

# Interim Commissioning Strategy for Older People's Services

April 2004



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**East Sussex Social Services**



# 1. Introduction

## 1.1 Purpose of this Interim Strategy

The purpose of this Commissioning Strategy is to contextualise and outline our broad commissioning intentions for older people's services for the medium-term.

In recent years there have been major developments in joint planning and collaboration with our key partners across health, housing, the voluntary and independent sectors, and this Strategy is strongly based on that joint work. However, we are not quite yet in a position to be able to produce a truly 'joint' commissioning strategy. A consultative process is however underway to move us closer to a joint commissioning strategy for beyond 05/06, so this Strategy seeks to clarify our position in the interim period.

## 1.2 Commissioning Definition:

Commissioning is the process of **"specifying, securing and monitoring services to meet individuals' needs both in the short and long term. It covers the purchasing process as well as a more strategic approach to shaping the market for care to meet future needs"**.

('Take Your Choice' - Audit Commission 1997)

This definition was adopted by Older People's Heads of Service, and supported by a range of staff involved in consultative commissioning workshops held in July/August 2003.

## 1.3 The East Sussex Vision for Older Peoples Services

The 2003/04 East Sussex County Council Plan identifies improved care for elderly people as the Councils' number one priority and commits increased resources to back up this commitment. Detailed plans are outlined in section 7.4 below.

A shared expression of the values which underpin such a key priority is a vital complement to this kind of organisational commitment. The shared vision for services for older people in East Sussex is the product of wide consultation through the development of the Whole Systems Strategic Plan for Older People (2002-2005), Joint Review Action Plan, Best Value Review and local NSF implementation work. The views of older people locally have been expressed in a variety of ways:

- Specific consultation exercises such as for the Joint Review & joint Best Value Review
- the Age Concern report, Going Round the Moon to Meet the Sun,
- the All Our Futures Conference,
- the Bexhill & Rother, Hastings & St. Leonards Ashburnham Conference
- the ESCHT Stakeholder Conference for users of mental health services
- Debate of the Age events
- and through older peoples representation in local NSF Implementation Groups.

In August 2003, work began on developing a multi-agency User & Carer Involvement Strategy and in the autumn, a series of workshop events are being led by Age Concern which will provide further opportunities to gain the views of older people and carers on service provision. Nationally, the Better Government for Older People Programme has provided invaluable guidance on better meeting the needs of older people. The learning from the above programme is reflected in **our shared vision** which can be summarised as follows:

"We are committed to transforming services and the user experience for older people in East Sussex, placing users and carers at the centre of our decision-making processes, ensuring user-friendly rapid access to assessment and services which are flexible, tailored to meet individual need, empowering and promoting independence, supporting older people in their own homes wherever possible.

We are committed to developing networks of services across East Sussex that provide older people with easy, equitable access to the care that they need and that is organised around them in a flexible seamless way.

We are committed to working together to pool our resources and expertise to achieve this vision, to develop integrated ways of working and delivering services that are complementary and user-focussed both within local care communities and across the County as appropriate.

We are committed to ensuring that a full range of services is available to meet older people's needs across the spectrum from prevention and health promotion through to acute and specialist services, with the primary objectives of maximising independence within the individuals capacity and providing the right care at the right time in the right place.

We are committed to achieving high standards and delivering continuous improvement in services making best use of available resources and employing evidence-based practice to achieve the best outcomes for older people”.

This shared vision as outlined in the Priorities for Older People’s Service Development in East Sussex 2003/04 report to Health & Social Care Executive, was agreed by the Executive in May 2003.

#### Equalities and Diversity

The above vision is underpinned by our commitment to responding to the diverse communities of East Sussex. The 2003/04 Council Plan states:

*“ESCC is committed to the principles of good practices of equal opportunities, both in employment and service delivery, to ensure that our employees, prospective employees, customers and the public are treated fairly and equitably and without discrimination.”*

The County Council has prepared an Equalities Scheme 2002-05 in accordance with the guidance which supports the Race Relations (Amendment) Act 2000. It is also building on its previous commitment, to now address the new obligations outlined in various European Directives on race, sexual orientation, religion or belief, disability and age. These new directives have a phased implementation that runs through until 2006, but the Equalities Scheme already states its commitment to:

*“...promote further equality of opportunity:*

- between persons of different religious belief, age, marital status, sexual orientation or gender identity;*
- between persons with a disability and persons without;*
- between persons with dependants and persons without;*
- between men and women generally.”*

In addition to responding more sensitively to these diverse groups, Social Services is also committed to actively addressing the issues of rurality through provision of rural premiums in various contracts and leadership of the Rural Issues Reference Group.

### **1.4 Older People’s Services in East Sussex Social Services**

Historically, services for older people in East Sussex have been concentrated on residential and institutional care at the expense of more rehabilitative and domiciliary care that promotes independence and seeks to maintain people in their own home. This has been a major cause of our historical high level of delayed discharges. There has been a planned reduction in admissions with a 36% fall over the past 3 years. Total numbers in residential care are falling as a result and savings flowing from this (estimated as £400k in 2003/4) are being re-invested in support to people living their own homes.

There has also been an under-funding of services for older people which created a major inability to provide appropriate services for everyone assessed as needing them which produced a substantial waiting list for services. There is now a political commitment to increase spending on older people and as a result the numbers waiting for services have been dramatically reduced.

Indeed, the SSI Inspection of Social Care Services for Older People in March 2003 found that, *“Overall, considerable progress had been made since the Joint Review visit in that took place in 2001. Improving services for older people was the top priority for the council.”* Their report also outlined a number of areas for improvement, which included the need to improve commissioning.

In December 2003 East Sussex County Council was rated as “Good” in the Audit Commission’s Comprehensive Performance Assessment (CPA) rating. In jumping 2 grades from the Council’s previous “Weak” rating, East Sussex was the most improved Council in the Country. Improvements to older people’s services were crucial in the re-assessment and this further external recognition of progress acts to endorse the ongoing commitment to modernise services.

### **1.5 Priorities - National & Local, and Key Outcomes**

This strategy is based on a range of national programmes and local plans, including:

#### National Programmes:

- Modernising Social Services

- National Service Framework for Older People (NSF Implementation Plans)
- The NHS Plan
- Building Capacity and Partnership in Care
- Best Value
- Better Care, Higher Standards
- Integrated Services For Older People, building a whole system approach in England

East Sussex Local Plans (many of which are joint with health):

Whole Systems Strategic Plan for Older People (2002-2005)	Best Value Review of Services for Older People 2002
Clinical Services Review	Local Delivery Plans
Priorities & Planning Framework 2003-2006	Performance Improvement Plan
Promoting Independence Service Strategy (S0&W)	Assessment of need for sheltered and Extra Service Housing in East Sussex
Joint Review Action Plan	Intermediate Care Development
Extra Care Housing Strategy	Public Service Agreement
Joint Investment Plan 2001-2004, Older People, including Older People with Mental Health Problems	Market Needs Analysis for Older People with Mental Health Needs in East Sussex
Comprehensive Plan For Older People's services in East Sussex 2003 – 2006 (Draft)	SSI Inspection of Social Care Services for Older People 2003
Supporting People Shadow Strategy	

Set in this context & in the light of Health's Financial Recovery Plan, the key joint priorities and objectives for modernising older people's services in East Sussex for 2003/04 have been identified and agreed by the Health, Education and Social Care Executive in May 2003:

- Access targets
- Service Re-design
- Intermediate Care
- Integration
- Delayed Transfers of Care & "Reimbursement"
- Other NSF Priorities
- Agreed Planning and Commissioning Arrangements

(See Priorities for Older People's Service Development in East Sussex 03/04 Report to Health & Social Care Executive May 2003, Beverly Hone)

The objectives outlined later in this document make explicit the Social Services elements of these shared priority areas for action.

