue to change over the next five years. All day services aim to become more community orientated, with people increasingly being supported to undertake more mainstream activities outside traditional day care settings. Day centres have developed specific satellite projects, such as the Nursery at Hampton Court.

Whilst there is likely to be demand for these services through the life of this strategy, numbers of people accessing day services from all client groups are falling. Whilst it is difficult to demonstrate, it seems likely that people want a more personalised approach. These trends are in line with national trends and increasingly people are using Direct Payments to create their own day services.

For all these services the strategic imperative is to continue the shift to more varied and personalised models. This will take different forms in each service area. There will be a shift in the pattern of spending to support this more

personalised approach. However, there will continue to be a role for the building-based services, locations where people can meet and interact together are important. There is a generational element to this that will require RBK to balance this progressive shift in resources with care. Some people have attended day services for many years and enjoy their time with friends as a key part of their life. Others, generally younger people, are keener to undertake mainstream activities and meet friends in mainstream locations.

Day services are often provided as a respite service, which enable a family to continue to care for someone. There are a range of other services for Carers, including respite services. A fuller exposition of the strategic direction of support and services for Carers is set out below and in the linked Carers' Strategy.

The nature of Home Care services has become more specialist over recent years, with more specialist care increasingly provided to some people. For instance, support to adults with Learning Disabilities often includes more than caring and practical tasks. In addition to this development in the type of care, there has been a diversification of providers. RBK now provides less than 30% of all home care, with the other 70% coming from a range of private suppliers. Block contracts are used to secure supply.

RBK will retain a level of in-house domiciliary care provision in contrast with some local authorities which have entirely outsourced these services. For the next five years RBK will retain a small but key role as provider, enabling the Borough to continue to meet the needs of individuals with complex needs, retain the highly valued skills of the in-house service and continue to develop the market for care.

### **Target**

RBK will continue to provide an in-house home care service for the next five years, although most Home Care will be provided by the independent sector. The in house service will work on new and complex packages of support.

People are also supported by the provision of equipment, aids and adaptations. These range from very simple pieces of equipment, to major structural work on people's homes. This service is provided by the Council's Occupational therapy staff who assess and plan this support.

Critically, these needs are sometimes urgent and RBK has an excellent track record of proving equipment rapidly. As part of RBK's ongoing partnership with KPCT, equipment is purchased and stored jointly.

### **Market Management**

The changing patterns of needs, financing and service outlined above require that RBK develops and commissions in a changing market for care services. The needs analysis identifies that market mapping could offer a clearer picture of the residential care service use in RBK. This will be done as part of the work regarding examining the commissioning requirements for older peoples' residential services over coming years.

A similar process of analysis will be undertaken for domiciliary care services, as suggested by the needs analysis.

The growth of personalised services and personalised budgets, whether Direct Payments or Individual Budgets, will mean that a new range of services and workers is required.

Therefore, RBK needs to facilitate a market and commission some services, rather than simply commissioning to meet the totality of local need. The development of this new model of commissioning is a key element of the transformation towards a more personalised model that underpins this strategy. Developing this new model of commissioning will take time and a range of different strategies, some of which will be specific to particular client groups and some universally applicable. Ensuring these changes are effective will require close working with service users, local organisations and carers, as the aim will be to produce a model of service that is personalised and individually offers choice.

### **Elements of this commissioning strategy will be:**

Attracting more providers into RBK

- Developing the local workforce, especially increasing the pool of Personal Assistants available locally, with particular focus on developing the capacity in local black and minority ethnic communities
- Working with voluntary groups to develop different transport options
- RBK is particularly keen to explore ways to develop local social enterprises, which could be vehicles for both service delivery and employment for local people. It is possible that some services presently run by RBK could move into the social business sector or the third sector

There are elements of each of these factors in the component/client group strategies. However, there is a need to make progress at a strategic level. To achieve this, a sub-group of the Adult Health and Wellbeing Board will be formed with key partners in the voluntary/third sector to devise a joint work programme to build this new capacity.

### **Target**

By 2011 RBK will have expanded the number of support/care providers by 25%  
By 2011 new models of community transport will be developed  
By 2011 RBK will have worked with partners to develop new social enterprises in the care field.

### **Getting Value for Money**

With shrinking resources for all parts of the health and social care economy it is vital that RBK secures value for money for the resources available. This is a particular challenge given the strategic shift envisaged by this strategy (and the Government). A focus on outcomes and personalisation requires the development of new models to ensure best value is being secured. Early work across the country suggests that work on personal/individual budgets can both secure better value and improved outcomes. However, the schemes examined were largely pilots and the users of them were often highly motivated.

It is important to be fair to all service users and to be clear about the level of resources available to meet their support needs. To help us achieve this, RBK's overall guide will be that resources provided to meet a person's assessed needs and to achieve their desired outcomes will be at the lowest level and would not usually exceed the cost of a residential package of care.

### **Income**

There are two types of charging regime for adult social care. One has the status of statutory Government guidance, which deals with charging for residential and nursing services. The second form is the non-statutory guidance for charging for services, such as domiciliary care, meals services and day services. This system is governed, although not prescribed, by the Government's Fairer Charging guidance. RBK's discretionary charging policy was reviewed and amended from August 2004. The changes in charging were incremental with the final annual adjustment taking place in April 2008.

The recent Commission for Social Care Inspection (CSCI) inspection of Services for People with Learning Disabilities made recommendations to simplify and improve the mechanism for charging Direct Payments users. This will be actioned in the spring of 2008.

The changing environment of greater personalisation and more people living at home will require RBK to undertake further work on Charging. The focus will not be on income generation, but to clarify the system and ensure it works equitably in changing circumstances.

The growth of people remaining in their own homes means that guidance on the cost of packages and the charging regime need to be clarified. For example, the Government's guidance on charging for residential services is such that if a person moves from their home into a residential home, provided that no one is living in that home, it would be sold to fund their care. If a person chooses to stay in their own home, only their income is taken into account.

This could give local council's an incentive to make more residential placements, particularly in an area, like RBK, where home ownership rates are high. Kingston has never sought to boost income in this way and has an excellent track record for ensuring people are supported at home. However, some other Council's are looking at different charging models. It is therefore desirable that Kingston clarifies policies in this area and ensures that this policy is made clear to potential service users and their families. This work will involve local partners and be complete by December 2008.

### **Target**

By February 2009 RBK will have reviewed the impact of personalisation on current charging policies; any suggested changes will require consultation and a decision from the Council's Executive.

Outcomes for most people can be improved by maximising income. RBK has a strategic partnership with the Pensions Service called the Kingston Information Partnership (KIP). This service started in 2005 and has enabled many more people, not just pensioners, but all adults, to access a wide range of benefits. The service responds rapidly and does active outreach. The service includes staff from the Pensions Service and from RBK, who undertake benefit assessments and checks, but also undertake financial assessments for RBK in relation to charging for services such as Home Care and Day Services. The service always seeks to support people to maximise their benefit take up, as well as signposting people to a range of other services.

## Capital and Assets

As services change the buildings and locations required to deliver them will also change. Capital assets and the available capital to modernise and develop new services are resources, require strategic management, as developing new locations takes time and have high set up costs. Furthermore services should be future-proofed to ensure that they are appropriate to meet need for the coming years.

RBK has made a significant investment in the provision of services for older people with dementia type illnesses through the re-provision of the Amy Woodgate residential home on a new site at Nigel Fisher Way.

A number of recent reports have stated that local Council's are not doing enough to support older people with mental health problems and their carers. Kingston will see a new Amy Woodgate opened in the summer/autumn of 2008 with the new building increasing capacity from 32 beds to 44, meeting and exceeding all the required standards.

At a corporate level RBK has engaged property consultants King Sturge to help us develop a comprehensive property and development strategy, which will enable the development of new services and manage the buildings the Council, owns and uses to generate the greatest value.

This work got started in February 2008.

Key elements for Community Care Services will be:

- Modernisation of the day services building for people with Learning Disabilities and people with a Physical Disability
- Ensuring that RBK registered homes continue to meet standards and deliver high quality services
- Ensuring the provision of accommodation for older people with Learning Disabilities
- Improving access to respite care, particularly for people with Learning Disabilities
- Developing more specialist and accessible housing, particularly for people with brain injuries

RBK may not be the provider of service in all the above, but these are areas where the development of new or improved buildings will significantly improve service delivery.

### **Community Hubs**

RBK is working with key local organisations to ensure that the best use and value can be made of the publicly owned estate. Work is underway across the whole Council together with Kingston Primary Care Trust, Kingston Hospital Trust and South West London & St Georges Mental Health Trust to look at how best to share resources to improve service delivery. One of the key aims of all parties is to develop a model, strategy and delivery plan to deliver improved services for local people through community hubs. During the preparation of this strategy joint work on community hubs was being taken forward, with a multi-agency event in March 2008, to begin to explore what Kingston's vision for community hubs will be.

### **Housing**

The trend over recent years to more community based support; with more people being supported to remain in their own home is likely to accelerate. This change has prompted a need for new housing options in the community. Community Care already works with a wide range of Housing providers, including the Council's own housing department, but also Housing Associations, charities, private landlords and developers. The continued development of a broader range of housing options, including purchase options, is a key goal for all client groups.

These new opportunities will be primarily small scale, for individuals or small groups. The needs analysis has further identified that options are needed for people wishing to downsize in Kingston who may struggle to find suitable properties. This need will be fed into the Local Development Plan process.

### **Target**

To work with local Housing providers: RBK, Housing Associations and private landlords to provide a wider range of Housing options.

### **Supporting People and Housing Related Support**

This cross-cutting programme provides and enables housing-related support for a wide and diverse range of vulnerable people to improve their quality of life. Since 2003 it has provided a more coordinated local approach to the provision of these non statutory services that enable and promote independence in housing for a range of client groups who have differing needs.

These services range from intensive accommodation-based support services through to floating support services provided to people in their own home.

Currently the local programme grant for Supporting People is £4.4 million and it provides services to nearly 2000 people in the borough, the largest client groups being older people, mental health, learning disabilities and single homeless. Ongoing needs analysis is identifying other groups where provision is insufficient e.g. substance misuse and offenders and new services are being developed to meet these needs by joint commissioning where appropriate. Supporting People also recognises the move towards personalisation and flexibility of services and has developed new forms of contracting to facilitate this.

In 2007 the Government produced a national strategy which has the following principles:

- Sustained prevention and enabling independence
- Integration with other services
- User focussed services and user choice
- Appropriate flexibility for local authorities
- Efficient, effective commissioning
- Recognition and support for the role of the voluntary and community sectors.

Following these principles Supporting People can contribute significantly to sustaining and developing preventative services locally along with other agencies.

A Community and Local Government (CLG) report has also recently concluded that in all client group areas spending on Supporting People services results in cost savings against alternative services that might have been required.

Nationally it was estimated that the net financial benefits from the Supporting People Programme is £2.77 billion per annum.

### **Financial Control**

Community Care Services budgets are largely demand led and the growth of more personalised models of support will reduce the proportion of the budget which is committed to block purchasing.

Managing this money so that the costs can be contained within available budgets and making sure that resources are available to meet demand through the year are key goals for Community Care Services. In RBK there are factors which can influence the demands on the budget beyond the Council's control; such as: bad weather, health issues ranging from stomach bugs to the possibility of pandemic flu. Budget and service risk management is closely monitored. Monthly reports are produced for all budget holders and budgets are reviewed through regular team meetings at all levels.

An overview is taken by the Departmental Management Team (DMT), who work with support from finance colleagues to identify and manage trends and pressures, as well as deliver economies wherever possible.

Bi-monthly Community Care Services budget figures are scrutinised by the Corporate Development team and the Executive.

### **Workforce**

The Workforce Development Strategy and plans will be based on the local needs identified by the yearly learning audit, Community Care Services' overall local priorities, as defined in this strategy and on RBK's Local Area Agreement. The key focus is to ensure that the workforce is appropriately skilled and qualified to deliver high quality, outcome based services to the people living in RBK. This focus will include maintaining the minimum qualification requirements of staff. At the moment 80% of Community Care Services staff meet this requirement, and the Kingston Skills for Care Training Strategy Implementation Fund partnership and the Train to Gain initiative is helping the Private and Voluntary Sector to achieve theirs. RBK has a substantial workforce of over 50 year olds, therefore, the current level of NVQ provision will continue to be needed as it is important to ensure that all new unqualified care staff meet the national standards. The use of Personal Assistants will continue to increase and Community Care Services is committed to supporting their personal development into their care roles. The Level 2 Skills for Life literacy and numeracy qualifications will continue to be implemented by Community Care Services and as part of the RBK's Skills for Life Partnership.

In order to attract local people into Kingston's workforce the aim is to hold further local recruitment events. In 2007 Community Care Services funded a Recruitment event for the local Private and Voluntary Sector providers and participated in Skills for care funded pan-London Compass Job Fair.

The development of the South West London Care Ambassador scheme will also benefit local employers. Eight Care Ambassadors have been trained in South West London. They will be going to schools and colleges to promote social care as a career.

