Market Position Statement

Older Adults



2014

WARRINGTON
Borough Council

Foreword

This is our first Market Position Statement (MPS) for Older Adults in Warrington and is intended for use by existing and prospective providers of care and support to individuals, families and communities. It is designed to describe the state of the care and support provision in the Borough and gives an indication of how that may be expected to change over time.

The MPS brings an intelligence led basis for the development of quality services that consider individual needs and can meet the financial and demographic challenges ahead and opportunities for the future. At the heart of this approach lies a mature dialogue with our partner organisations and builds on the strong relationships we already have in place.

We have consulted widely in producing this document and have gathered some useful feedback for its development and use going forward. We recognise it is still very much work in progress and will publish it online to allow us to regularly update and refine it – in close dialogue with service users and carers, and local providers in the private, independent and voluntary sector organisations.

We hope that you will find it useful and look forward to your continued feedback so that we can continue to improve it.

Councillor Pat Wright
Executive Member for Health and Wellbeing and Adult Services

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1. Introduction

We want this Market Position statement to be the start of an evolving, constructive and creative dialogue between the Council and its commissioning partner, Warrington NHS Clinical Commissioning Group and public, private and voluntary sector providers. The aim of the Market Position Statement is to convey clear messages for providers, whether operating in the Warrington area currently or interested in operating in the Warrington area in the future, about the following:

- the strategic vision and direction for older adults support services and future demand in respect of what the Joint Strategic Needs Assessment (JSNA) tells us about our local population
- describe how the market looks currently and what our JSNA tells us are going to be demands in the future, including identifying gaps in the market
- the funding implications for the future
- identify what good quality services look like based on national guidance and the best available evidence and how we will measure the quality of those services
- assist in identifying opportunities for service redesign and new developments that can shape the market
- how we can support providers in developing services that are fit for purpose and fit for the future
- we will share future commissioning intentions with our partners enabling them to build on their own knowledge of local needs and support the development of new and innovative activities and services.

Background and strategic context

The national picture is of increasing demand, due to an ageing population and greater numbers of individuals who will be either self funding or in receipt of a personal budget combined. Alongside restrictions in local government expenditure this means that there will need to be a significant change to the social care market in the coming years. Successive governments have identified that if social care is to be transformed then those eligible for social care provision should have greater choice and control over the services they may wish to use. However, it is also recognised that the achievement of greater choice requires the creation of a more diverse social care market. The Governments white paper 'Caring for Our Future: reforming care and support' (DOH 2012) has two core principles at its heart.

The first principle is that we should do everything we can, as individuals, as communities and as a Government, to prevent, postpone and minimise people's need for formal care and support. The system should be built around the simple notion of promoting people's independence and well being.

The second principle is that people should be in control of their own care and support. Things like personal budgets and direct payments, backed by clear, comparable information and advice, will empower individuals and their carers to make the choices that are right for them. This will encourage providers to up their game, to provide high-quality, integrated services built around the needs of individuals.

As previously mentioned, all public sector partners nationally are experiencing unprecedented change as a result of significant budget restrictions and major policy changes e.g. Health and Social Care Act 2012 and the Care Act which will impact on how services are commissioned and delivered. These issues also need to be considered in light of newly formed partnerships that will support the health and wellbeing of the population of Warrington such as the Warrington NHS Clinical Commissioning Group and the transfer of Public Health responsibilities from the previous Primary Care Trust to the Local Authourity. All of these major changes present challenges to the Council in terms of how we continue to support our local communities, however these changes can also be viewed as a catalyst and present opportunities to do things differently in order to achieve positive outcomes for the population of Warrington.

As commissioners, we would like to work even more closely with partners to find new, more innovative and efficient ways to meet the health and well being needs of the local population. Increasingly this means focusing on early intervention and prevention so that people are able to have a healthier life and stay independent in their own community for as long as possible.