## 2 Needs Assessment

Initiatives In Care Ltd is currently undertaking a formal analysis of the needs of older people for support to live in their own homes. Due in early 2004, the report should provide a comprehensive overview of the current situation in East Sussex. It will also provide valuable insight into the priority areas for action in terms of strengthening the department's ongoing approach to analysing need as a basis for better informed commissioning.

What follows is a summary, drawn from current material, of key aspects of need.

### 2.1 Older People

The 2001 Census confirms that East Sussex has a relatively elderly population with 27% of residents over pensionable age (137,000 of a total population of 503,000 as at 2001) compared to just over 18% in the South East and in England and Wales. Eastbourne and Rother have a particularly high proportion of residents over pensionable age, especially Rother at 31%, which is the third highest in any District in England. All five localities in East Sussex rank amongst the top thirty of all English Districts with the highest proportion of residents over the age of 85 years. 44% of all households have at least one person of pensionable age living there, whilst 35% have only pensioners and 20% are pensioners living alone.

#### 2.1.1 Population change

Population growth between 2001 and 2011 is projected to be around 39,900 persons (+8.1%) across the county as a whole, which compares with 4.4% growth over the previous decade to 2001. Population growth varies from -0.2% in Lewes to +15.4% in Rother. These figures (and those in the table below) are still based on projections calculated from 1991 Census data as projections based on the 2001 Census date are not yet available. New projections may

indicate a different pattern, in that Parish-level data from the 2001 Census indicated that the key areas of growth in the Districts since the 2001 Census were quite specifically in the market towns of Wealden (Uckfield at 13.2% and Hailsham at 9.6%) and the coastal fringe areas of Lewes (Newhaven at 9.3% and Seaford at 9.0%). All other non-urban areas increased by an average of just 4.5%. Eastbourne increased by 10.2% compared to Hastings at 5.2%.

Table 2.1 East Sussex Population Projections

Local Authority Area	1991 Census	2001 Census	Projected 2011 (Projection based on 1991 data)	Percentage Change 2001 - 2011
Eastbourne	84,900	89,667	99,400	10.9
Hastings	83,400	85,027	90,700	6.7
Lewes	88,600	92,187	92,000	-0.2
Rother	83,100	85,422	98,600	15.4
Wealden	131,700	140,021	151,400	8.1
<b>East Sussex</b>	<b>471,700</b>	<b>492,324</b>	<b>532,200</b>	<b>8.1</b>

Source: 1991 and 2001 Census Data

### Components of population change

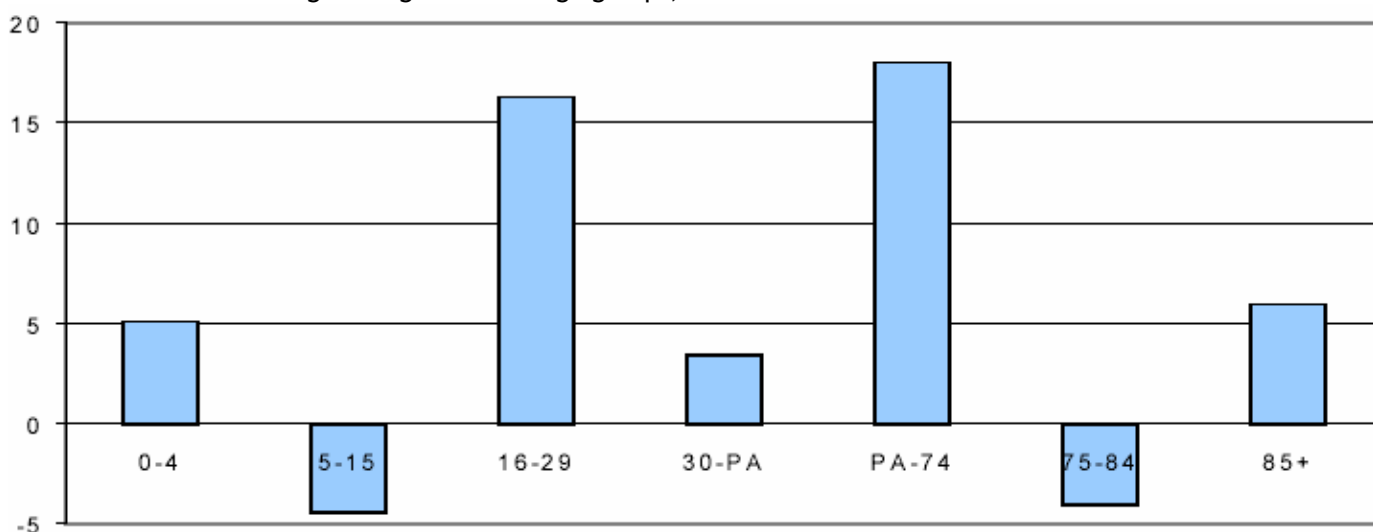
In East Sussex, with around 5,000 births and 7,000 deaths each year, natural change is -2,000 persons per year. Gross migration flows to/from East Sussex and Brighton & Hove average around 35,000 persons in and 28,000 persons out per year, producing a net gain of around 7,000 persons per year, of which around 5,000 locate within East Sussex. When compared to other counties in England, East Sussex has both the highest rate of net in-migration and the highest rate of natural decline per 1,000 residents.

With population growth entirely dependent on migration flows, the age characteristics of movers are fundamental to the changing age profile of the county. Young adults form between 40-45% of all gross migrant flows, and account for one quarter of net in-migration to East Sussex. Retirement migration is no longer a very significant feature of population change in the county as persons over pensionable age now only represent about 12% of net in-migration each year.

### Age group characteristics

Over the coming decade the overall growth rate of +5.7% is spread more variably across broad age groups, with small declines projected amongst both primary and secondary school age groups, and a substantial increase in young adults aged 16-29. Older workers and pensioner age groups are projected to increase considerably, by around 11,000 persons each, boosted in part by the ageing of the post-war baby boom generation. The very elderly age group (aged 85 and over) is expected to grow by around 1,100 persons over the decade, to 20,100 by 2011. The rate of growth for this age group is markedly less than that actually experienced during the 1990s.

Table 2.2 Percentage change in broad age groups, 2001 - 2011



PA: Pensionable age (65 for men, 60 for women)

## 2.2 Older People with Mental Health Needs

Prevalence of dementia for people over 80 years old is 1 in 5 (or 20%) according to Alzheimer's Society statistics. In November 2002 John Windebank reported that a computer-generated analysis calculates that there are approximately 8300 people with a moderate or severe cognitive disability in East Sussex. It also estimates that of these, 3200 (or 39%) will be in institutional care.

Several challenges feature for this service area, including the varied availability of the new anti-dementia drugs which are able to support those with early dementia to remain in the community longer; and the existence of multiple pathways to care, which results in services being provided, appropriately, from either an Independent Living Team when social care needs predominate or the Older People's Community Mental Health Team when mental health needs predominate. Because of this however, there is an inevitable degree of variation in service provision and some blurring of spend patterns. A mental health service modernisation project is currently underway which will help address these and other issues.