The Community Care Services workforce development activities will support the Skills for Care priorities and Options for Excellence recommendations which include development of:

- Leadership and management skills (two separate leadership courses and various management qualifications are already offered)
- Ambassador Scheme to train young people to promote social care as a career (RBK's part of the South West London Ambassador project)
- National Minimum Data Set - Skills for Care national social care workforce intelligence data. Community Care Services is working with RBK Human Resources to meet the requirements
- Involving people who use services. Community Care Services already involves and supports Mental Health service users in training. This involvement has been recognised by a number of national and local accolades. The aim is to widen the involvement of service users into other service areas
- Commissioning standards will be incorporated in the workforce development plan, as soon as the standards and the requirements are approved and publicised by Skills for Care
- New types of working - a number of new roles have already been developed, and new ones will be developed, to meet the needs of the changing care services. As an example, the Eden Alternative way of working within our resource centres for older people has been shortlisted for the Skills for Care accolade under the category of 'New ways of working'
- Reviewing the role of the Social Worker – including introduction of Brokers and Care Navigators - as per the Options for Excellence timescale. In RBK we already have the Care Broker role
- The new Post Qualifying framework (Community Care Services Draft Strategy due April 2008)
- The Learning Disability Qualification Framework (LDQ) will guide the development of the Learning Disability Services staff

Other important factors influencing the workforce development plans include:

- General Social Care Council registration (and re-registration) of social care workforce
- Continual professional development needs of staff
- Commission for Social Care Inspection actions and recommendations
- Changes in legislation – such as the Mental Capacity Act
- Personalised approach to social care

Community Care Services workforce development is and will continue to be closely involved with many internal partners: RBK's corporate Human Resources, Learning and Children's Services, Adult Education and others.

The key external partners include:

- Skills for Care
- Private and Voluntary Sector
- Service Users
- Local College and University providers
- Kingston Primary Care Trust
- St George's NHS Mental Health Trust
- London Councils
- The SW London Boroughs (as a Skills for Care Partnership)
- Independent training and development providers

The aim is to develop joint development opportunities with Kingston Hospital in areas such as Safeguarding. Kingston Hospital is represented on the Safeguarding Training Group which is meeting in mid August 2008.

The evaluation of outcomes that workforce development activities have delivered will be measured through:

- Local Area Agreement outcomes
- Course participant feedback
- Observed practice improvement at the workplace
- Measures against national targets
- Quarterly performance data
- Evaluation reports

In 2007/08, over half of the workforce development activities have been funded by the Department of Health (DH) workforce development and other Personal Social Services (PSS) grants (£262k), the remainder being made up of RBK's own contribution (£217k, which represents about 42%), Skills for Care funding, Training to Gain and some joint funding with other partners. Community Care Services spends approximately 45% of its grants within the private and voluntary sector. The grants have been allocated for three years until 2010/11. There is no guarantee of grants beyond 2011; therefore, it is important to develop a strategy to fund workforce development activities after 2011.

There is a national drive, through Skills for Care, DH and other key organisations to improve the status of the social care workforce, and to standardise the quality of care provision.

RBK will continue to align its activities with Skills for Care national and pan-London priorities, by being involved in relevant local and national groups and transferring these standards locally.

## **5. PERFORMANCE MANAGEMENT, REGULATION AND QUALITY ASSURANCE**

Setting targets that will demonstrate performance and improvement is a key part of developing the service. For Community Care Services this operates at a number of levels. There is a range of national performance measures and targets. Some of these are joint with other agencies, such as the NHS. There are local targets, devised by RBK, included in team plans and individual appraisals for all staff. There are also measures and targets for individual users of service, which are often devised as care plans are written and might include goals that individual people may wish to set.

The national performance management mechanisms and measures are changing. The Government is committed to lightening the burden of inspection and regulation on local Councils. In November 2007 the Government revised the local performance framework. Council's will now be measured on 198 indicators. RBK has now agreed the Local Area Agreement (LAA). The targets that broadly cover Community Care Services included as part of the agreement are:

- **NI 40** - Number of drug users recorded as being in effective treatment
- **NI 121** - Mortality rate from all circulatory diseases at ages under 75
- **NI 123** - Stopping smoking
- **NI 130** - Social Care clients receiving Self Directed Support per 100,000 population
- **NI 135** - Carers receiving a needs assessment or review and a specific carer's service, or advice & information
- **NI 141** - Percentage of vulnerable people achieving independent living
- **NI 152** - Working age people on out of work benefits
- **NI 173** - Flows on to incapacity benefits from employment

Full details of the LAA can be found on the RBK website at:

[http://www.kingston.gov.uk/information/your\\_council/council\\_and\\_democracy/community\\_leadership.htm](http://www.kingston.gov.uk/information/your_council/council_and_democracy/community_leadership.htm)

### **Promoting Independence, Choice and Control**

The statutory regulator for Community Care Services is the Commission for Social Care Inspection (CSCI).

The CSCI collects the nationally agreed indicators on behalf of the DH. RBK has a named Business Inspector from the CSCI. The process of performance management includes an annual submission of indicators; this is likely to change with the introduction of the new Performance Framework. There is a process of regular meetings, an annual review meeting and an annual assessment of performance. This has been a star rating system, but this is set to change after 2008.

In addition to the set of national targets and indicators, Kingston has a range of local targets. They include details and measures of fixed term projects, for instance, the numbers of people accessing the self-assessment pilot in the first six months; or they may represent longer term targets, such as the development of services for particular groups in the community.

These targets are supported by team plans, which include key targets for each team. This strategy and the component strategies attached will set a clear direction for the team plans for the life of this strategy.

A number of services which Kingston commissions and provides are regulated by the CSCI. These are residential and nursing home provision, the Adult Placement scheme and Home Care. Supporting People services are regulated by the Borough, although the scheme as a whole is inspected by the Audit Commission and regulated by Communities and Local Government (CLG). Services directly inspected by the CSCI have to meet national standards. RBK's in-house services will meet and where possible exceed these standards and the services commissioned by RBK will always meet the required standards.

Assuring the quality of the services commissioned and provided by Kingston is a key task for Community Care Services. The range and variety of services provided is large, but the most important test of quality is personal; does the service meet the outcomes expected? Does the service promote independence, dignity, quality and equality? The drive towards more personalisation will offer greater choice and control to people using services. However, there remains a role for RBK to ensure services meet the necessary quality standards, particularly as some service users may find it difficult both to exert control and comment upon the services they receive.

There is a range of mechanisms to assure quality of services. All of Kingston's in-house and commissioned services are required to have internal quality assurance systems. These may include resident or user committees and surveys. RBK has done targeted work with older people in residential and nursing homes to empower them through the Step Project, which has worked with voluntary sector partners. All providers are required to have complaints procedures and the Social Services statutory complaints procedure underpins all of these systems.

The process of regular review is also used to ensure that services meet required standards. For instance, when a residential review is undertaken, the individual is always seen alone for at least part of the review, their room is always seen and most recent CSCI regulatory reports are referred to. All providers are required to comply with the Council's safeguarding policy and procedure, to ensure appropriate protection for vulnerable adults.

## 6. KEY COMMISSIONING OUTCOMES FOR RBK

The eight key outcomes:

- Targeting the most vulnerable
- Prevention, rehabilitation and recovery
- Resources and value for money
- Integration, seamlessness and partnership
- Independence, autonomy and personalisation
- Safeguarding vulnerable adults
- Dignity, respect and equality
- Engagement and co-production

## 7. INTEGRATION, SEAMLESSNESS AND PARTNERSHIP

It has been Government policy and a reality in RBK for some years to work towards providing integrated and seamless services. RBK already has integrated and co-located teams with the NHS for Older People, Older People with Mental Health problems, people of working age with Mental Health problems Community Mental Health Teams (CMHTs), People with Learning Disabilities and People with Physical Disabilities. There is a joint Intermediate Care team at Kingston Hospital and many other examples of close working relationships with the NHS.

This integration has two aims. The first is to improve the service to citizens, by ensuring that services are joined up and complementary. This means colleagues can work together to support individuals. For example, supporting a person with a severe and enduring mental health problem is a team effort involving several individuals: Psychiatrist, Nurse, Social Worker, Support Worker and Occupational Therapist.

The second aim of such integration is to be more efficient; sharing premises, information, support costs etc. This integration leads to joint posts and there is a range of these across services at a commissioning, administrative and professional level. Integration is not an end in itself; it must produce improved outcomes for citizens and offer the possibility of improved value and efficiency.

As well as integration with the NHS in services, there is also integration in terms of systems. The Single Assessment Process has been a key Government objective since 2001. RBK has invested to develop integrated systems and whilst the IT environment has made this more difficult than expected, the Single Assessment Process has now been implemented in full and Kingston is exploring possibilities of working more closely by using the systems to support people with long term conditions.

During the life of this strategy RBK will continue to work with NHS partners to integrate and improve services. There are possibilities created by the work on community hubs and by the development of an independent community health provider service. This is now an arms-length management organisation within Kingston Primary Care Trust (KPCT), but is likely to become fully independent of KPCT during the life of this strategy.

Both as commissioner and provider, RBK is committed to working with NHS Partners. RBK will explore with KPCT the opportunities for the development of joint commissioning; embracing the possibilities of Practice Based commissioning. The commissioning arrangements for Learning Disabilities will change following Government guidance that Local Authorities will be the sole commissioners of social care for PLD from April 2009.

RBK and KPCT will look at the opportunities for other client groups. These joined up approaches will aim to improve efficiency and outcomes.

### **Target**

RBK and KPCT will explore the possibilities for joint commissioning by December 2008, with a view to developing more joint commissioning.

RBK and the NHS already have services where there is joint provision of services; such as Mental Health and Intermediate Care. As local NHS Trusts move towards Foundation Status and the PCT provider arm becomes independent, there will be opportunities to develop new service delivery partnerships, which meet the twin aims of improving efficiency and improving outcomes.

Although Partnerships with the KPCT and the NHS as a whole are important, they are by no means the only partnerships which Community Care Services is involved in or wishes to develop.

There are partnerships with a range of other, largely third sector organisations. For example, the Council's Direct Payment Scheme is administered by the Kingston Centre for Independent Living.

The changing environment envisaged by the Government in the January 2008 circular and set out for RBK above anticipates that the wide range of partnerships with local organisations and providers will grow and diversify.

The Promoting Independence and Wellbeing Plan is likely to see the development of more such partnerships. The plans to develop more social businesses will expand these partnerships, and the plans set out in para 3.14 will see the growth and development of more local and locally based organisations.

It is recognised that RBK and the other larger local organisations such as the NHS will have a role to play in developing the capacity of local organisations to enable them to grow and offer a different range of services, advice and support to local people

## 8. INDEPENDENCE, AUTONOMY AND PERSONALISATION

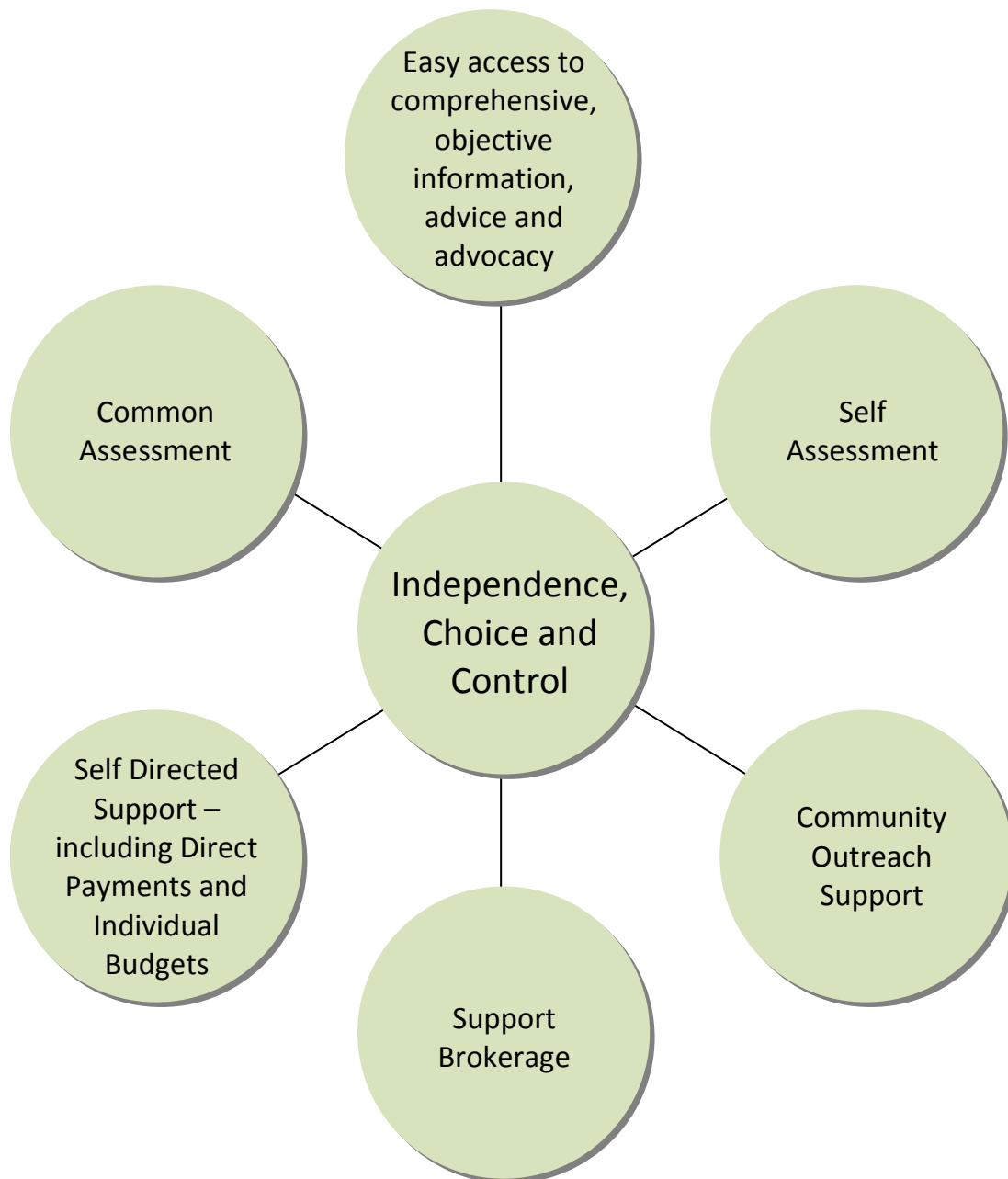
There are number of words and phrases that have been used in recent years to describe the shift to developing more personalised services. These include:

Self-Directed support	An overall description of more personalised models of care
In Control	A pilot method of allocating resources to individuals
Direct Payments	<p>Cash payments given to service users in lieu of community care services they have been assessed as needing are intended to give users greater choice in their care. The payment must be sufficient to enable the service user to purchase services to meet their needs, and must be spent on services that users need.</p> <p>Like commissioned care, Direct Payments are means-tested so assume that, in many cases, people will contribute to the cost of their care.</p> <p>Direct Payments confer responsibilities on recipients to employ people or commission services for themselves. They take on all the responsibilities of an employer, such as payroll, meeting minimum wage and other legislative requirements and establishing contracts of employment. Some of these services can be contracted out and many councils have commissioned support organisations to help service users handle these responsibilities.</p>
Individual budgets	<p>Go beyond social care, to cover Supporting People, Disabled Facilities Grant, Independent Living Fund, Access to Work and community equipment services. An overall budget is set for all of these services, which users can choose to take as cash payments, services or a mixture of both.</p> <p>As a result, they provide a potentially good option for people who do not want to take on the responsibilities of a Direct Payment.</p>
Personal budgets	A term used by the DH in the 2008 circular, the full paragraph is set out below.