'Putting People First', the national agenda to transform adult social care also seeks to extend choice and control for service users (personalisation/ person centred care) which further brings into question the sustainability of our current service models and lends weight to the need to review and overhaul our approach to improving and maintaining the health and well being of Older Adults ensuring services are fit for purpose and fit for the future.

2. Direction of travel for Warrington Borough Council and its partners

Within this section we aim to identify the models required going forward to support our older adult population in the future. Person centred approaches will be the core value that needs to underpin the transformation of services. Services need to develop that focus not only on those individuals within our community that have critical and substantial needs and are eligible under Warrington Borough Council's current Fair Access to Care (FACS) criteria, but also need to be designed to promote health and well being for the wider population, offering low level early intervention and prevention services. We want people to remain independent for longer by;

- continuing to develop person centred approaches that give service users greater choice and control
- working with partners to reshape the social care market to provide efficient services that promote positive risk and independence delaying the reliance on formal care

Warrington's Health and Wellbeing Strategy, 2012 to 2015 identifies the key strategic priorities for partners. The strategy is kept deliberately as a high level strategic document, which gives an overview of the identified priority areas for action in Warrington. The strategy provides an overarching framework and direction for local policy-making, without being too prescriptive as to how different partners and agencies should address the various issues. The strategy sets the direction of travel at a local level. There is a significant financial imperative across the health and social care economy to target resources at those with highest needs, however resources into preventing the root causes of problems and addressing the wider determinants of wellbeing are needed if the system is to be sustainable in the future.

More recently new governance structures have been put in place to support making the shift towards prevention and improving health and wellbeing in Warrington that are based on an integrated approach. Warrington's Health and Well Being Board and Warrington's Integrated Commissioning Governance Board aim to deliver improved outcomes for the population through the strategic commissioning of services.

The Health and Social care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. They aim to achieve this by:

- having strategic influence over commissioning decisions across health, public health and social care.
- strengthening democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards will also provide a forum for challenge, discussion, and the involvement of local people.
- bringing together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.
- Through undertaking the JSNA, the board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

Promoting independence

Our future model will be based upon prevention and early intervention to support healthy ageing and targeting specialist services at those individuals that have the most complex health and social care needs.

Prevention and early intervention models are recognised as supporting people to stay well, live independently and remain healthy for longer. Warrington's Healthy Ageing Strategy defines the key supports/interventions that will support the early intervention and prevention model. In order to support the transition to prevention and early intervention it is important to ensure that a wide range of preventative services are available to support people across the spectrum of need, including those who do not approach us for support or meet our eligibility criteria. Our future commissioning intentions will support the need to grow capacity across partners within the early intervention and prevention model in order to meet population needs.

This will ensure that people do not go without the support, which could prevent critical needs developing in the future.

Public Health's Making Every Contact Count training initiative will underpin the prevention and early intervention model and will be part of our offer to all providers to support service transformation and the achievement of positive outcomes for individuals.

Integrated approaches

> *People with long term conditions make up around 80% of GP consultations nationally and take up the majority of hospital beds, as well as creating large demand on social care services.*

For those individuals living with ill health and long term conditions specialist support will be required to enable them to self care and manage their condition and service redesign framed within an integrated model across health and social care will support this.

In Warrington we know that older people who go to A&E are more likely to be admitted to hospital than younger people. Admissions are significantly higher than the England average for injuries and poisonings, circulatory and respiratory conditions in people aged 65 and over.

> *Older people are more at risk of serious injury from trips and falls.*

We also know that, although life expectancy is increasing in Warrington, the number of years that a person over the age of 65 years can expect to live without some sort of disability (disability free life expectancy) is lower here than the England average. This not only highlights the need for effective services now, but also the need over the longer term to focus on promotion of health and well being amongst younger people in order to increase their chances of remaining healthy and disability free as they grow older. In addition, the challenges of providing high quality and choice in end of life care are particularly relevant to older people and their families.

We know that old age is a risk factor for most diseases and that the very old are less equipped to fight illness due to having less effective immune systems.