There is also some early evidence emerging that the rehabilitative agenda being emphasised in home care and day care provision (see 5.1 below) may be less appropriate to the specialised, longer term and often chronic nature of mental health issues for older people. This type of specialist provision ideally needs linking to the provision of EMI respite nursing care for this group. Discussions have commenced to investigate how best to address these issues.

## 2.3 Carers

Data from the 2001 Census indicates that there are nearly 51,000 unpaid carers in East Sussex, 12,331 (24%) of whom are over 65. As a point of comparison, in the 02/03 year, Social Services provided 2815 people over 65 with home care (see 3.1 below). Some 4610 people over 65 are providing 50 or more hours of unpaid care per week, including 340 people who are themselves over 85 (123 of whom indicated that they were not in good health). Clearly, the role of unpaid carers is vital and the department's role in supporting carers themselves and working with voluntary sector groups such as Care for the Carers, William Daly Care Support Schemes, Crossroads Care and Age Concern will continue and grow. A countywide Carers Strategy Group oversees the implementation of the Carers Joint Strategy 2002 -2004 and seeks to improve responses to carers' issues.

## 2.4 People from Black and Minority Ethnic Communities

People from Black and Minority Ethnic (BME) communities comprise 2.3% (11,504 people) of the total population of East Sussex, compared to 8.7% across England and Wales. Of this group, 591 people are aged 65 or over and as such comprise 0.53% of the ES older people's population.

In terms of services provided by Adults services, our 2002-03 Referrals, Assessment % Packages of care (RAP) report to the DoH indicates that we had 36 service users aged over 65 from 'non-white' communities. This number constitutes 0.41% of our total service users over 65, and as such indicates that BME communities are under-represented by 33% compared to their distribution in the wider community (0.53%). It should be noted that there are significant levels of non-recording of ethnicity on CareFirst, some 3358 cases, or 27% of the 12,239 total number of older people receiving services. See Table 2.3 below.

Table 2.4 Numbers of People over 65 Receiving Services by Ethnic Group and Service Area

Ethnic Group (as per Census)	Physical/Sensory/Frailty	Learning Disability	Mental Health Needs	Substance Misuse	Other Vulnerable Person
White - British	7511	87	1014	8	45
White - Irish	52	1	8	1	
White - Any Other Background	100		18		
Mixed - White and Black Caribbean	2		1		
Mixed - W & Asian			1		
Mixed - Any Other Mixed Background			2		
Asian/Asian British - Indian	3		2		
Asian/Asian British - Pakistani	1				
Asian/Asian British - Bangladeshi	1				
Asian/Asian British - Any Other Asian	3		1		
Black/British - Caribbean	5				
Black/British - African	2		1		
Black/British - Any Other Black Background	3				
Any Other Ethnic Group - Chinese	4				
Any Other Ethnic Grp - Any Other Ethnic Grp	2		2		
Not Stated	2853	84	401	5	15
<b>Total</b>	<b>10542</b>	<b>172</b>	<b>1451</b>	<b>14</b>	<b>60</b>
Total Recorded ["Not Stated" are removed]	8881				
Total 'Non-white' ["Not Stated" are removed]	36 (0.41%)				

Source: RAP Return data 2002-03

The most significant minority group amongst our service users are those categorised as "White - Any Other Background". There are 118 people in this group and Social Services doesn't collect any further detail on their culture or nationality. The Census data indicates that this group across ES (11,000 people, of all ages) is comprised largely of people born in Western European countries or North America. If any group was likely to be vulnerable, it would probably be those from Eastern Europe and this group constitutes about 9% of the total. Assuming an even age distribution and proportionate need for services, this would suggest that approximately 25 members of these communities would/should be in receipt of our services.

The disproportionately low numbers of service users from BME communities has led to a low rating (2 blobs) on this Performance Assessment Framework (PAF) indicator (E47) and the SSI Inspection of Social Care Services for Older People in March 2003 highlighted the need for us to better promote our services to members of BME communities.

Two main streams of activity should enhance our service provision, or at least our understanding of the issues, to BME communities over the next several years. Firstly, the department's strong involvement in an East Sussex-wide Connecting Communities project, led by Sompriti and involving 10 public sector organisations in improving awareness and uptake of public services by members of BME communities. This contract, for £170,000 between January 2004 and March 2006, involves one-to-one case work with individuals, research on needs and barriers to access experienced by BME communities and analysis and improvements to service delivery and employment practices by public sector organisations. Secondly, the Performance and Quality Division will be leading an initiative to improve recording practices.

## 2.5 Housing

In May 2000 the five District and Borough Housing Authorities and Social Services commissioned a joint report from Peter Fletcher Associates on the need for sheltered and Extra-service housing in East Sussex. Peter Fletcher looked in detail at sheltered housing provision by local authorities and concluded that not all schemes are up to the required standard or indeed in the right location. Many of them have shared facilities and bed-sitting rooms which prove difficult to let. He highlighted a mismatch between current sheltered housing provision and future need and demand. A number of pointers came out of the report, namely:

- There is a need to re-configure some residential homes and sheltered housing schemes.
- There is a shortage of rented sheltered housing that is :
  - ◆ designed to support 'ageing in place'
  - ◆ in an appropriate location
  - ◆ designed to meet the changing aspirations of older people
  - ◆ of a good standard

- People are moving to sheltered housing later in life.
- There is a need to reassess the requirement for a “home for life” with an extension of services such as Lifeline, aids and adaptations and domiciliary care.
- There is a desire by older people to retain control and independence rather than move to institutional care.
- There is no “intermediate stage” provision between sheltered housing and residential/nursing care and a high proportion of those moving out of sheltered housing move on to a higher care setting, consequently there has been an over reliance on residential care provision.
- Consideration needs to be given to the changing role of the scheme manager or wardens of sheltered housing schemes.

The findings of this report have formed a basis for the inter-agency Extra-Care Strategy 2003-2008. Further Extra Care Housing needs analysis work has been completed in July 2003 and it documented the following provision of sheltered and residential places:

Table 2.5 Sheltered and Residential Housing Provision in East Sussex (Extra Care Housing Needs Analysis July 2003)

District	Sheltered Places	% Against County Average	Residential Places	% Against County Average	Extra Care Places	Extra Provision Recom'd by Fletcher Rpt
Eastbourne	1704	Slightly less than	1040	+15%	13 Gwent Court	80 Older People 24 Specialist Dementia
Hastings	1541	+40%	846	+35%	40 The Marlborough	40 Older People 24 Specialist Dementia
Lewes	1383	Slightly less than	632	-26%	None	72 Older People 24 Specialist Dementia
Rother	1272	-27%	1172	+18%	None	80 Older People 30 Specialist Dementia
Wealden	2152	Consistent with	905	-25%	None	120 Older People 48 Specialist Dementia

The analysis went on to draw the following conclusions:

#### Resource and Market Factors (Residential Care, Sheltered Housing)

- Wealden has the highest base if actual number of units is used, but this is accounted for by the high number of sheltered housing units, in particular, flats for sale. Wealden’s residential care base is low for the size of it’s older people’s population.
- If the number of residential units per thousand of the population over 65 is used, Lewes’ resources base is the lowest, followed by Wealden.
- Eastbourne’s resource base is high with a fairly even distribution across residential and sheltered housing.
- In Rother, the residential sector is well provided for, but the number of sheltered housing units is the lowest in the county.
- Intensive support packages are highest in Lewes where the residential resource base is the lowest: this may reflect assessment and commissioning activity to provide community based alternatives to residential care.