"In the future, all individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and wellbeing. Having an understanding of what is available will enable people to use resources flexibly and innovatively, no longer simply choosing from an existing menu, but shaping their own menu of support. A person will be able to take all or part of their personal budget as a direct payment, to pay for their own support either by employing individuals themselves or for purchasing support through an agency. Others may wish, once they have decided on their preferred care package, to have the council continue to pay for this directly. The approach, which may be a combination of both, will depend on what works best for them. The term personal budget will describe this transparent allocation of resources."

RBK was in the vanguard of the development of the Direct Payments Scheme some years ago and is determined to be similarly placed in relation to personalisation as whole. There is a relatively high level of Direct Payment use in RBK, although there is always room for improvement. We have made good progress with individual budgets; this will accelerate and be sustained. There is a wealth of policy guidance driving RBK on this path and there is a strong commitment from RBK that these models offer the best way to secure good outcomes for individuals and to manage resources efficiently.

## Personalisation of services



The DH's Social Care Green Paper, 'Independence, Well-being and Choice' (2005), reinforced in the White Paper, 'Our health, our care, our say: a new direction for community services' (2006), sets out the Government's priorities for the development of health and social care. Central to this is a continued emphasis upon services that are individually tailored to the needs of service users, received by them in or near to their own homes. In RBK we have done much to pursue this agenda including our well established Direct Payments (DP) Scheme and, more recently, the development of online Self Assessment and Individualised Budgets.

In January 2008, 238 RBK residents were receiving a Direct Payment - including 82 Carers - and 12 people were receiving an Individualised Budget (IB) – the majority of whom are people with a learning disability.

Work is currently in progress to make it possible to offer Individual Budgets to all user groups (See target box below). In-house support brokerage is being developed for people with a learning disability and externally contracted support brokerage is being piloted for physically disabled people, in partnership with Age Concern Kingston. Direct Payments guidance has been updated to be more in line with the personalisation ethos. Further work is needed to bring IBs and DPs together into one unified Self Directed Support Strategy, further developing Resource Allocation, Support Brokerage and internal Virtual Budget systems across all user groups. Work is underway to ensure the consistent delivery of the personalisation agenda across all client groups. To support this work consideration is being given to creating a new role to co-ordinate the delivery of this agenda across all areas. Such a programme manager type post would ensure consistency, support delivery and engage a wide range of stakeholders.

The purpose of this strategy is not to plan services per se but to achieve key personally desirable outcomes for local people. These include:

- **Ability to make informed decisions** - accessible information, to ensure that people know what they are entitled to and what services are available to them
- **Ability to continue to live in their own homes in the community** – support services to prevent the need for people to be placed in care homes
- **Ability to choose from a range of options and to control their own lives** – access to Direct Payments and Individualised Budgets
- **Ability to sustain and increase their level of independence and to access local work, education and recreational opportunities** - access to flexible community outreach support
- **Ability to define their own needs and to “help themselves” to services, where appropriate** - access to self assessment and comprehensive, objective information
- **Ability to fulfil parenting roles** - support for disabled parents
- **Equal access to services** - ensuring that service users from Black and Minority Ethnic (BME) communities can access resources that appropriately meet their needs

## Targets

Increase the number of people using either Direct Payments and Individual Budgets by 20% every year

Enable all users to have a virtual individual budget by April 2010

## 9. DIGNITY, RESPECT AND EQUALITY

Ensuring that services and support offered by RBK's Community Care Service is available to all parts of the community and promotes dignity and respect is a key aim for Community Care Services and part of a larger picture for the Council as whole. The role of Community Care Services in delivering these objectives is part of the Council's wider Putting People First policy, which aims to ensure that the whole community benefits from and contributes to life in this community. A key role for RBK is to take a lead role in Safeguarding adults. There is a separate Safeguarding Strategy, which sets out RBK's key aims and objectives for effective Safeguarding.

The support offered by Community Care Services, whether through services or personal budgets, such as Direct Payments or Individual Budgets, seeks to promote and enable people to live as active citizens.

There are a number of ways that this agenda is pursued. The Step project, which supported people living in care homes to be more involved in the running and planning of their home, has now been absorbed into work on the Eden system, which is an internationally acclaimed process to promote dignity, respect and choice within care settings. The University of Surrey helped us benchmark our person-centred care prior to the introduction of the Eden approach and will benchmark our care again following the completion of our training programme in 2008.

RBK is encouraging other local providers to adopt the scheme and is actively promoting the Eden approach as part of its commissioning process. Eden training is being rolled out to care home residents, relatives and carers and review officers are using Eden best practice standards when they are checking people's care arrangements.

Person centred approaches and the development of brokerage models of support will build on RBK's good record in care planning and focusing on individual needs. Adults with disabilities are vulnerable to a range of risks that can diminish their choices and autonomy; these include: bullying, financial or sexual abuse.

The Council's Safeguarding Adults Policy sets out the approach to dealing with such allegations and issues. Key to challenging these behaviours is encouraging people to speak up and assert their rights.

RBK will work with partners and providers to ensure that in all care settings; residential, day services, domiciliary care there are systems and processes to support people speaking out. Part of this will be taken forward by the Safeguarding Strategy, but there is also a need in each service to ensure that commissioned and provided services have in-built robust systems to encourage people to express their concerns.

The needs analysis shows that RBK is becoming an increasingly diverse community. It identifies that the local population is changing and Community Care Services strategies need to change to reflect this. It also identifies that relatively more people from BME communities receive assessments than receive services. It suggests that RBK needs to look at the performance and policies of other Local Authorities and engage with local community and faith groups. Comparison work with other Council's will be undertaken over the next six months.

Work with community leaders and faith groups is already underway. There has been significant engagement with these groups already, which has led to the development of new support and training for people who do not have English as their first language.

It is the aim of Community Care Services to ensure that all sections of the community can benefit from and be appropriately supported.

The groups recognised by Government are:

- Race
- Gender
- Religion and Belief
- Disability
- Sexual orientation
- Age

RBK will continue to actively combat discrimination in all these areas. Individual team plans contain equalities targets. There is a range of measures to work with different communities and improve access and take up of services.

These range from men only sessions at Devon Way centre; as take up of day care is roughly 70% women and 30% men in older people.

There has also been work in residential care with a Charity Polari, which seeks to raise awareness and support older gay men and lesbians.

There is ongoing engagement with a range of community groups from different communities and an increasing number of services and support for different groups.

This process of engaging with community groups, analysing take up of services and developing new models of service, works towards meeting the aim of targeting under-represented groups and shaping services to meet individuals needs including cultural and religious needs.

Language can be a significant barrier to the take up and awareness of services. Engagement with local black and minority ethnic groups and faith leaders has shown that one of the key ways to enhance public health and service take up is to improve English skills. A project to deliver this has now received some funding from KPCT.

RBK also has the Kingston Interpreting Service (KIS), which can translate to virtually any language used locally as well as offering a taping service and sign language interpreters.

## **10. ENGAGEMENT AND CO-PRODUCTION**

Whilst this strategy sets out the direction for RBK's Adult Social Care for the next five years, this is not a process in which the Council is or will be acting alone. The development of social care for adults is a co-production; from the individual care package designed by a citizen and supported by a Care Manager, broker or Occupational Therapist, to the development of new models of care for particular client groups. At all levels, the Council is working in partnership with people and organisations to deliver care and support. The transformation set out in the Local Authority circular of January 2008 envisages a growth in the cooperation and collaboration. In RBK making a fundamental shift will require an expansion of the existing mechanisms and process in which local people, local organisations and the Council work together.

Each of the major service user group areas has a partnership board, which enables the Council, and other organisations to work together to improve services. There are the following partnership boards:

- Learning Disability Partnership Board
- Older Peoples Partnership Board
- Mental Health Partnership Board (or Local Implementation Team - LIT)
- Physical Disabilities Partnership Board
- Carers Board

There is a range of other arenas where the Council and its partners meet:

- Safeguarding Board
- Low vision Committee
- Mental Capacity Act implementation Team
- Choosing Health Partnership Board

Key developments and aims and targets from these Boards are reported to the Adults Health and Wellbeing Board, the overarching partnership board for health and social care services for adults.

These existing structures will be expanded and developed. In January 2008 the DH produced 'A dialogue of equals', which is a pace setter programme for community engagement. The document is directed largely at the NHS, but contains useful guidance for Local Authorities.

Amongst other things it defines three levels of engagement:

- Information gathering
- Consultation
- Participation

It also makes clear that engagement leads to better decision making. Some of this work is done at a corporate level in the Council, through the democratic process and corporate partnerships. However, we recognise there is a need to improve further Community Care Services engagement with the public.

This strategy and the component strategies that accompany it has been subject to formal consultation. As the implementation of this strategy transforms se progressively services, Community Care Services will work with partners through existing boards and engagement arrangements to ensure that the community helps to drive change.

Developing new services and changing existing ones will require consultation and participation. Whilst the commitment from the Council is strong, the test of whether it is working is if other partners feel engaged and involved in decision making and change. To measure this, a survey or feedback questionnaire will developed that will give Community Care Services some structured feedback on the process of engagement. The results of this survey will inform our future plans and policies. The first survey/questionnaire will be undertaken in April 2009.

### **Target**

Community Care Services will undertake a feedback questionnaire to measure the success of engagement with users and carers. First questionnaire April 2009

To enable people to have a stronger voice and a choice in how services are developed, each Council with Social Services responsibility is required to commission a host organisation to run a Local Involvement Network (LINK) to act as a key patient and public engagement mechanism for local people and organisations to contribute to the planning, design, development and commissioning of local health and social care services. The local LINK host has now been appointed and is the local Citizens Advice Bureau. The LINK will be a key public involvement mechanism for the future and we are looking forward to working with this new arrangement.

## 11. COMPONENT STRATEGIES AND ACTION PLANNING

The strategy outlined above sets out the overall direction for Adult Social Care in Kingston, however each main area of activity has a separate Strategy.

These RBK Strategies are:

- Older People Services Strategy
- Learning Disability Services Strategy
- Physical Disability and Sensory Impairment Services Strategy
- Safeguarding Vulnerable Adults Strategy
- Carers' Services Strategy
- Mental Health Social Care. In addition a joint Working Age Mental Health Strategy has been commissioned jointly with KPCT and SWLStG's Mental Health Trust. This will be completed in October 2008.
- Older Peoples Mental Health Services - commissioned jointly with KPCT and SWLStG's Mental Health Trust. This will be completed in October 2008.

These Strategies can be found at:

[www.kingston.gov.uk/social\\_care/communitycareservices](http://www.kingston.gov.uk/social_care/communitycareservices)

Set out below is a brief high level summary of each of these strategies. Each document deals with the key issues for the service area, covering commissioning plans and responses to national policy. The national policy drivers vary across the range of activity; there is a national service framework for Mental Health and Older Peoples services, the Valuing People initiative for Learning disabilities, but no such frameworks for Physical Disability services. Consequently each strategy is tailored to the area it covers and each is slightly different.

Each strategy, including this overall Strategy will have an action plan. These will cover the coming year and a look ahead to the year beyond. These action plans will be taken to the Adult Health and Wellbeing Board each year and published on the Council's website. The annual production of these strategies will be a 'bottom up' process informed by user and public engagement process.

## **12. EXECUTIVE SUMMARY - LEARNING DISABILITIES STRATEGY**

This describes RBK's commitment to improving the lives of people with learning disabilities over the next 5 years.

The strategy and action plan describe how the council will shift its approach to commissioning, from block contracts with traditional service providers to individualised community focused responses to meeting people's support needs. This is in line with both the national agenda and in response to local demand.

### **The priorities for commissioning over the next 5 years will be:**

#### **Personalisation, choice and control**

We will make sure that we include the views of people with learning disabilities in the planning of services, by developing the User Parliament.

People with learning disabilities and their families will have more choice over the support they need and how they receive it. People will be involved in all planning and decision making that affects them.

The development of Direct Payments and Individual Budgets will ensure that people have real control over their lives. We will offer people a choice about who supports them to make changes in their lives and how they are supported.

#### **Housing**

People with learning disabilities will have more choice over where they live and with whom. More people will be supported to live in their own homes with their own tenancies.

People with complex needs or whose behaviour challenges services, will also be supported to live in tenancy-based accommodation with individually tailored support to meet their needs.

#### **Day, Evening and Weekend Activities**

People with learning disabilities will have greater opportunities to learn, get a paid job and enjoy leisure opportunities in the community.

The Council will move away from block purchasing arrangements enabling existing day services to be more flexible and responsive to individual needs.

## Health

People with learning disabilities will have improved access to health services and be supported by specialist health services when necessary.

Commissioning responsibility for the KPCT's learning disability budgets will be transferred to the Council by April 2009 as per DH policy.

Approaches to commissioning will be individual and outcome focussed, and will promote community development and social inclusion. RBK is committed to making change happen for all people with learning disabilities.

## 13. EXECUTIVE SUMMARY – CARERS' SERVICES STRATEGY

The proposed Action Plan aims to build on the previous RBK Carers' Action Plan (2003-2008). It reflects the requirements of current and emerging agendas and seeks to take account of what Carers across all service areas have told us would help them in their caring role.

The five year Action Plan sets out the following objectives:

- To extend the range and accessibility of break opportunities for Carers including short term, home-based respite at times of crisis or an emergency
- To have in place a wider range of Carers' services, including services that can be accessed through self-assessment by Carers and through a Direct Payment
- To have a robust multi-agency process for the identification of young Carers and the provision of support to these young Carers
- To work with partners and local employers to help Carers to take up and remain in employment
- Through work with health our aim is for Carers to be able to maintain an acceptable level of good physical and emotional health and access and receive health checks and advice on looking after themselves
- To ensure carers receive appropriate and timely information
- To ensure Carers are actively involved in the delivery of training to staff
- To promote Carers assessments and ensure that carers are advised about entitlements, eligibility criteria and the complaints procedure

- To ensure all Carers, including Carers from the diverse communities, have opportunities to share their views and influence the way services are planned and delivered
- To protect vulnerable adults and ensure Carers have an opportunity to be aware of legislation including the Mental Capacity Act

## **14. EXECUTIVE SUMMARY - MENTAL HEALTH SOCIAL CARE STRATEGY**

The Adult Mental Health Social Care Commissioning Strategy will inform the development of a Joint Mental Health Strategy and a Joint Drug and Alcohol Strategy to be developed in partnership with KPCT, DAAT (Drug and Alcohol Action Team) and other partner organisations by October 2008 for implementation in 2010/ 2011.

Mental Health Services are delivered by South West London and St George's Mental Health NHS Trust (SWLSTG) under a Section 75 Partnership Agreement on behalf of the Borough using flexibilities under the 1999 Mental Health Act.

There is a strong history of integrated health and social care services in Kingston and partnership working. Stronger working partnerships have benefited as a result of the full integration of community teams for mental health and drugs and alcohol over a decade ago.

Over the next 5 years, the Royal Borough of Kingston will improve the health and well being and quality of life of people with mental health needs/ and or drug and alcohol problems.

We will:

- continue to commission the Section 75 partnership agreement with South West London and St George's Mental Health NHS Trust
- ensure that we meet our statutory responsibilities, including the delivery of the Approved Social Worker/Approved Mental Health Practitioner and Emergency Duty Social Work service, and respond to the Mental Health Act 2007

- maintain and modernise the integrated community models and continue to support the robust social care presence into the Community Mental Health Teams, Assertive Outreach Team, Early Intervention Team and Kingston Community Drug and Alcohol Team, including the funding of Support and Recovery (STR) workers and two Mental Health Carers Workers. The Borough will also ensure social care input into the developing Crisis and Home Treatment Team
- work with partner agencies in RBK to explore the proposal to have services localised where possible in polyclinics to provide one stop shops for health and well being which would further promote local access and a seamless service
- promote the implementation of the recovery and social inclusion model through the Kingston Project Group, and continue to support to the vocational and access services that support social inclusion
- ensure that people can live in community settings and in accommodation of their choice and increase the number of people living in and maintaining their own tenancies
- work with the Drug and Alcohol Action Team to optimise community support for people who misuse drug and alcohol services, including the joint commissioning of a day programme in 2008

The Borough will enable service users and their carers to make a positive contribution, exercise choice and control, and ensure those who need social care have equal access to support without hindrance from discrimination which continues to form a barrier for people with mental health problems.

We will:

- continue to respond to the diversity and changing needs in our communities through the work programme of the Kingston Race and Equalities Group
- work with partners to reduce the stigma associated with mental health problems through continued support of the user and carer led Mental Health awareness training and work on our Mental Health Promotion Strategy
- build on the partnership arrangements with the voluntary sector to increase capacity to deliver a range of services providing choice and value for money
- focus on individual need and choices, and maximise the meaningful involvement of service users and carers in the review, development and delivery of services

- develop models that promote self directed care and personalisation by
  - increasing the number of people receiving a Direct Payment year on year
  - develop brokerage options for service users
  - provide individualised budgets by March 2011
  - continue to commission citizen advocacy, independent mental capacity advocacy and an appropriate adult service
  - implement advanced directives in all services by April 2009
- deliver a year in year increase to the number of carers receiving a needs assessment or review and a specific carer's service, or advice and information

Finally, the Borough will work with partner agencies to improve the economic well being and personal dignity of people with mental health needs/ and or drug and alcohol problems.

We will:

- work with health partners to optimise the numbers of service users gaining and maintaining employment in primary and secondary care
- ensure service users and their carers know where to get help on safeguarding issues when needed

## 15. EXECUTIVE SUMMARY – PHYSICAL DISABILITY AND SENSORY IMPAIRMENT SERVICES STRATEGY

This strategy builds on 'Towards Full Inclusion' (2004 – 2009). It further develops our approach to commissioning services for people who are: Physically disabled; live with a long term medical condition; have a sensory impairment and/or live with HIV. We outline our Strategic Commissioning priorities below.

### **Disabled People are able to make informed decisions and, where appropriate and desired, "Help themselves to services"**

**Information and "signposting"** We plan to continue to develop information and signposting services including: Online self-assessments; Mediated self assessments (aided by a professional or volunteer); Online website information; Succinct, printable information sheets; and Information Prescriptions

**Assistive Equipment** In line with the Retail Market Model of community equipment provision, we plan to develop an Independent Living Centre in RBK. This will offer access to basic assessment, in relation to simple equipment, for people who do not meet our eligibility criteria or those who wish to buy their own equipment. It will offer equipment demonstration, trial and sale, in addition to impartial advice and access to the online self-assessment service (SmartAssist). It will also promote and supply Telecare products.

**Disabled People are able to live in their own homes in the community** We aim to develop support services in RBK for people with complex needs, particularly people with acquired brain injuries, to enable them maintain tenancies and to continue to live safely in the community, rather than moving to a care home outside the Borough.

**Accessible Housing** We will continue to work with colleagues in Housing Services to improve the supply of fully wheelchair accessible property, both in the RSL (Registered Social Landlord) and Owner Occupier Sectors. We will also work with housing colleagues to continue to provide streamlined access to grants (e.g. Disabled Facilities Grants) to enable disabled people to appropriately adapt their homes. We will scope options for increasing flexibility, choice and control, including that of making DFG funding available to users as part of an Individualised Budget.

### **Disabled People are able to choose from a range of options and to control their own lives - personalisation of services**

**Direct Payments and Individualised Budgets** We will continue to develop Individual Budgets (IBs). It will be possible to use them in the form of cash (a Direct Payment) and/or “virtual budgets” administered on the service user’s behalf by the Council. People will have unhindered choice about the service that they purchase with IBs, provided that they meet their own assessed needs adequately and do not use monies inappropriately. We will develop a new procedure to monitor the use of Individual Budgets, which recognises this whilst also making explicit what they should not be used to purchase.

### **Disabled people able to define their own needs and "help themselves"**

**Self assessment** We will expand self assessment, to cover assessment of eligibility for services and broaden its scope so that it can facilitate access to the full range of personal support services, including Individualised Budgets. At present, we intend to maintain the existing online self assessment, SmartAssist, but to scope the possibilities for expanding the services that it provides.

### **Ability to fulfil parenting roles**

**Support for disabled parents** We will continue to place a high priority on providing support to disabled parents. The first task must be to revise our Disabled Parents Protocol in the light of changes in our eligibility criteria.

### **Disabled People are able to sustain and increase their level of independence - Outreach Support**

We will continue the work already started to provide disabled people who need community care services with individually tailored support to enable them to access mainstream work, education and recreational opportunities and to gain new skills to enhance their level of independence. We support the further development of community outreach support though acknowledge that personalisation will require some disinvestments in existing day services.

## 16. EXECUTIVE SUMMARY – SAFEGUARDING ADULTS STRATEGY

### Our Vision

By 2011 we will have developed Safeguarding Champions for each of the major service user groups:-

- Older People
- Younger people with Physical disabilities
- People with Mental Health needs
- People with learning disabilities
- People with needs arising from their abuse of drugs and/or alcohol

Safeguarding champions will have the responsibility of promoting safeguarding issues and acting as a conduit between service user area and the Safeguarding Board.

All staff in statutory agencies will have safeguarding as a specific topic covered during the induction of new staff.

More staff in RBK and private and voluntary care homes and day centres and community services will have received training in safeguarding. A list of trained investigator will be kept.

A new post of Protection of Vulnerable adults and Mental Capacity Act Coordinator (VA&MCAC) is in post and supporting all safeguarding functions including outcome monitoring, lessons learned and data collection.

The general public will have a greater awareness of Safeguarding issues.

## 17. EXECUTIVE SUMMARY - JOINT OLDER PEOPLE'S SERVICES STRATEGY

This Joint Older People's Strategy "Pensioner's First", sets out how RBK, its partners in the statutory, independent and voluntary sectors, who provide health and social care will work together to help ensure that older people lead healthy, independent and fulfilling lives in the community. The strategy has been developed in partnership with older people and carers, alongside the Kingston Pensioners Forum, Kingston Community Care Services, Kingston Primary Care Trust and Age Concern Kingston.

It identifies the national and local priorities for older people's services during the next five years (2008 -2013). An extensive needs analysis and range of consultation has been undertaken to identify the key issues affecting older people and their carer's in the Borough. The strategy is a working document to identify priority areas and drive improvements in Older Peoples Services that matter to local older people. To achieve this, the strategy sets out a detailed action plan in section 6, which identifies a framework of objectives and outcomes to be delivered by services and informs the priorities for the commissioning of services.

The main outcomes identified within the strategy are based on two policy documents; The "White Paper Your Health, Your Care, Your Say" and the National Service Framework for Older People (2001). These have created significant policy shifts towards developing services to achieve greater personalisation, choice and control. Other guidance and initiatives such as "A New Ambition for Old Age Next Steps in Implementing the National Service Framework for Older People", "Long Term Conditions National Service Framework" and Local Area Agreements, also set out national priorities for the NHS and social care, these have been addressed within the strategy where they are specifically focused on older people and their carer's.

The strategy will be delivered through a partnership approach, working with a range of stakeholders in order to provide services that enable older people and their carers to have choice and control over their lives and access to services which respond to the uniqueness of each individual.

## **18. MAKING IT HAPPEN ACTION PLAN FOR THE ADULTS**

### **COMMUNITY CARE STRATEGY**

Ensuring that the transformation and improvement outlined in these strategies are delivered will be a responsibility shared by many. The overall responsibility will be shared between RBK and its partners through the Adult Health and Well-being Board.

The component strategies will deliver the detailed changes and are all congruent, with this overarching strategy. Below is a list of the high level targets contained in the overall strategy. In addition to these the services will ensure improvement on the key performance indicators, which cover this area. These are currently under review as the New Local Performance Framework seeks to reduce and refocus the performance targets for Councils as a whole.

The key targets for delivery of this overarching strategy are set out in the table below:

## Action Plan 2008 - 2013

Target	When	How	Who
<p><b>Target 1</b> Information and advice provided in an accessible way, by informed providers in a format that can be understood by all.</p> <p>Providing comprehensive information and advice is critical to improving people's choices and wellbeing. The Independence and Wellbeing strategy will help to plan this, to deliver the Council's commitment to undertake a review of information and advice systems within this financial year</p>	<p>Information and advice review to be commissioned in autumn 2008. Implementation April 2009 to April 2010</p>	<p>A scoping report will be commissioned to look at the technical issues arising from the Independence and wellbeing strategy, which will also look at best practice across the country.</p> <p>Following this a specification will be drawn up to commission the new service. It is likely that resources to pump prime this development will come from the Transforming Social Care grant.</p>	<p>Head of Community Care and Head of strategy and performance</p>
<p><b>Target 2</b> Build on the success of the Self-assessment system for community equipment to enable self assessment for all services</p>	<p>April 2009.</p>	<p>Mechanisms which enable self assessment may vary, but all assessments will have the facility for self assessment.</p>	<p>Community Care Management Team and Team Managers</p>
<p><b>Target 3</b> By July 2008 Kin RBK will have revised risk management guidance for all staff, to enable staff to support people to make choices and live independently</p>	<p>July 2008</p>	<p>Risk management re-written. Complete</p>	<p>Assessment &amp; Care Management Development Officer</p>

#### Target 4

To complete the evaluation of brokerage by September 2008

September 2008

The Learning Disability Brokerage service is being formally evaluated, by September 2008 an initial evaluation will be complete, with ongoing work, which will be completed by April 2009

Head of PLD supported by Foundation for People with Learning disabilities

By 2010, everyone using Community Care services will have the option of using a support brokerage model, to help them achieve their planned outcomes

December 2010

Part of Kingston's drive to modernise Social Care

Transforming Social Care project manager and head of Community Care

#### Target 5

RBK will continue to provide an in-house home care service for the next five years. Most Home Care will be provided in the independent sector. The in house service will work on new and complex packages of support.