#### Priorities for Development

- Different types of extra care units will be needed in different Districts, depending on the local resource base and demographic factors.
- In Wealden, where demographic pressure is high in actual numbers, and sheltered provision is high, but residential care provision is low - extra care housing as an alternative to residential care is a priority. This could be provided by a new build opportunity or by re-provisioning existing sheltered housing.
- In Lewes, where residential care provision is lowest, but demographic pressures are less (second lowest in the county), extra care developments should focus on an alternative to residential care.
- Eastbourne’s resource base appears to be well developed, but the significant demographic pressures would suggest that extra care provision continues to be developed as an alternative to residential care, but with particular focus on integrating intensive support package provision into the community as this part of the market is underdeveloped.
- Rother’s greatest challenge is from demographic pressures with a very high proportion of older people in it’s population. Although the residential care resource base is high, the majority of places are in the coastal strip, and provision in rural areas is very limited. Extra care should be developed in rural Rother, possibly utilising sheltered housing units, but there would also be capacity for new build schemes.

- Overall, because Hastings' demographic pressures are less significant, the resource allocation and use of resources appears satisfactory for its population size. The Marlborough is a significant extra care resource for St Leonards. Any future extra care developments would not be a priority for Hastings.

### Owner Occupation

Given that the levels of owner occupation in East Sussex varies from 67% to 86% (averages 75%), it is important that the commissioning approach to housing for older people reflects this. There fore it is anticipated that consideration will be given to the development of mixed tenure housing, as well as the development of support and care to older people in the owner-occupied sector. This will include the continued development of Home Improvement Agencies (in line with Government guidance), telecare and floating support schemes.

## 3 Current Services

### 3.1 Older People Receiving Services

As at 31/3/03, the numbers of older people receiving services were as follows:

Age	Primary Client Type	Home Care	Day Care	Meals	Planned short term breaks	Direct Payments	Prof Support	Transport	Equip and Adapt	Other
65 - 74	Physical Sensory Disability Frailty	323	78	99	27	5	224	6	395	28
	Learning Disability	3	19	1	4	0	16	1	2	2
	Mental Health	75	86	23	13	1	97	2	15	8
	Substance Misuse	3	0	0	0	0	0	0	0	1
	Other Vulnerable people	2	0	1	0	0	1	0	0	0
	<b>TOTAL</b>	<b>406</b>	<b>183</b>	<b>124</b>	<b>44</b>	<b>6</b>	<b>338</b>	<b>9</b>	<b>412</b>	<b>39</b>
75 - 84	Physical Sensory Disability Frailty	958	337	481	153	2	596	14	946	140
	Learning Disability	3	4	1	1	0	5	0	2	0
	Mental Health	110	110	49	29	0	138	3	23	13
	Substance Misuse	0	1	0	0	0	2	0	0	0
	Other Vulnerable People	5	2	6	0	0	1	0	1	1
	<b>TOTAL</b>	<b>1076</b>	<b>454</b>	<b>537</b>	<b>183</b>	<b>2</b>	<b>742</b>	<b>17</b>	<b>972</b>	<b>154</b>
85+	Physical Sensory Disability Frailty	1239	352	876	211	3	692	10	883	210
	Learning Disabilities	1	1	0	2	0	5	0	0	1
	Mental Health	83	65	37	32	0	128	1	18	12
	Sub Misuse	1	1	0	0	0	0	0	0	0
	Other Vulnerable People	9	4	9	3	0	8	0	1	4
	<b>TOTAL</b>	<b>1333</b>	<b>423</b>	<b>922</b>	<b>248</b>	<b>3</b>	<b>833</b>	<b>11</b>	<b>902</b>	<b>227</b>
<b>Total All Ages</b>		<b>2815</b>	<b>1060</b>	<b>1583</b>	<b>475</b>	<b>11</b>	<b>1913</b>	<b>27</b>	<b>2286</b>	<b>420</b>

Source: RAP Return 02/03

It should be noted that, in addition to the figures reported above, there will be those who are receiving a service from the Community Mental Health Team structure whereby a social worker will be providing advice and possibly a

joint assessment which is not necessarily recorded on CareFirst. Therefore there is probably a degree of under-reporting of mental health service provision.

### 3.2 'Modernised' Services

Social Services are in the process of modernising services, continuing their increased investment in services for older people, with increased support of older people in their own homes, where this is a safe and appropriate option, completion of the Homes Review, implementation of an agreed model of home care within the directly provided services (DPS), the creation of Service Level Agreements with DPS, and a continued shift in investment from institutional models of care to person-centred care that promotes optimum independence for older people. In implementing our strategies to promote independence and reduce dependency, we now have a number of services oriented to support this work. And these include:

#### Intermediate Care Services

We have a range of intermediate care and rehabilitative services across the county and have extended these in the last year, particularly to respond to the need to provide services to prevent inappropriate admission to hospital and as alternatives to residential and nursing care for people discharged from hospital. These include the Community Collaborative Rehabilitative Team in Hastings, the Living at Home Programme of rehabilitative care within some of our residential homes and the Rapid Response Team in part of South Downs and Weald.

#### Prevention

We provide some preventive services such as the Take Home and Settle service commissioned from Age Concern that allows vulnerable people to be helped to move back home from hospital earlier than they would otherwise have done through the support of Age Concern volunteers. However we acknowledge the need to develop more preventive services and the Comprehensive Plan includes the development of these over the next 3 years.

#### Out of Hours

Some services are provided out of office hours, such as Milton Court resource centre for older people with mental health needs which is open at weekends. We have recently extended the hours of the hospital social work teams to weekday evenings and Saturday mornings to improve our response to facilitating early discharge. However the majority of services are only available during office hours with access to duty workers in emergencies outside of these.

These types of modernised services need to be further developed. The vehicle for this change will be this Commissioning Strategy and the Priorities for Older People's Service Development in East Sussex 2003/04 report to Health & Social Care Executive May 2003, which specifies the need to develop more flexible services to meet individual needs such as direct payments, a voucher scheme and more intermediate care services. It also clearly identifies the need for more preventive services that will reduce or delay the need for intensive services from both health and social care. Two extra-care housing schemes, partially funded by Supporting People monies, have been completed in the first half of 2003. These are providing community-based alternatives to residential care that enable older people to remain independent whilst living in a safe environment with flexible support.

### 3.3 Partnerships

Social Services maintains and develops crucial partnerships with other organisations and sectors across East Sussex, without which effective service provision to older people would be impossible. Key partnerships include:

- Health
- Housing
- Voluntary Sector
- Independent Provider Sector
- Black & Minority Ethnic Communities
- Local Strategic Partnerships
- Crime and Disorder Reduction Partnerships
- Rural issues
- Training Organisation for the Personal Social Services (including lifelong learning issues and workforce development)

## 4 Financial Position

### 4.1 Financial Context

Over the last four years there has been a change in direction in the way the Council has prioritised Community Care spend. In the past there has been a historical over-reliance on residential care manifesting itself in very high admission rates and an attrition rate as low as 13% for residential care. This meant that significant base resources were 'tied up' in the quantum of people receiving residential and nursing care.

Another major factor was the shifting of resources into other Adult service areas and, in particular, Learning Disabilities through a centralised Community Care Panel.

A new strategy of investing in Older People's Community Care has now been adopted. The main driving forces behind the new strategy are as follows:

- A shift away from residential care towards home care and community based services.
- A concentration on expanding this service specifically in relation to Older People to improve performance.
- A determination to reduce the levels of delayed discharges in the local health economy.
- A promise to keep clients waiting for service to a minimum.
- To increase fee rates paid to providers across the board to redress a history of extremely low rates, and in order to secure continuity of supply.

To move these areas forward the following actions were taken in 2002/03:

- Splitting the Community Care Panel by service groups.
- Splitting Older People's community care spend to the three localities, with a ring-fenced budget for home care.
- The setting up of a home care purchasing unit.
- A strategic targeting of resources into home care to increase numbers supported at home.
- A separate PIP to monitor these areas as well as the number of delayed discharges.
- An increase of fee rates for 2003 / 04 which focussed specifically on increasing home care capacity.
- The creation of block contracted providers in home care and specific 'hard to purchase' areas.

To pay for this change in direction, injections of resources have been made available from the following sources:

- Corporate investment of 7% per year in Social Services labelled as 'standstill pressures' and the recovery plan
- A reinvestment of internally generated resources from savings made through reviewing in-house provision and where appropriate the externalisation of services to the independent sector

As well as this it has been anticipated that the numbers of people in residential care would reduce as the historical practice of early admission to residential care would taper thus releasing more resource through attrition. The history of early admission has meant that residential and nursing service users could require services for up to ten years of funded service.

The attrition percentages, while increasing, have not risen as fast as first estimated. Because of its impact on short and medium term financial modelling, this situation is being closely monitored and alternative scenarios prepared.

### 4.2 Overall Spend

- Overall spend on older people in 03/04 is budgeted at £44,250,000, some 41% of the total Social Services spend of £108m.

## 4.3 Spend Breakdown

Table 4.3.1 Current Spend on Older People's Services 2003/04

Services for Older People	Mainstream [Directly Provided Services]	Community Care [Provided By Others]	Total
	£000	£000	
Residential Homes	6,062	19,193	25,255
Day Centres	2,000	276	2,276
Home Care	4,165	5,778	9,943
Meals in the Community	0	549	549
Assessment	5,484	0	5,484
Community Services	193	0	193
CPF & Other Services	550	0	550
<b>Total</b>	<b>18,454</b>	<b>25,796</b>	<b>44,250</b>

Of a total spend in 03/04 of £110 million on providing and purchasing services for older people, at £5.7 m, home care accounted for 5.7% of the total and residential and nursing care at £19.1 m accounted for 17%. Compared to 02/03, when the equivalent figures were 3.8% and 16% respectively, there has been a significant shift away from residential care and towards home care. In the case of home care, there has been a 50% increase.

Table 4.3.2 Indicative Unit Costs for Various Services to Older People  
(Management and Support overheads are included)

PAF Indicator (Gross weekly expenditure per person, with Performance Band 'blobs')	01/02	02/03	'Nearest Neighbour' Comparator
B12 Unit Cost of Intensive Social Care for Adults and Older People (new definition used)	429 ..	446 ..	402
B13 Unit Cost of Residential and Nursing Care for Older People (new definition used)	351 ...	382 ..	343
B17 Unit Cost of Home Care for Adults and Older People	13.8 ..	13.5 ...	12.3

Source: Social Services PAF Indicators, DOH 2002-2003

Table 4.3.2 indicates an improved unit cost for home care (B17) because of the shift to more cost-effective independent sector provision. Residential and nursing care unit costs (B13) have increased because market pressures required an increase to fees and services such as intermediate care are relatively expensive (up to £900/week). The overall increase was mitigated however, through increased use of cost-effective independent sector providers.

## 5 Local Care Market and Contracting Arrangements

### 5.1 Local Market Context

A study carried out in mid-2002 outlined the following difficulties in the local market:

- History of low fees paid by Local Authorities.
  - PSSRU Survey investigating Closures of Care Homes for Older People (Feb '02) - 50% of providers leaving the market said LA fees not covering costs was the decisive factor.
- Reduced demand for publicly funded places.
  - PSSRU Survey - 40% of providers leaving the market cited reduced demand for publicly funded places as decisive. The total number of places commissioned by the Council for older people in the independent sector has fallen by 10.9% in the last two years (from 2223 places in 99/00 to 1980 places in 01/02).
- The cost implications of implementing the National Minimum Standards by 2007.
- Increasing land and property values.
  - The average price of a house in the UK has risen by 75% in the past 10 years (16% in the past year).
- Difficulties in the recruitment and retention of staff.

- PSSRU Survey - 30% of residential and 30% of nursing providers identified staff recruitment as a factor contributing to their closure. The age profile of owner managers in East Sussex is also a factor, given the number having reached or exceeded retirement age.

The Council is a significant purchaser of nursing home beds within the economy of East Sussex, purchasing 1000 beds out of a current capacity of 2500. For the reasons just outlined, the market is reducing both nationally and locally, and the effect of this reduction has been particularly felt in areas such as Lewes, where there is competition for beds with other authorities, and also an upward pressure on fee rates from privately funded individuals. EMI placements are particularly problematic.

Fees paid by the Council have historically been lower than those paid by other authorities, who continue to place in East Sussex at higher rates, but at a lower cost than placing within their own boundaries. A recent comparison revealed that, amongst ten comparable authorities with similar fee structures, the average rate for nursing care is £400.00; £43.00 per week higher than the current East Sussex declared rate. It is however, increasingly difficult to make accurate comparisons, as many authorities purchase at 'spot' rates, rather than their declared rates.

### **Nursing Care**

Currently a mixture of block and spot contracts, new block contracts are being implemented for nursing care. These offer greater stability of supply and a means to manage future cost pressures within an agreed framework. To tackle the dramatic decline in the availability of nursing care services for older people with mental health needs we have introduced block contracts in each locality. Tendering procedures required under Standing Orders were waived by the Council's Cabinet in order to secure the market in a timely way but also to allow 'Structured Negotiation' with service providers to identify unique factors which would support the stability of the service and improved service quality. Steps are also being undertaken to develop strategies with the Primary Care Trusts which will not only improve the administrative arrangements for contracting and payments, but also identify joint commissioning priorities.

### **Residential Care**

Residential care is predominantly purchased through spot contracts, although services re-provisioned as part of the council's homes review process such as respite care, are achieved through block contractual arrangements in order to ensure service continuity. The Department is currently developing a dual structured approach to pricing care purchased from independent sector residential and nursing home providers. The first element is a baseline cost for the provision of residential care. The second is a "high dependency premium" which is added to the baseline cost to recognise the additional input required by some users with higher than average needs. This is to avoid unnecessary or premature admission to nursing care. The payment of the premium is triggered by the (joint) completion, by the assessor and care home, of a dependency assessment tool. Dependency assessment tools and ratings will, over time, be developed for other client categories (e.g. Mental Health, EMI, learning disability) and also be extended to include the nursing home sector.

Improved use of resources is being achieved through the appointment of a bed co-ordinator within the Contracts and Purchasing Unit to readily identify and manage market gaps and voids with various operational teams and to provide an immediate point of contact for service providers.

### **Home Care**

In recent years there have been significant developments in the purchase of home care, with a shift of some 35% being purchased from the independent sector instead being directly provided. A further move in this direction has been agreed for 2004/05. This change has improved cost-effectiveness, streamlined processes and also enabled the department to shift the emphasis of its own Directly Provided Service towards being much more oriented to shorter-term, rehabilitation-focussed interventions. DPS only now provides about 700 hours a week.