September 2008

RBK will transform the in –house Home Care service into a short term and expert service, which focuses on complex cases and re-ablement.

Principal Manager Home Care

#### Target 6

- By 2011 RBK will have expanded the numbers of support/care providers by 25%

2011

All parts of Community care will expand their provider base.

Community Care Management Team

- By 2011 there will developed new models of community transport.

New models of Community transport are already being developed, these will be available to all users.

- By 2011 RBK will have worked with partners to develop new Social enterprises in the care field.

New social enterprises will be developed with local partners.

<p><b>Target 7</b> RBK will have reviewed the impact of personalisation on current charging policies; any suggested changes will require consultation and a decision from the Council's Executive.</p>	February 2008	A report will set out clear policies in relation to charging for services. It is not planned to increase charges, but to clarify the system.	Head of Community Care Services
<p><b>Target 8</b> To work with local Housing providers:- RBK, Housing Associations and private landlords to provide a wider range of Housing options.</p>	Ongoing	Community Care Services will work with colleagues in Housing from RBK and with colleagues in the Registered Social Landlord, Housing charity and private sector to development more Housing options. Outcomes sought: greater choice of housing, more adapted housing and greater supply	Community Care Management Team
<p><b>Target 9</b> RBK and Kingston Primary Care Trust will explore the possibilities for joint commissioning with a view to developing more joint commissioning.</p>	December 2008	Work is already underway to look at joint commissioning opportunities this work will be ongoing, but an initial review of opportunities will be completed by December 2008	Head of Community Care Services
<p><b>Target 10</b></p> <ul style="list-style-type: none"> <li>• Increase the number of people using either Direct Payments and Individual Budgets combined by 20% every year</li> <li>• Enable all users to have a virtual individual budget.</li> </ul>	<p>The Local Area Agreement sets out the nature of this target in NI 130</p> <p>April 2010</p>	<p>NI 130-Social Care clients receiving Self Directed support per 100,000 population This is part of the shift to a more personalised approach and one of the key targets in Transforming Social Care</p> <p>176/100,000 population (estimate 2007/08)</p> <p>220 250 320</p>	<p>Community Care Management Team</p> <p>Community Care Management Team</p>

**Target 11**

Community care will undertake a feedback questionnaire to measure the success of engagement with users and carers.

First questionnaire  
April 2009

A questionnaire will be developed to canvass the views of users and carers to help us understand and measure how the Council is improving engagement with users and carers

Head of  
Community Care

## 19. CONSULTATION ON THE STRATEGIES

The component Service Strategies were consulted on via existing mechanism and forums. For example, there have been stakeholder events for older people in the development of the Older People's Services Strategy, as well as involvement by the Older People's Partnership Board. The Learning Disability Services Strategy closely follows the action plan arising from the CSCI inspection carried out in 2007. The outcomes from these consultations have been incorporated within the revised Strategies.

The overall Community Care Services Strategy required greater, more extensive consultation beyond existing feedback mechanisms as it is a major development and step change for adult social care services in RBK. The Strategy was consulted on from 10 April 2008 to 18 July 2008 and was presented in various formats to make sure that it reached the broadest possible audience. These formats included:

- Full document
- A simple PowerPoint presentation
- Web-based information and feedback forms

Eight consultation meetings were held across the Borough. Only a small number of people attended these but the resulting discussions and outcomes were very productive and helpful.

The main themes arising from the consultation were:

**Information and advice** – making sure people have easy access to user-friendly and comprehensive information about local services that can help them keep independent, safe and well or support them when they are unwell, at risk of harm or need a lot of help to stay independent.

**Review, evaluation and involvement** – making sure services, resources and the way we do things work to the benefit of the local community. This quality assurance/ performance management process should actively involve the people who use services and the local community.

**Inclusive partnership working** – making sure all organisations and groups work well together to make it easy for people to access support, particularly hard to reach groups.

More detailed information on the results of the consultation may be found in the report to the Council's 30th September 2008 Executive meeting.

We have revised our Strategy, and in particular the associated Action Plan, to reflect the outcomes of the consultation. The revised Strategy addresses people's questions and concerns in a way that strengthens its comprehensiveness and integrity.

Moreover, many of people's questions and concerns have also been addressed in the Council's **Independence and Wellbeing Plan** presented to the Executive Committee on 22 July 2008. This Plan was developed to make sure that, in partnership with local organisations and communities, RBK residents were supported to help themselves to keep independent, safe and well.

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- Care Services improvement Partnership Lessons from the Commissioning Exemplar project June 2007
- Our health Our Care our say DH white Paper January 2006
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- Dept of Health Transforming Social Care LAC 2008 (1)
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Royal Borough of Kingston upon Thames  
Needs Analysis – Adult Social Care  
7<sup>th</sup> March 2008

Services for life

Needs analysis

This has been commissioned from Tribal and is below.

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## 1. Introduction

The Royal Borough of Kingston upon Thames (RBK) is in the process of developing the Commissioning Strategy for Adult Social Care Services for the next five years, 2008 - 2013. This strategy is due to be agreed for consultation by the Council's Executive in March/April 2008. Tribal Consulting were engaged on the 15th January 2008 to bring together the needs analysis to support this strategy by Friday 7th March 2008. This allowed a timescale of just over 7 weeks to complete the needs analysis.

The Council and the Primary Care Trust have undertaken a number of similar analytical pieces of work to date including the needs analysis work for the Joint Annual Public Health report and the needs analysis for the Older People's Strategy. In addition various consultations have also been undertaken and are planned for the coming months ahead.

It was recognised that in some areas little information was unavailable without conducting further primary research. In the timescales allowed this was not possible and the focus of the needs analysis has been on RBK data and information available and local, regional and national data and information sources. We have taken steps to suggest how any information gaps might be approached and a half day workshop will be facilitated (to be arranged) for senior managers to develop their understanding and skills for undertaking a needs analysis and respond to emerging key issues.

## 2. Needs Analysis

### Approach

In order to bring together the needs analysis within the short timescale, the following approach and activities were undertaken:

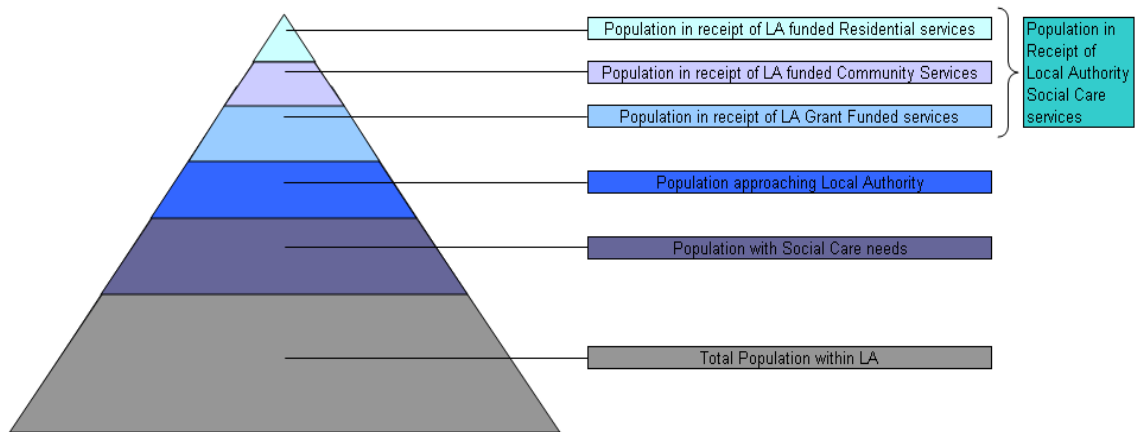
- an initial set up meeting with Simon Pearce and Charlotte Fitzgerald on Tuesday 15th January 2008 during which the scope was confirmed and preference was agreed to follow the Derby model template example
- attendance at a meeting with the departmental management on Thursday 17th January 2008 to explore key issues and priorities for adult social care
- a data and information gathering exercise with RBK to collate key data and information to support the needs analysis. The types of data and information requested included:
  - performance information and data, strategy documents and plans, surveys, trend information over time, outcomes from reviews, analysis work
  - meetings and telephone conversations with a selection of key internal and external stakeholders arranged by RBK to understand further the key issues and priorities for services and support to be required
  - further data and information gathering from local, regional and national sources
  - analysis of all data and information
  - preparation of the needs analysis

We discuss our methodology in more detail below which provides detail on the approach taken and opportunities for further analysis by RBK. We will share our methodology in more detail at the workshop with senior managers.

### Structuring the Analysis

Clearly the numbers of people who received funded Social Care services from any authority are considerably smaller in number than the whole population of an area. Therefore there are a number of stages to go through looking at what is happening as this large population group is “filtered” into the smaller group of people who go on to receive a services.

The diagram below illustrates the methodology used in this Needs Analysis:



The bottom of the pyramid helps us to understand the size of the whole population in the area as this forms the baseline cohort of people. There is relatively up to date information available to have a fairly solid understanding of the number of people in different age groups currently living in Kingston. When preparing the needs analysis it is essential to build on this baseline and look forward. Consideration has been given as to how this population might change in the future. At this point it is important to understand the factors that may be affecting population numbers in the coming years. Within Kingston there are population estimates to suggest that there is a diminishing population of older people, however rather than taking this fact on face value, it is important to gain a real understanding of why this is happening as if the reasons are factors that could be or are being reversed, the future could look very different.

The second layer of the pyramid relates to those people who have some kind of Social Care need that needs to be met. There are a vast number of people who live in Kingston (and anywhere else) will live long and full lives without ever experiencing sufficient health or social care difficulties that require intervention from the Local Authority. Even those individuals who require intervention from the Health Service (public or private) may never develop Social Care needs as a result of those health conditions. The task then, is to make an informed judgement about the number of people who either now or in the future, will have needs that qualify them for Social Care intervention.

Moving up the diagram, not all of those who have a Social Care need will approach RBK with a request for the authority to meet that need. The key question then becomes; Why do some people with Social Care needs fail to approach RBK to have those needs met? Are those needs being met elsewhere, by other means, or are there individuals in the community who are experiencing difficulties that are not being met at all.

Of those who approach RBK for help, there are a number of people who will not go on to receive funded services, even if they have been through a full assessment

process. In addition some service users will receive services for a limited period of time and will then withdraw. Therefore it is important to identify the reasons for the difference between the number of people who approach RBK, and the number who then do not go on to receive a service.

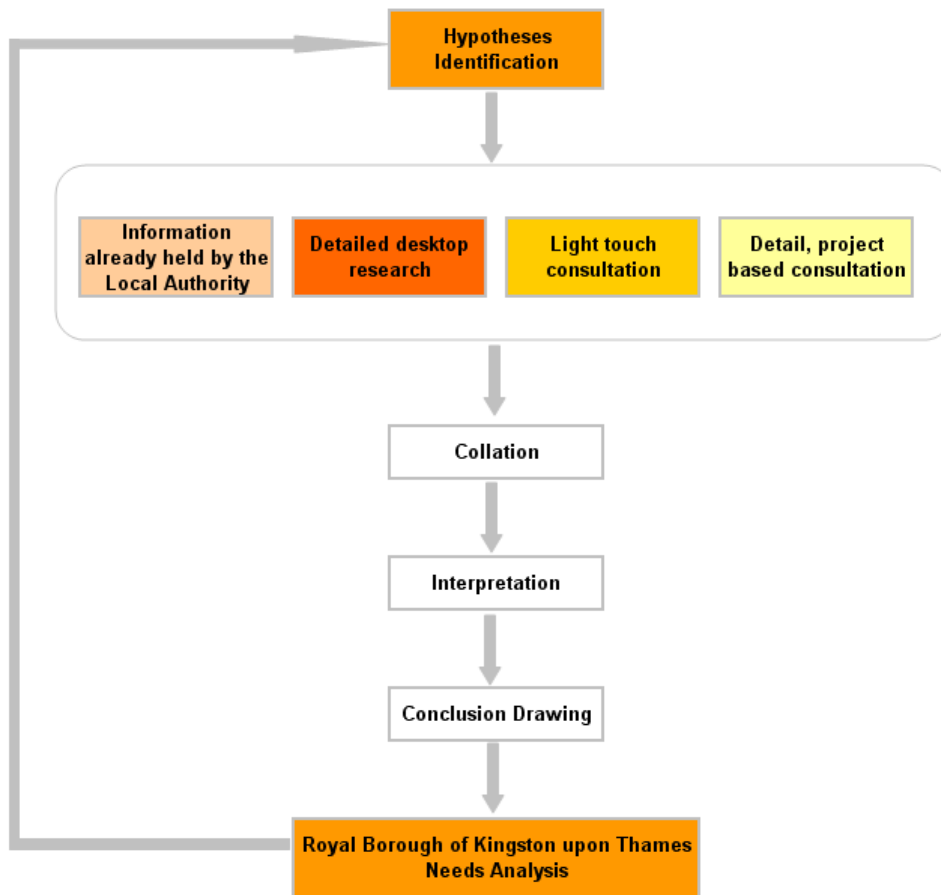
As can be seen in the pyramid this group of people who are having services has been split into three sections. Those who are receiving services, via the third sector, that are actually at least partially funded by RBK (in fact there are probably a considerable number of people out there who are not fully aware that the service that they are receiving is linked to the Authority at all). The second group are those who receive their care directly from RBK (including through contractual arrangements with the independent and/or voluntary sector). Finally there are those who receive their care in a residential setting. There are a number of financial issues and issues of perception and preference that make it important to consider this “service receiving” group in these three components.