Until recently, Home Care was purchased using individual spot contracts for over 1500 service users. In April 2003, the Department, via a new Contracts and Purchasing Unit, re-contracted for the provision of home care services and established a lead locality provider for 13 localities across the county, which had been designed to complement revised Social Services and health structures. In particular, areas where supply had historically been problematic were identified and supported by improved fee rates based upon the provision of rural premiums. Areas are also supported by grouping (clustering) of service activity to improve the sustainability of services where staff resources may be in short supply. Arrangements have been developed through extensive consultation and comparative analysis. A fee rate increase worth some £500,000 was also reflected in the new contracts. The new contractual and purchasing arrangements will improve the interface between the Department and independent sector providers through closer working with the 13 lead providers (as opposed to the previous approved list of 40+ providers) ensuring better day to day representation. Home Care Services are now commissioned via a Purchasing Unit with lead officers supporting each locality.

### **Day Care**

The Department is reviewing the current balance of services from the historic position of day care being directly provided to exploring ways in which services can be re-provisioned within the independent sector. Underpinned by models of rehabilitation and social day care provision, this process is closely linked to the homes review process. At this stage, day care contracts with the independent sector are entered into on a spot contractual basis. A model for directly provided day care centres has been agreed, which emphasises rehabilitation and promotion of independence.

### Extra Care Housing

Extra Care Housing is being developed as an important alternative to residential care and as a means of further promoting independence. This year, 2 schemes have been established (The Marlborough and Gwent Court) and there are agreed proposals for a further 3 pilots. These are very much partnership initiatives. The schemes also offer opportunities to explore the benefits of new technologies through the use of assistive technologies.

## 6 Monitoring Arrangements

Monitoring and performance management occurs at a number of levels across the organisation, and can be summarised as follows:

- **Corporate Governance** occurs through a variety of means, including the Annual County Council Business Planning process, which is monitored and reported in a quarterly basis, Cabinet and Scrutiny processes and internal line management structures. The SSI, District Audit and the National Care Standards Commission provide an external audit.
- **Overall strategic governance** for the delivery older people’s services sits with the Older People’s Strategy Group, with its close links to the Health, Education and Social Care Executive.
- **User and Carer Involvement** is being further developed by a multi-agency group to ensure that services are informed by the experiences of users and carers.
- **Contracted Services** are monitored through several levels of process:
  - a. A recent countywide tender process for home care services which included criteria based on quality and capacity. Age Concern undertook a quality audit of short-listed providers and worked with the Department to weight evaluation criteria.
  - b. Inclusion of Quality Standards and contract documentation which includes service specifications and performance indicators which are monitored through contract reviews. Service specifications include requirements for user satisfaction surveys to be undertaken by service providers who need to evidence the steps taken in both service delivery and development as a result of feedback received.
  - c. Dedicated staff in the Contracts & Purchasing Unit ensure monitoring processes occur and undertake direct service monitoring activity which includes meetings with service users and their carers to obtain feedback on provider performance. Feedback is then given to providers during contract review activity with service commissioners.
- A **Performance Management Framework** for the department is in place and is being further enhanced with the recent creation of a dedicated Performance and Quality Unit. A key aspect of performance management are processes for monitoring and evaluation. A generic tool based on the “Logical Framework” approach has recently been developed for local use and is being used to ensure that the effectiveness of new initiatives can be measured. For example this approach has been used to monitor the effectiveness of the discharge facilitating teams, and is informing our developing strategies to address Reimbursement Charging issues.

## 7 Policy & Resources - Strategic Commissioning Aims

### 7.1 The 3 Year Financial Strategy 2002 - 2005

This strategy sets out the overall spend and financial strategy for Social Services across this period as follows:

Table 7.1 3 Year Financial Strategy - Older People’s Services

<b>3 Year Financial Appraisal</b>		
<i>(All figures are in £000s)</i>		
<b>Social Services - Older Peoples Spend</b>	<b>Budget</b>	<b>Budget Changes</b>
<b>Starting Budget 2002/03</b>	38,234	
Cash Increase	3,328	
Inflation		1,032
Service Pressures		4,028
Savings Made		(1,732)
<b>Final Budget 2002/03</b>	41,562	
<b>Starting Budget 2003/04</b>	41,562	
Base Changes (Free Nursing Care)	(973)	

Cash Increase	3,661	
Inflation		1,315
Service Pressures		3,680
Savings Required		(1,334)
<b>Final Budget 2003/04</b>	<b>44,250</b>	

<b>Starting Budget 2004/05</b>	<b>44,250</b>	
Base Change	542	
Cash Increase	3,100	
Inflation		1,141
Service Pressures		2,930
Savings Required		(971)
<b>Provisional Final Budget 2004/05</b>	<b>47,892</b>	

Table 7.2 Budget for Older People's Services 2004/05

<b>Budget for 2004/05 (as part of 3 Year Financial Strategy)</b>		<b>(All figures are in £000s)</b>			
Final budget from 2003/04					44,250
Base adjustment for residential care allowance					542
<b>Starting Budget (after base changes)</b>					<b>44,792</b>
<b>Areas of Proposed Spend</b>					
Inflation			1,141		
Service Pressures:					
Community Care Fee increases			1,000		
Increased Care at Home			1,000		
Previous Self-Funders			930		
<b>Total Gross Increase</b>					<b>4,071</b>
<b>Less Savings/Reinvested Resources:</b>					
Re-provision of home care to indpt sector			365		
Re-provision of Rye Day Care			10		
Maintaining inflation pressures			596		(971)
<b>Total Resources Invested</b>					<b>3,100</b>
<b>Final Budget</b>					<b>47,892</b>

## 7.2 Investment Linked to Performance

The Financial Strategy provides the financial parameters within which we will operate for the next 2 years. Within this framework we set our high-level commissioning intentions for services for Older People by planned shifts in expenditure from residential and nursing care to increased use of home care and other non-residential services.

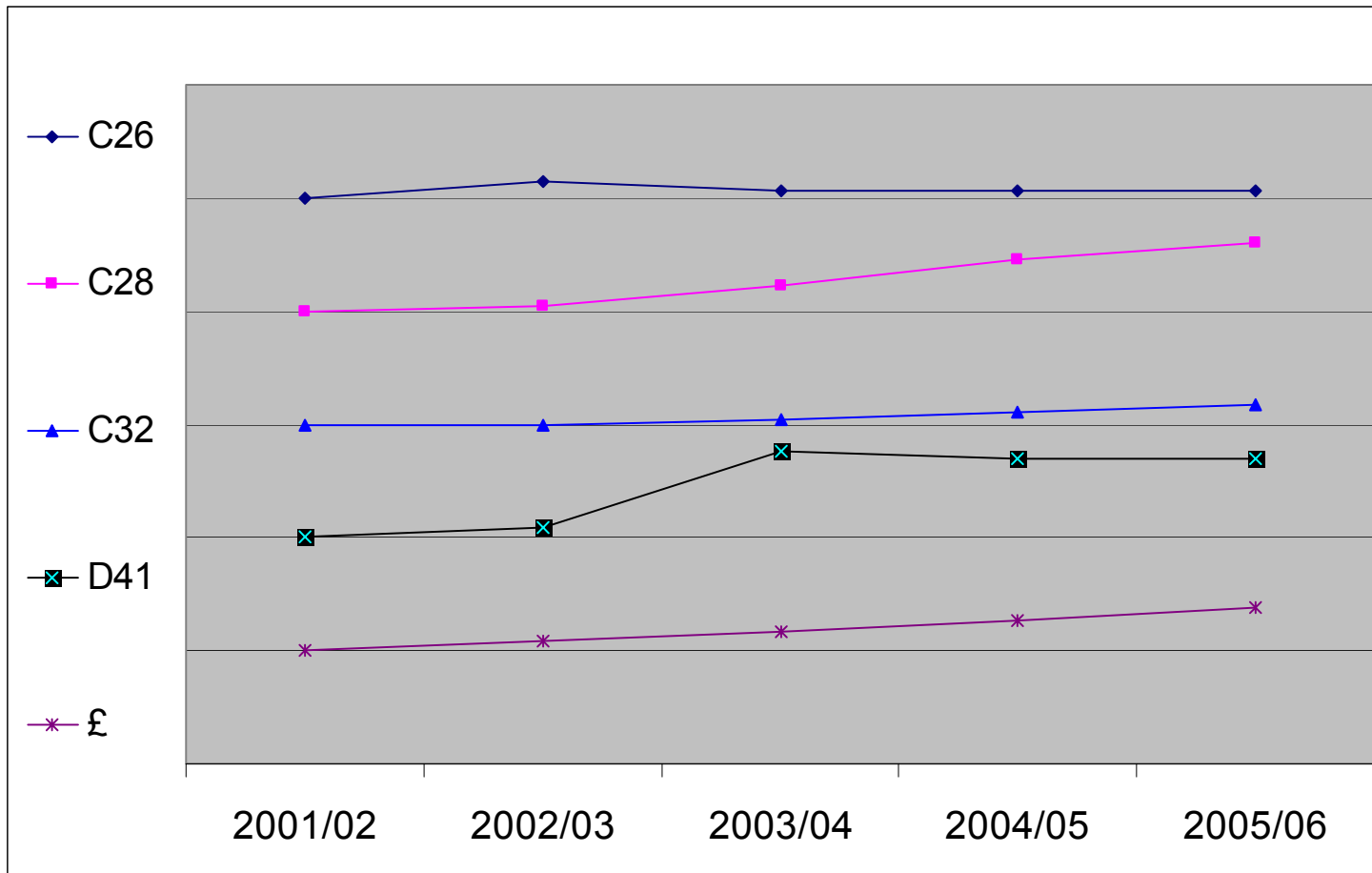
As the Strategy is implemented, the effects of the shift in practice and resources should be evidenced in resultant shifts in performance in key areas. The table below outlines our current and recent past performance on the key PAF Performance Indicators and also details our targets to the end of 05/06. Our annual overall spend on Older People's services is shown against these years.

**Table 7.3 Key PIs - Performance Over Time and Spend Over Time**

PAF Ref	Definition	2001/02 score + Blob Rating	2002/03 score + Blob Rating	TARGET 2003/04	TARGET 2004/05	TARGET 2005/06	Targeted 05/06 Improvement on 02/03 Performance
B11	Intensive Home Care as a percentage of intensive home and residential care - PSA	13.4 ●●	14.8 ●●	16.9	20	23.1 ●●●●	+ 2 Blobs
B13	Unit cost of residential and nursing care for older people	351.4 ●●●	382.1 ●●	340	n/a	n/a	
B17	Unit cost of home care for adults and older people	13.8 ●●	13.5 ●●●	14.00	n/a	n/a	
C26	Admissions of supported residents aged 65 or over to residential/nursing care	76.4 ●●●●●	87.9 ●●●●●	85	85	85 ●●●●●	Neutral
C28	Intensive home care (BVPI 53) - PSA	4.1 ●●	4.3 ●●	5.3	6.2	6.7 ●●	Neutral
C32	Older people helped to live at home (BVPI 54)	62.6 ●●	62.8 ●●	67.5	69	73.4 ●●	Neutral
D41	<i>Delayed transfers of care (interface)</i>	n/a	5.0 ●●	9.0	8.5	8.5 ●●	Neutral
E49	Assessment of older people	91.2 ●●●	91.4 ●●●●	94	114	116 ●●●●●	+ 1 Blob
C51	Direct payments	n/a	25.6 ●●	≥ 30 ●●●	≥ 30 ●●●	≥ 30 ●●●	+1 Blob
D39	% of people receiving a statement of their needs and how they will be met (BVPI58)	94 ●●	93 ●●●	97	97	97 ●●●●	+ 1 Blob
D40	Clients receiving a review (BVPI55)	45.2 ●●	32 ●●	50	55	60 ●●●●	+ 2 Blobs
D42	Carer assessments	4.9 ●●	5.0 ●●	15	17.5	20 ●●●	+ 2 Blob
D43	Waiting time for care packages	51.7 ●●	51.5 ●	40	30	30 ●●●	+ 2 Blobs
D52	Users who were very or extremely satisfied with social services (BVPI 182)	n/a	54.8 ●●	60	n/a	59.5 ●●●●	+2 Blobs
D53	Users that asked for changes to social services who were satisfied with those changes (BVPI 190)	n/a	57.7 ●	64	n/a	64 ●●●	+2 Blobs
E50	Assessments of adults and older people leading to provision of service	60.0 ●●●●●	54.9 ●●●●	65	70	70 ●●●●●	+ 1 Blob
<b>Overall Older People's Spend</b>		<b>£38.2 m</b>	<b>£41.6 m</b>	<b>£44.2 m</b>	<b>£47.9 m</b>	<b>£52.9 m</b>	<b>+ 17 %</b> (after adjusting for inflation)

### 7.3 Shifts in Commissioning Linked to Performance

Table 7.4 Key Performance Indicators and Older People's Spend



**Key to Table 7.4 - Performance Indicators:**  
**C26** - Admissions of supported residents aged 65 or over to residential/nursing care  
**C28** - Intensive home care (BVPI 53)  
**C32** - Older people helped to live at home (BVPI 54)  
**D41** - Delayed transfers of care (interface) - NB data was not collected in 01/02  
**£** - Overall annual spend on Older People's services

## 7.4 Key Commissioning Objectives 2004/05:

The following high level objectives were agreed for the Council Plan 03/04. Objectives for 04/05 are currently being finalised but are sufficiently similar to enable 2004/05 Commissioning Objectives to be set.