Under the heading of each of these layers of the diagram, it becomes possible to begin to draw up a list of the questions that require answers in order to gain the insight wanted. The process of undertaking a needs analysis is ongoing, and therefore, in an ideal world the list of questions will continue to increase over time. It is often the case that once one question has been answered; the answer itself sets off another train of thought and ultimately another question. The key is to continue to find answers to those questions.

The questions outlined against each of the headings from the “pyramid” in Appendix A are a record of our thinking so far and provide an excellent starting point for future thought and work on further needs analysis for Kingston. Whilst we do not claim that they are revolutionary, by structuring needs analysis in this way, it becomes possible to take a methodical approach, and by keeping such as a list of questions close at hand, it helps to keep people’s minds focused on lines of enquiry for the needs analysis when they are undertaking other pieces of work.

### **Undertaking the Analysis**

The paragraphs above identify the thought process that needs to be undertaken to complete the analysis; however, this must to be translated into a string of actions to find the answers. This process is outline below:



Based on previous experience there are four main ways of accessing the information required for the needs analysis.

### Information already held within the Local Authority

There is often a wealth of information already held within the organisation, often it is a case that those who hold it are not aware how powerful it can be in terms of needs analysis. By pulling this information into one place where it can be put together with other information. RBK has collected a significant amount of information which has been utilised extensively in the work undertaken by Tribal so far.

### Desktop Research

In this age of electronic information, there is a wealth of information available on the internet to address issues in relation to needs analysis. Particularly fruitful areas of research include The Health and Social Care Information Centre, The Office of National Statistics and HES. Where the information is itself not readily available online, perhaps in the case of voluntary sector organisations without the manpower

or financial resources to maintain a detailed webpage, access to phone numbers and contact details provide a useful starting point.

### **Light Touch Consultation**

Whilst there is a wealth of national level data available electronically, however when the information required becomes necessarily at a more local level, the volume of data available diminishes dramatically. Similarly whilst desk top information can often provide a strong case to believe that something is the case, it is often advisable look for reassurance from people at a local level. That way it becomes more realistic to base large strategic decisions on the information collected. Activities undertaken under this heading might include paper or telephone surveys of a sample of relevant people asking for comment, discussions with practitioners at team meetings or away days.

### **Detailed, Project Based Consultation**

There are a number of areas where there is little available on line or though quick ad-hoc, consultation. Learning Disability is one area where this is almost universally true, especially in a Local Authority the size of Kingston where the numbers involved are small, and disclosure of even anonymised data risks exposing personal and sensitive data. Similarly, where information is required from independent providers, the information that would be most valuable is commercially sensitive. Under these circumstances a more robust process is required in order to provide a framework for sharing the information.

This information then needs to be drawn together; this process can be summarised as follows:

### **Collation**

One of the common errors in developing a Needs Analysis is that people collect the information together rather than collating it. Collating the information requires the information to be grouped together and cross referenced, to present a case for decision making. At this point the quality of the information collected and the “volume with which it speaks” can be far more important than the quantity. A good needs analysis cannot be judged by the number of pages!

### **Interpretation**

The information collected together for a Needs Analysis effectively provides the analyst with a series of “indicators” on which to make a judgement. Information alone doesn’t provide the answers. Therefore it is important to ensure that a view is taken as to what the data means in terms of the current situation and future provision.

## Needs Analysis in Kingston

### Information already held within the Local Authority

Throughout this project reference has been made to the wealth of information made available by RBK, especially in areas where it has been in agreement or dispute with fresh research and new sources of data.

### Desktop Research

Desktop research has been undertaken at length throughout the project, there are a number of areas in which this research has been very fruitful. By trawling systematically through the Office of National Statistics website we have been able to extract a number of key data sets in particular in the areas of:

- Health
- Affluence and Deprivation
- Household arrangements
- Ethnic and religious make up of the population.

It is worth acknowledging that the length of time since the last census makes some of the information available out of date, however that does not mean that the information is useless, it is merely important to take a view as to the information's validity and consider what factors may have changed in the intervening years. A systematic approach was also taken in looking at the Health Information Available from The Health and Social Care Information Centre and HES. Whilst the information available here on a local level is less prolific, it has been possible to identify trends specifically in relation to Kingston Hospital and also to utilise national trends where there is no reason to believe that the situation in Kingston is any different.

Other web resources have been used in a slightly less systematic way using searches to identify sources of information in relation to specific lines of enquiry, in an attempt to unlock data from sources that may not previously have been considered. For example exploration of potential causes of Physical Disability highlighted the availability of relevant data on the Department for Transport's website.

We have been able to draw on information from the ADASS Performance Networks which are groups supported by Tribal and undertake projects in relation to Performance on a region by region basis. Knowledge from these groups has both given lines of enquiry for us to follow and has also provided some solid data in relation to RBK's relative need when compared with other Local Authorities in the London area.

There have however been a number of key areas where this desk based research has consistently failed to yield a return. Information available in relation to Learning Disability is widely available on line; however it is usually in the form of medical explanation or advice and support for people who have experience of Learning

Disability in their own lives. Similarly information in relation to maternity, birth defects, etc. has only been available on a global and often non statistical basis.

It is fair to say that this project has been restricted by time and therefore further desktop research may yield further results, however, future investment of time is likely to be better spent exploring more practical avenues. In the key finding table outlined in the next section, we have indicated these areas in blue.

One area identified where some further desk top analysis may be beneficial is around the average age of older people who come into service for the first time to see whether or not people are beginning their receipt of Social Care services later and later in life. Whilst in theory this is a straight forward exercise, careful thought needs to be put into how a new service user is defined so as to account for scenarios where people have had services on and off over a period of time.

### **Light Touch Consultation**

Following a meeting with the departmental management team to explore key issues and priorities, further meetings and telephone conversations were undertaken with:

- Sue Todd and Kirstie Cochrane - Carers
- Bill Brittain and Lesley Bateman – Physical disability
- Glen Mills and Lesley Bateman – Learning disabilities
- Jane Bearman, Liz Trayhorn and Martha Earley – Older People’s Strategy
- Susanna Daly – Quality and Performance
- Francis Arokiasamy – Equalities
- Helen Wilkinson – Management Information
- Charlotte Fitzgerald – Strategy and Performance
- Shane Brennan – Age Concern
- Lisa Nichols – Kingston Centre for Independent Living
- Vicky Boswell – Mental Health
- Simon Cole – Placements

In addition, a number of people have been contacted in an attempt to get a quick overview in particular areas. For example, given the proposal that has been made that older people from Kingston move to Eastbourne in retirement, clarification was sort with contacts in East Sussex (who suggested that this was not the case). Similarly questions about the physical environment in Kingston were raised with local estate agents and so on.

There is reason to believe that given further time RBK could use this method of light touch consultation to gain greater insight and confirmation of hypotheses fairly quickly and easily. Suggestions for further work would include the following:

- Exploration of Religious and Cultural Issues (including issues of access) - There are a number of Local Authorities where there is exceedingly high representation of BME residents and services users. Information from the Performance Assessment Framework indicators will identify those Authorities who have a high number of BME services users. By making contact with representatives from these Local Authorities it should be possible to gain some headline information and key issues that are pertinent to the cultural and religious needs of RBK's residents. In turn this will allow RBK to identify whether their services take account of these needs.
- Within the analysis we have identified the fact that particular communities may (for whatever reason) be particularly affluent and therefore affluence is a primary factor as to why they do not receive services. Minimal discussions with community representatives, as well as utilisation of general knowledge among RBK staff should identify whether this in fact the case or not.
- The information presented about hospital discharge is necessarily reported on the basis of all age groups. Whilst this analysis suggests that older people are indeed being discharged from hospital more quickly on the evidence available, some fairly brief discussion with staff (both Social Care and medical) would confirm this. At the same time it may be possible to glean some information as to whether or not reduced waiting lists are improving recovery times for patients who have not deteriorated as far as they might previously have done before treatment.

These represent three next steps that could be taken quite easily. However there are a number of key areas where further insight into the current and future need of Kingston's population will require greater time and resources. RBK will have to take a view as to whether the investment of either their staff or financial resources can be justified.

### **Detailed, Project Based Consultation**

Within the scope and timescales of this project, it has not been possible to undertake detailed consultation. However the exercises undertaken as part of this project have identified three areas where this approach is likely to be the most productive approach.

- **Independent Sector Market Mapping**

Once of the key questions for RBK and other Local Authorities (particularly those in affluent parts of the country) is whether or not a significant

proportion of the service users that might be expected present to the Local Authority are actually accessing care independently, paying for it themselves.

Within this project some efforts were made to gain some high level indicative information, however, with little success. We have been able to establish that RBK is only purchasing a portion of the total number of residential places available in the Borough, by utilising the CSCI website to calculate the number of registered residential places within the Local Authority and then comparing this against the number of people who have been placed within the Borough by RBK. However this does not take into account the level of vacancies within each of the registered homes and it certainly does not give any insight into who the non RBK residents are or where they are from. The only people who hold detailed information about the people receiving care without going through the Local Authority are the providers themselves. This sort of information is both confidential with respect to the service user themselves but also commercially sensitive within a competitive market.

We have tried to make contact with a couple of local homecare agencies to test the water as to how much information they would be willing to share with me about the percentage of their business that comes from the Local

Authority and the percentage that is accessed directly from services users. Providers were (perhaps not surprisingly) unwilling to discuss this. However there was some suggestion that they may be willing to discuss a limited amount under the right circumstances.

Considerations should be given as to whether it is possible to work with providers, perhaps through a provider forum, to identify with them, information that they feel able to share and which will be of value in the context of RBK's Needs Analysis.

#### ■ **Mapping Community Support**

At the opposite end of the care scale, the question arises as to whether or not there is considerable provision for RBK residents within the voluntary and community sector. Whilst it is not viable to try to ascertain how many people are receiving services within the community, it is possible to map the breadth of provision and then extrapolate this to conclude whether or not it is possible that community support is for some people replacing contact with RBK. It would be possible to undertake a mapping exercise, cataloguing services and support available to people, starting with known contacts such as the Council for Voluntary services.

### ■ The Extent of Informal Caring

Reported measures of provision of informal care suggest that there are a smaller proportion of carers in RBK than elsewhere. However, asking people whether or not they provide informal care relies upon them identifying with the concept of being a carer, rather than fulfilling the role that a “good” husband, wife, friend, child, might be expected to provide. This leaves RBK with the question as to whether there are a significant number of carers within the Borough who would benefit from services, would like to access services from RBK, but who are not receiving them at present. It is probably unlikely that RBK or any other Local Authority will ever know accurately the number of people who might be eligible for services, therefore we are suggesting that the best way forward is to raise the profile of caring and advertise more widely the help that is available to for people in their caring role and then seeing whether requests for help begin to increase. Such profile improvement could include closer collaboration with local GP surgeries and discussions with voluntary sector services such as Crossroads.

### ■ Learning Disability

There is more exploration required in the area of Learning Disability. RBK is certainly not alone in terms of struggling to identify whether or not there is unmet Learning Disability need within the Community. Conversations with the Chair of Kingston Mencap have identified that they are in contact with a greater number of people with Learning Disability than RBK, however it is not clear how many of these people are eligible RBK residents.

It was noted that restrictions relating to the data protection act make it impossible to compare information from different sources to identify the degree of overlap. Some consideration should be given as to whether it is possible to overcome any of these difficulties within the constraints of the law. Further discussion with other relevant groups may bring forward additional new ideas.

It is also possible that work undertaken to raise the profile of caring and carer services may identify Learning Disability services users. There are thought be a significant population nationally (and anecdotally locally) of older people providing a caring role for adult children with Learning Disability. Many of these people have fulfilled this role for many years without asking for help. However the strains of caring are often uncovered in people’s physical and mental health, therefore, by working more closely with GPs it may be possible to identify these carers (and hence those who they care for), at times of medical crisis.

### 3. Key Findings

	Headline	Evidence	Consequence
Population	There is some evidence to suggest that the Older People population of RBK is decreasing	<p>There is conflicting data available about the changes expected in the Older People population of Kingston.</p> <p>The information included in RBK’s 2007 Needs Assessment based on the ONS mid year figures for 2005, predicts that the number of people in the 65-84 age bracket will decrease, suggesting that between 2005 and 2011 the population in this age group will fall by 2.5% (slightly less than the decrease in London as a whole which is 2.7%). There is however and increase in numbers of those 85+ of 2% identified in this period. (Source: RBK Needs Assessment 07)</p> <p>Anecdotal evidence suggests there are an increasing number of families with children moving into Kingston to access good schools. This is potentially changing the age profile of the area. (Source: Discussions with local estate agents)</p> <p>The information available from POPPI suggests that there will be a steady increase in the number of older people in all age categories between now and 2025. This information is based on the 2004 sub national populations for England. The projections are derived from assumptions about births, deaths and migration based on trends over the last five years (Source: POPPI)</p> <p>In 2005-06 there was a net decrease in population across all age groups. Losses are particularly noted in the age bands between 40 and 64. These are the potential service users of the next 5, 10 20 years and so on. (Source: Office of National Statistics)</p>	<p>Any decrease in the number of Older People will have an adverse effect on the financial allocation received by RBK for the provision of Social Care services.</p> <p>A net reduction in the RBK’s “middle aged” population will reduce the number of people reaching older age and potentially requiring Older People’s services.</p>

	Headline	Evidence	Consequence
Population	Residents are not moving to Eastbourne in particular, however there is some evidence that the coast in general is a popular destination	<p>East Sussex county council suggest there they have not identified a trend for movement from Kingston to Eastbourne or East Sussex in general. This is substantiated by the only statistical evidence available. In the twelve months prior to the 2001 census only 12 people moved from Kingston to East Sussex. (Source: East Sussex County Council)</p> <p>There is some anecdotal evidence to suggest that people selling their properties are moving to the coast, but not to any area in particular. (Source: Discussions with local estate agents)</p>	Some of RBK's potential services users may be retiring elsewhere
Affluence	A significant proportion of Kingston's population have the financial capacity to fund their own care	<p>69% of Kingston residents fall into the top two categories of the Social Grade measure developed by Social Grade is the socio-economic classification and used by the Market Research and Marketing Industries. This means the more than two thirds of the population of Kingston have a social grading equivalent to being employed within the jobs described as Higher and intermediate managerial / administrative / professional or Supervisory, clerical, junior managerial / administrative / professional). This far exceeds the both figures for London and the rest of England, where only 59% and 52% of people fall into the same categories respectively. (Source: Office of National Statistics)</p> <p>Only 1 in 6 of the White British population in Kingston is in a routine and manual occupation, compared to over 1 in 4 of the White British population in England as a whole. (Source: Community Health Profiles.org)</p>	<p>There will always be a considerably smaller number of people requiring assistance from RBK Council, than have care needs of the population.</p> <p>This fact will reduce the effect for RBK of other increases in requirement for social care.</p>

	Headline	Evidence	Consequence
Affluence	Based on the Relative Needs formula RBK is the Outer London Borough with the least level of Social Care need	<p>The Relative Needs Formula: statistical model of local need, based on the following:</p> <ul style="list-style-type: none"> <li>■ Population projection for households and supported residents aged 65 and over</li> <li>■ Households and supported residents aged 90 and over</li> <li>■ Households and supported residents aged 65 and over</li> <li>■ Older people on attendance allowance</li> <li>■ Older people in rented accommodation</li> <li>■ Older people living in one person households</li> <li>■ Older people receiving pension credit/Income based JSA</li> <li>■ Older people living in rented accommodation</li> <li>■ Population sparsity of those above 65</li> <li>■ According to this calculation, RBK is 20 out of 20 when compared with the other outer London Boroughs. (Source: ADASS South West Performance Network in collaboration with Tribal)</li> </ul>	RBK is unlikely to be one of the areas of the country providing care to a high proportion of its population.

	Headline	Evidence	Consequence
Market	The private care market appears to use a considerable share of the care services available in Kingston.	There are approximately 850 registered care home places in Kingston available for use by older people (depending on use of mixed registration places). In March 2007 RBK indicated through their SR1 return that they fund 321 Older People in residential placements, 249 of whom are in Borough, this suggests that RBK residents make up less than 40% of older people in residential care in the area. (Source: CSCI & RBK SR1 Collection)	There are a considerable number of RBK residents who require care but who either do not wish to have it provided by the council or who have sufficient funding not to seek assistance. The places in RBK may be being used by people funded by other boroughs. Market mapping could be undertaken to gain greater understanding of the residential landscape in Kingston. Consideration should be given to the impact on RBK of self funders who move into residential accommodation in Kingston and whose assets then fall below the threshold. These individuals will require assistance from RBK as they are technically RBK residents.
Market	Service user choice of residential accommodation is not particularly limited by borough boundaries	72 funded RBK residential care users took up residential placement outside of RBK (Source: RBK SR1 Collection)	Consideration should be given to working in partnership with other boroughs to provide for residents across the whole area.

	Headline	Evidence	Consequence
Affluence	Provision of RBK funded residential and nursing care is likely to decrease with more service users being able to fund their entire period in residential care in full and other individuals requiring state funding for a reduced period of time.	<p>The vast majority of RBK residents own their own home. Owner occupation in RBK is significantly higher than elsewhere in the country. 75% of all pensioners in Kingston own and occupy their home compared with 68% in England and 59% across London. (Source: Office of National Statistics)</p> <p>The rise in house prices experienced in the area means that when considered under CRAG more people will be identified as over the threshold for financial assistance from RBK. (Source: Discussions with local estate agents)</p>	An increasing number of people in Kingston will not receive funded residential and nursing care from RBK. There is an increasing incentive for people to remain in their own home and hence not have it's value taken into account in the consideration of funding for their care. There could be an increase in the number of people approaching RBK for funded homecare when they no longer have the capacity to pay for it themselves.
Population	Housing stock may be having an effect on the number of people still living in RBK at the time that they require Social Care services.	<p>Choice of property for those wishing to downsize or move to a property with easy or level access is limited, potentially causing people to move outside of the Kingston area. There are very few bungalows in RBK. There have also been a considerable number of incidences of people building a second floor to add value; therefore the number of single floor properties is actually decreasing. The main option for those wishing to downsize is flats. (Source :Discussions with local estate agents)</p> <p>RBK's Strategic Housing Review also touches briefly on the issue of downsizing. 32% of the people resident in sheltered accommodation surveyed suggested that the reason for them moving into sheltered accommodation was that their previous property was too big. (Source: RBK Extra Care Housing Report)</p>	There is a significant chance that people wishing to downsize as they get older, or move into a property with easy access following the acquisition of a physical disability, will move out of borough. Reducing the Older People and Younger Disabled population requiring assistance from RBK.

	Headline	Evidence	Consequence
Health	Residents of RBK are living longer than previously	<p>Life expectancy across the country has increase over the last few years. Life expectancy in RBK has always been higher than both the London average and the country in general, however the gap between the two has grown. Data from the period 2001 to 2006 suggests that life expectancy in RBK was originally 6 months longer than the England average but that the difference has now stretch to 1.25 years. RBK has also seen an increase above that of the increase across London in general, differing from London by 0.4 years in 01-03 and 0.8 years in 04-06. (Source: Office of National Statistics)</p> <p>All available measures of Healthy Life Expectancy and Disability Free life expectancy suggest that RBK residents are healthier than both the London and England averages. . (Source: Office of National Statistics)</p> <p>However there are discrepancies between different wards within the borough with men in the least deprived areas of Kingston living on average 4.0 years longer, and women 1.7 years longer than those in the most deprived parts of the Borough. (Source: Community Health Profiles.org)</p>	<p>Greater life expectancy in itself is not a reason for a greater number of people to require Social Care intervention or present themselves to the Local Authority for services. What is more likely is that these people are living longer because they are healthier and therefore do not require services as early in life as was historically the care.</p> <p>Consideration should be given to undertaking a piece of analysis to confirm this, by looking at the average age at which service users receive their first service now compared with data from earlier period.</p> <p>Should FACS criteria be extended to include people with lower levels of need, increased life expectancy could generate a greater pool of people potentially with lower level needs.</p> <p>Whilst higher level need may relate more closely to health than age, social interaction needs may increase with extended life expectancy. Consideration should be given as to whether the community and voluntary provision within Kingston does/would meet these needs rather than RBK. These sources do not have the same stigma attached as state provided care, even when they are in fact often partially funded by the Local Authority.</p>

	Headline	Evidence	Consequence
Health	In general the population of RBK are healthier than the national and regional averages	In each of the following RBK has a lower occurrence per head:  Deaths from Smoking  Early death from heart disease and strokes  Early death from cancer  Diabetes  (Source: APHO and Department of Health @ communityprofiles.org)	Despite the fact that people will be living longer, old age in itself does not bring with it a requirement for support. Compared with elsewhere, the older people in RBK are more often healthy elderly and are therefore they are still unlikely to require assistance from RBK.
Health	In general the population of RBK is likely to remain healthier for longer	A number of key data sets suggest that people in Kingston exhibit healthy lifestyle behaviours. Examples include: High incidence of people eating five fruit & vegetables each day (8th highest in London) Numbers of people smoking are lower than both the London and national average (9th lowest in London) Obesity levels are lower than both the London and National average (10th lowest in London) (Source: Office of National Statistics)	There is every reason to believe that the population of Kingston will remain healthier for longer and therefore fewer people will require support from RBK. Those who do require support may require it for a reduced period of time.
Informal Carers	There appear to be relatively few informal carers in Kingston	In the 2001 census, the numbers of people stating that they provide unpaid care was proportionally less than that reported across London, or in England. 92% of RBK residents stated that they provided no care at all (compared with 91% across London and 90% across England). At the highest end of caring only 1% of RBK residents provide care for more than 50 hours caring a week, compared with 2% across both London and England. It should be noted that this question relies on spouses, children and so on recognising themselves as a carer. (Source: Office of National Statistics)	Further investigation is required to understand whether incidence of caring are really lower in Kingston than elsewhere or whether it is actually people's perception of themselves as a carer that is lower.

	Headline	Evidence	Consequence
Health	There is evidence to suggest that there is a high occurrence of falls amongst Older People in RBK	The rate of hip fracture in older people in Kingston is higher than the England average. (Source: APHO and Department of Health @ communityprofiles.org)	Potentially a larger number of services users access Social Care service via hospital referral than elsewhere.
Health	Levels of Obesity and hence obesity related illness are likely to increase.	<p>In England, the proportion of men classed as obese increased from 13.2 per cent in 1993 to 23.1 per cent in 2005 and from 16.4 per cent to 24.8 per cent for women during the same period.</p> <p>The Foresight: Tackling Obesities: Future Choices project, predict that if no action is taken, by 2050, 60% of men and 50% of women and 25% of children will be obese. There is no evidence to suggest that obesity of the residents of RBK is not in line with national trends.</p> <p>It has been estimated that approx 13,637 over 65s are overweight &amp; obese and that a further 10,000 have a greater health risk of being overweight. In those from 55-64 the numbers are approx 10277 are overweight &amp; obese and that a further 7,000 have a greater health risk of being overweight. (Source: RBK)</p>	<p>The most significant health consequences of obesity include amongst others: Hypertension, Type 2 diabetes, Cardiovascular disease, Gallbladder disease, Certain cancers, Psychosocial problems, Gout, Breathlessness, Asthma, Osteo-arthritis (Source: International Obesity TaskForce <a href="http://www.iotf.org">www.iotf.org</a>)</p> <p>For example, obese women are almost 13 times more likely to develop Type 2 Diabetes than non-obese women, whilst obese men are nearly 5 times more likely to develop the illness. Increased prevalence of such conditions in the population of RBK is likely to increase the need for social care services. However the effect in RBK may be lessened by residents' general good health and healthy behaviours.</p>

	Headline	Evidence	Consequence
Health	High levels of Alcohol and Drug misuse are not evident through health data	Health data suggest a prevalence of 5.2 per 1000 head of population for drug misuse in RBK compared with an England average of 9.9. (Source: APHO and Department of Health @ communityprofiles.org) Health data suggests a rate 205.8 per 10,000 head of standardised population for hospital admissions relating to alcohol compared with an England average of 247.7. (Source: APHO and Department of Health @ communityprofiles.org)	Provision by RBK's for services to people with drug or alcohol problems can be expected to be comparably low. Service provider later in life as a result of drug and alcohol abuse can also be expected to be relatively low.
Disability	When compared with other London Boroughs, RBK's supports a fairly sizable number of Older People to live in their own home;	When PAF C32 figures are compared with those of other London Boroughs, RBK is the fourth best performer with an outturn of 104 (Source CSCI) However it should be noted that these figures include some service users who could be considered not to meet the most stringent interpretation of the definition as a result of the performance imperative to report higher numbers	No specific consequence highlighted
Disability	RBK's supports a comparably small number of people with Learning Disability or Physical Disability.	When PAF C29 and C30 figures are compared with those of other London Boroughs, RBK is the sixth worst and fourth worst respectively. (Source CSCI)	No specific consequence highlighted

	Headline	Evidence	Consequence
Disability	The Voluntary Sector are in touch with a higher number of people with Learning Disabilities than RBK	Kingston Mencap’s most recent Newsletter was sent out to a mailing list of 670 people. However this includes people with all levels of Learning Disability and people who are not necessarily still living within the boundaries of the borough and children. There is a general perception by the chair of Kingston Mencap that the vast majority of people with whom they have contact are also users of statutory services. However the chair also highlighted the difficulties that are caused in cross referencing information held by different groups as a result of issue of data protection. (Source: Chair Of Kingston Mencap)	Further work is required to understand the situation with regard to Learning Disability; reference is made to this in the documents attached to this report.
Disability	There is evidence to suggest that there is a lower prevalence of Physical Disability in Kingston than elsewhere.	Data from 2006 suggests that there are a total of 3260 people in RBK claiming Disability Living Allowance. This represents 2.21% of the population of Kingston. Per head of population this is lower than in London 3.89% and in England 6.47%. (Source: Office of National Statistics)	This lower level of Disability Living Allowance suggests that it is in turn not surprising that comparably, RBK has a low number of younger Physically Disabled service users.
Affluence	There is evidence of a considerably greater number of people with Physical Disability living in RBK than are receiving services from RBK	Only 10% of the numbers receiving DLA access Adult Social Care services from RBK. (Source: Office of National Statistics & CSCI)	Disability Living Allowance is a non means tested benefit. In contrast access to Social Care services is means tested. The data suggests that when affluence is taken into account, a significant number of potential service users are not eligible for a services from RBK

	Headline	Evidence	Consequence
Disability	Incidences of acquired Physical Disability from car accidents are lower in RBK than elsewhere	Data suggests that the rate of casualties from road accidents for those living in RBK is 0.58% compared with 0.72 for London and 0.66% nationally. (Source: Department for Transport (DfT), Statistics Roads Division (SR))	Fewer people in Kingston will require physical disability services from RBK as a result of injury through care accidents.