	Council Plan objectives for 03/04.	Commissioning Objectives for Services for Older People
1	Support more people in their own homes, while retaining the current low rate of admission to residential care and reducing delayed discharge from hospitals.	<p>1.1 Increase fee rates for Home Care (this occurred through the signing of new Locality Provider contracts in July 2003), Residential and Nursing care to a level comparable to neighbouring authorities by Summer 04.</p> <p>1.2 Building improved capacity within the market through the use of a Management Information framework as a key means of analysing need so that clear commissioning intentions can shape the market. Framework to be agreed by 06/04.</p> <p>1.3 Change Panel Process - increased spending controls for home care packages have been devolved to Locality Operations Managers to maximise the utilisation of these preventative interventions which both maximise the leverage and throughput of spend on Older People's services.</p> <p>1.4 Continue to negotiate new Residential Care contracts with menu pricing/Fair Price for Care across other service areas throughout 2004-05 with a view to increase use of block contracts to 20% by end 2005.</p> <p>1.5 Linked to the outcomes of the Mental Health Service Modernisation project, consider more specialised service provision for older people with mental health problems, including home care and day care and EMI respite nursing care provision. Issues considered by 12/04.</p> <p>1.6 Implement the Integrated Community Equipment Service with health partners by 10/04.</p> <p>1.7 Clear the OT Waiting List Backlog by using a mixed economy of in-house assessors and independent OTs to reduce the maximum waiting time by 75% by 12/04.</p> <p>1.8 Increase engagement and improve capacity of voluntary sector organisations in supporting service modernisation.</p> <p>1.9 Support carers through implementation of the Carers Joint Strategy 2002 -2004 and support ongoing developments agreed by the Carers Strategy Group.</p>
2	Expand intensive support at home, including the development of new services, where possible joint with Health and Housing, including intermediate care and extra care housing.	<p>2.1 Expand Intermediate Care services through:</p> <ol style="list-style-type: none"> <li>The appointment of 3 Locality Intermediate Care Co-ordinators (by 04/04).</li> <li>Increased integration at point of delivery in Firwood (04/04), Thornwood (04/04) and the Moreton Centre (Autumn 04).</li> <li>Countywide internal integration of OP Intermediate Care services, commencing with 2/3 pilots in 01/04.</li> </ol> <p>2.2 Support the implementation of the Extra Care Housing Strategy 2003 - 08, in the first instance through:</p> <ol style="list-style-type: none"> <li>Pursuing joint proposals for a 3 further bids, one of which is prioritised for older people with dementia, throughout 2004/05.</li> <li>Developing new schemes, dependant on success of multi-agency bids.</li> </ol> <p>2.3 Develop Supporting People 5 Year Strategy, based on Shadow Strategy 04/04.</p> <p>2.4 Strengthen engagement with the voluntary sector in supporting the development of new services.</p>
3	Continue the move towards being increasingly a commissioning, rather than	<p>3.1 Monitor the efficacy of new block contracts for Home Care using the newly agreed Monitoring and Review Toolkit for Lead and Back-up Locality Providers. First reviews to be completed by 05/04.</p> <p>3.2 Develop Service Level Agreements with Directly Provided Services which will include a countywide and locality</p>

	providing, organisation and develop more effective strategic commissioning jointly with Health.	<p>overarching SLA to be developed and in place by 04/04. Individual service areas SLAs to be developed by 12/04.</p> <p>3.3 Implement an agreed role for the directly provided services by 06/04.</p> <p>3.4 Undertake negotiation with independent sector to ensure the accommodation of transferred services by 04/04, as outlined in a Re-provisioning Implementation Plan.</p> <p>3.5 Develop a joint commissioning framework with health partners. Framework to be developed by 12/04.</p> <p>3.6. Develop stronger Locality commissioning functions through closer joint working with PCTs and District Councils, and more sensitive local needs analysis and commissioning (with linkages to county-level commissioning) through new Locality structures. Management Information and Joint Commissioning Frameworks to be place by 06/04 and 12/04 respectively.</p> <p>3.7 Link with the emerging Mental Health Commissioning Strategy in regards to services for older people with mental health problems (as per MH Commissioning Strategy development timetable).</p>
4	Continue to increase the proportion of the Social Services Department's budget spent on older people.	4.1 As per Financial Strategy above, increase the proportion of the Social Services budget spend on older people from 40% in 2002/03 to 41% for 03/04 and 42% for 04/05.
5	Increase further use of direct payments to achieve the efficient use of resources and encourage individual choice.	5.1 Expand the Direct Payments scheme as per PSA pump-priming through raising awareness of the scheme by holding sessions by 04/04, expanding the support service provided by East Sussex Disability Association and developing further capacity in supporting people to access direct payments.

## 7.5 Other Key Areas of Development which will support these objectives:

The following initiatives will also support our strategic commissioning intentions:

- Single Assessment Process implementation from 04/04 with key Strategic Health Authority area-wide IT developments being introduced from late 2004.
- Care Management & FACS implementation by 04/04.
- Improved joint planning and commissioning activity and structures developing in an ongoing way. In the first instance, with health partners this will principally occur through Integration workshops which will act as precursors to the development of a joint commissioning framework and the Locality-specific activity in relation to the new Locality structures and teams. In the first instance with Housing, this will principally occur through the Supporting People agenda and the Commissioning Body.
- Improved Performance Management processes, particularly the development of joint performance indicators with ESCH Trust and working with the independent sector to ensure that performance management information across sectors is collected and analysed.
- Training and Workforce Development - the Older People's Services Workforce Development group has recently had its Terms of Reference agreed by the Older People's Strategy Group, who will also sponsor its work. Key areas to be addressed include more generic worker roles in relation to the delivery of home care and intermediate care, consideration of Out of Hours delivery and opportunities for joint training between health and social care.

## 7.6 Future Key Change Themes - Intermediate Term

As the 03/04 programme of change progresses, the next tranche of key areas for change will be introduced. These will develop from the following high-level themes:

### 1. Directly Provided Services becoming more exclusively rehabilitation focussed

As 'straightforward' home care provision is increasingly purchased from the independent sector, our in-house Home Care service will increasingly be concentrating on those service users with rehabilitation potential. This shift will require ongoing training and development of Home Care staff, changes in commissioning practice of assessing staff and an overall monitoring of the service and the sector to ensure that an appropriate and cost-effective balance is maintained across the home care market.

### 2. Outcomes of Homes Reviews

The patterns to date across the 14 reviews has been to continue direct, joint provision with health of services to older people with mental health problems, to re-invest resources into intermediate care and to commission long stay and respite care from the independent sector when it has proven to be more cost-effective to so do. The final Homes Reviews have identified the need to explore accessing government PFI credits to replace Ridgewood Rise in Uckfield, redevelop Harvard Road in Ringmer and develop a new provision in rural Rother.

### 3. Integrated Management of Home Care and the Living At Home Programme

It is intended that the management of Home Care and the Living At Home Programme will be integrated with the objectives of:

- Further sharpening the focus on rehabilitation potential
- Improving the value of home care support across a wider range of settings through more generic working patterns facilitating more flexible care and provision out of normal hours
- Streamlining management arrangements
- Better integrating care pathways

## 7.7 Future Key Change Theme - Longer Term

### 1. Evaluate the effectiveness of Intermediate Care and respond appropriately

Over the course of the next few years of implementing this Strategy (and the more detailed ones which will follow), there should be an evident shift of resources and practice towards intermediate care services and other preventative services. Having made these shifts, it will be crucial to monitor and review their effectiveness and make any necessary adjustments to the models, balance of services, locality issues, etc.

## 8 The Way Forward

The next level of development of this strategy will involve the following:

- Joint work with health and housing in particular, to develop joint commissioning as far as is possible and appropriate. This will include development of how to respond to commissioning needs on both county wide and locality levels. This Strategy already reflects joint aspirations and agreed 2003/04 priorities with the health economies, but needs to be further developed through shared strategic planning and commissioning processes and costed plans. The completion of the Transformation Plan for the health economies should provide a foundation for future discussions. In Housing, the joint commissioning mechanisms are already in place through the Commissioning Body for Supporting People. This group will increasingly be involved in joint, strategic commissioning, particularly as the Supporting People programme identifies opportunities for re-commissioning or new investment.
- Engagement with further stakeholders to develop the detailed plans.
- Using this document as a base, consultation with users and carers and other stakeholders.