	Headline	Evidence	Consequence
Diversity	Services in RBK must, and will increasingly, have to take into account the requirements of an increasing mix of ethnic and religious requirements	<p>The White population (comprising British, Irish and Other White groups) is projected to decline by 5% between 2001 and 2025, with the greatest percentage reduction occurring in the 65+ age group</p> <p>The Black population ( Black Caribbean, African and Mixed White and Black groups) is projected to increase with the greatest % increase in the 65+ age group</p> <p>The Asian population ( comprising Indian, Pakistani, Bangladeshi, Mixed White and Asian and Other Asian ) is projected to grow, again with the largest increase in the 65+ age group</p> <p>The proportion of Chinese people living in Kingston is anticipated to increase from 1.4% in 2001 to 2.5% in 2025 and the ‘Other’ population group is also projected to grow from 3.2% in 2001 to 8.8% in 2025. The ‘Other’ population group probably includes the Korean population;</p> <p>Within the ‘Other White’ category there are also a proportion of non-English speaking people from countries outside of the UK including those from Eastern Europe. (Source: RBK)</p> <p>The 2001 census highlights a higher than average incidence of “no religion” than elsewhere in the country, with 18% of respondents stating that they have no religion compared with 16% in London and 15% in England. Excluding Christianity, the most represented religions were:</p> <p>Hindu (3.6%) a prevalence rate lower than that of London but higher than England. Muslim (3.9) a prevalence rate lower than that of London but higher than England. Prevalence of Buddhism higher than elsewhere in the country (0.8 cf. 0.76 and 0.28) – Does this link to Korean population</p>	<p>Consideration should be given to the differing requirements of people from different ethnic communities in terms of:</p> <ul style="list-style-type: none"> <li>• Accessibility of services (including language)</li> <li>• Nature of general service delivery</li> <li>• The role of Direct Payments in delivering a tailored service</li> </ul> <p>Further desk based research may be possible in this area however the most productive methodology would be to undertake research amongst representatives of these groups to identify potential developments to make service more culturally and religiously appropriate. It may also be useful to look at whether there is a link between certain communities and levels of affluence. For example are the Korean community in the main affluent and therefore it is as likely to be their affluence that keeps them from requiring services from RBK rather than any cultural barriers. Increase cultural and religious appropriateness may increase the number of BME service users and carers who approach and receive services from RBK.</p>

	Headline	Evidence	Consequence
Diversity		<p>Whilst data from the 2001 census is becoming out of date it serves as a useful starting point. (Source: Office of National Statistics) Kingston has an extensive Korean Population. Metropolitan Police state that Kingston has 22,000 Korean residents (Source: Metropolitan Police). However, the number of people in the last census who identified themselves as having been born in the far east is considerably lower, which suggests one of two things: Either there is a considerable population of second generation Korean residents, or there has been a dramatic increase in numbers since the last census in 2001. (Source Office of National Statistics)</p>	
Diversity	<p>There is some evidence to suggest there is under representation of BME communities amongst service users.</p>	<p>The performance of RBK against PAF E47 and E48 suggests that whilst there are a higher proportion of people from BME groups than might be expected receiving an assessment. A small proportion of these potential service users do not go on to receive a service. (Source CCS Performance Report February 2008)</p> <p>The distribution of service users by ward and ethnicity does not match the profile of the whole population in each ward. In the main each ward has a slightly higher percentage of White British and Irish service users than the proportion of White British and Irish individuals in the general population. Similarly in the main the percentage of service users from each ward in each BME group is smaller than the percentage of the general population that is from each BME group.</p> <p>It is the slight over representation of White Other service users in a significant number of wards that means when the population as a whole is observed there are proportionally the expected number of BME service users.</p> <p>It should be noted that the small number of service users under 65 makes a similar analysis unreliable.</p>	<p>The data suggests that for some reason, people from some BME groups approach RBK for an assessment but do not then go on to take up a service. Further consultation with the BME community and RBK frontline staff is required to understand the reasons for this.</p>

	Headline	Evidence	Consequence
Disability	There is a swell of young people with Physical Disability due to come through transition in three years time.	It is anticipated that Adult Services will take responsibility for 10 young people with Physical Disability during 08/09, 10 during 09/10, and 18 during 2010/2011. (Source: RBK Glen Mills)	Young people coming to adult’s services from Children’s services through transition are often receiving significant and expensive packages of care. Therefore expectations and therefore cost are often higher. In 2010/2011 almost twice as many children are expected to enter adult’s services than in an average year. This is likely to increase the numbers of service users over all with PD as the number coming in are likely to exceed the number leaving services. This increase will have financial consequences.

	Headline	Evidence	Consequence
Health	<p>Admissions of Older People to hospital are increasing</p>	<p>Figures suggest that over the last five year there has been an increase in the number of people being admitted into hospital. When comparing 2006-07 with 2002-03, there has been an increase in admissions of 4788 RBK residents in the over 60s age group.</p> <p>Not surprisingly given Government initiatives, the length of time waiting has decreased (Source: HES Statistics)</p> <p>There has been a decrease in the number of waiting admissions and an increase in the number of emergency admissions. This may be as a result of policy and drivers around waiting lists however some further investigation would be required to identify whether this is the case.</p>	<p>An increase in the number of people being admitted into hospital could result in an increase in the number of Kingston residents requiring post hospitalisation services from RBK. This is especially true where reduced waiting times result in people receiving interventions that they would not previously have lived long enough to see.</p> <p>However reduced waiting lists could also mean that peoples’ level of independence and fitness at the time of medical intervention is improved as a result of a reduced wait and therefore less Social Care intervention is required post operatively. Further research would be required to test whether either of these statements is true.</p> <p>It is certainly the case that when people enter the hospital system they discuss with professionals, problems that they have been experiencing and are then referred to Local Authority teams. These are often people who without the hospital episode would not have presented themselves to the Local Authority. Hence increased hospital admissions are likely to increase provision of Social Care services.</p>

	Headline	Evidence	Consequence
Health	Older People are being discharged from hospital after a shorter period of time	<p>The average length of stay in hospitals for all age groups has decreased from 9 days to 6.9 with the most frequent length of stay being 2 days (down from 3 in 02-03). This data is not readily available at a local level for over 60s/65s age groups only, however some further investigations could be possible to confirm that this reduction in length of stay applies to all age groups including older people.</p> <p>RBK’s performance against D41 suggests that there has been a steady decline in delayed discharges of care since a peak in 2004-05. (Source: CCS Performance Report Jan 08)</p>	<p>Reduced hospital length of stay can be as a result of a number of factors:</p> <ul style="list-style-type: none"> <li>■ More robust discharge procedures following the bedding in of the Community Care (Delayed Discharges) Bill</li> <li>■ Technological advances</li> <li>■ Imperatives to reduce exposure to viruses such as MRSA and Clostridium difficile.</li> </ul> <p>The likely explanation for decreased bed days is a combination of all of the above, therefore it is possible that in a proportion of cases more speedy discharge from hospital will result in an increased requirement for Social Care input on discharge and in some of those cases the input will be required from RBK. The extent of the effect is not quantifiable without further research including discussion with health and social care professionals</p>

	Headline	Evidence	Consequence
Health	The number of people requiring services as a result of hospital acquired infection is not increasing in RBK	The number of reported incidence of MRSA at Kingston Hospital has remained stable and at a fairly low level since April 2006 with approximately 7 to 8 reported incidence each quarter. (Source: Health Protection Agency) Similarly Kingston Hospital compares well in relation to the number of reported incidence of Clostridium difficile with an average of 81 cases per quarter in patients over the age of 65 since January 2006. (Source: Health Protection Agency)	When patients (especially elderly patients) contract one of the so called “Superbugs” it reduces their independence on discharge from hospital. As a result of both the physical and emotional effect of the infection, patients who under normal circumstances may have been discharged with a short term package of Social Care services or no service at all are instead provided with a greater level of care often for a considerable length of time. Whilst RBK residents are at liberty to attend any hospital for treatment, the fact that Kingston Hospital does not have rising levels infection, suggests that unlikely to be a rise in Social Care services to meet needs generated by hospital acquired infections.

## Appendix A – Key Questions

	Key Questions	Sub Questions
Total Population within LA	<p>How big is the pool of people from which service users will come?</p> <p>How many people live in the Local Authority?</p> <p>Are people migrating out of the Authority</p> <p>Are people migrating into the Authority?</p> <p>What is the net effect of migration</p>	<p>How big is the pool of people from which service users will come?</p> <p>What is the general profile of the people leaving?</p> <p>Why are they leaving?</p> <p>Are they older people potentially receiving services imminently?</p> <p>Middle aged people potentially receiving services in the future?</p> <p>Younger people?</p> <p>What is the profile of the people moving in?</p> <p>Why are people moving in?</p> <p>Are they older people potentially receiving services imminently?</p> <p>Middle aged people potentially receiving services in the future?</p> <p>Younger people?</p> <p>What is the status of these people in terms of eligibility to receive services from their new Local Authority</p> <p>Will the pool of people potentially receiving services get bigger or smaller?</p> <p>Within what timescales?</p>
Population with Social Care needs	<p>How many of the total population are likely to develop Social Care needs?</p> <p>What is the life expectancy of people in the Local Authority?</p> <p>How healthy are people in the Local Authority?</p> <p>How does health intervention affect Social Care need</p> <p>How many people suffer from conditions that prompt them to require services?</p> <p>How many people acquire conditions that require them to require services?</p>	<p>Are people living longer?</p> <p>Are people dying younger?</p> <p>How often do people suffer illness? Particularly those that often result in Social Care need?</p> <p>Do residents of the Local Authority have healthy lifestyles?</p> <p>In relation to Smoking, substance misuse, obesity etc.</p> <p>How many people are admitted and discharged from hospital?</p> <p>How long do those people remain in hospital?</p> <p>What are their needs when they leave hospital?</p> <p>How many people have a Learning Disability?</p> <p>How many people have a severe Learning Disability</p> <p>How many people acquire a physical disability as a result of car accidents?</p> <p>Do a significant number of people suffer from falls?</p>
Population approaching Local Authority	<p>Of those who develop Social Care needs, how many people will approach the Local Authority to have those needs met?</p> <p>Do people have the money to buy their own care?</p> <p>Is the Local Authority perceived well and viewed as somewhere that can help</p> <p>Do people have easy access to the Local Authority</p> <p>Are people supported by their own informal networks?</p> <p>Does the community "look after it's own"?</p> <p>Is there a ready supply of private provision in the area?</p> <p>Do people come to the attention of the Local Authority via health services?</p>	<p>Are people accessing services from the private market without contacting the Local Authority?</p> <p>Do people report good experience when they have been in contact with the Local Authority?</p> <p>Do people know what the Local Authority can provide?</p> <p>Is material available in appropriate formats? Languages, Braille, Audio etc.</p> <p>How many people live alone?</p> <p>How many people in the Local Authority provide informal care?</p> <p>How much community and voluntary support exists that does not link with the Local Authority?</p> <p>How widely are these accessed?</p> <p>Does access to this kind of support reduce higher level needs?</p> <p>Is it of good quality?</p>
Population in Receipt of Local Authority Social Care services	<p>Of those people who approach the Local Authority how many people go on to receive a service?</p> <p>Do people access services that they do not realise are partially funded by the Local Authority?</p> <p>Does the Local Authority put significant funds into services provided by the voluntary sector</p> <p>Do people in the Local Authority have a preference for a particular type of care?</p> <p>Are the services that people want available to them through the Local Authority?</p> <p>Is the Local Authority purchasing the right care?</p>	<p>Are people willing to receive services from the Voluntary sector where they would not want "Local Authority" services</p> <p>Does the Local Authority fund services users that it does not hold details for?</p> <p>Does provision of these services prevent people from entering more high level services?</p> <p>Do people wish to remain in their own home?</p> <p>Is this sometimes for financial reasons?</p> <p>Is it the care that people want?</p> <p>Is the care in the same places as the people?</p> <p>Are there sufficient variety of services available for people to purchase using direct payments?</p> <p>Do people perceive the quality of the care being provided to be of a high enough quality?</p> <p>Are service users attracted out of the Local Authority to preferred services elsewhere?</p>