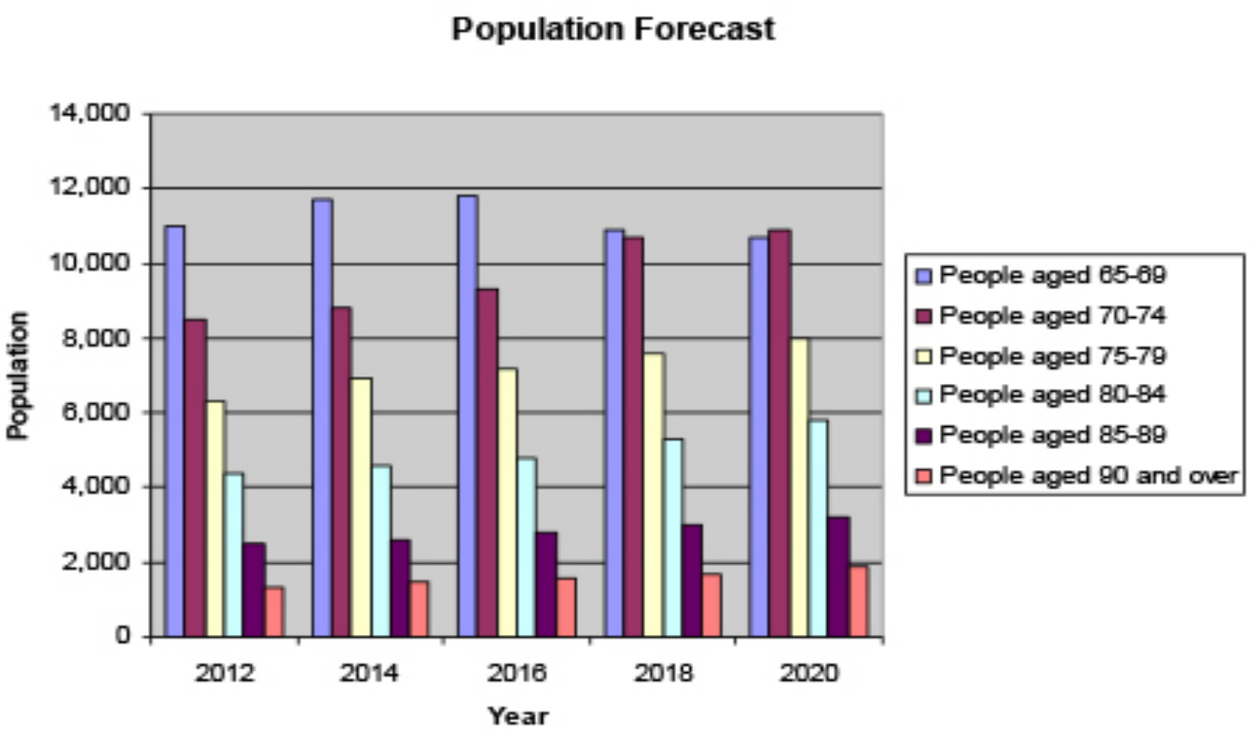
3. Prediction of future demand and key pressure points- Older People

This section will highlight the major demographic pressures facing Warrington in terms of an ageing population and also the key aspects of health and well being which we will need collectively to focus on.

By 2030 it is predicted that the population aged 65+ in Warrington will have increased by nearly 60% from 2010 levels. Over the same period the population aged 16-64 is projected to rise by only 0.3%. Warrington will have higher than the national average in relation to the 65+ age group and this is the group we would target early intervention and prevention initiatives towards.

Utilising data based on current usage of health and social care services and mapping this against age profiles demonstrates that it is anticipated that older people will access health and social care services at a much later age of 75 years plus.

Chart 1. Projected population by age



This startling change in local demography clearly highlights the need to ensure service providers and communities are prepared for a much older population, which will have very different needs and aspirations to the current one.

Population by Ward

The 65+ population is not evenly spread across Warrington; it ranges from 8% (Whittle Hall) to 26% (Penketh and Cuerdley),

Chart 2. Population by ward

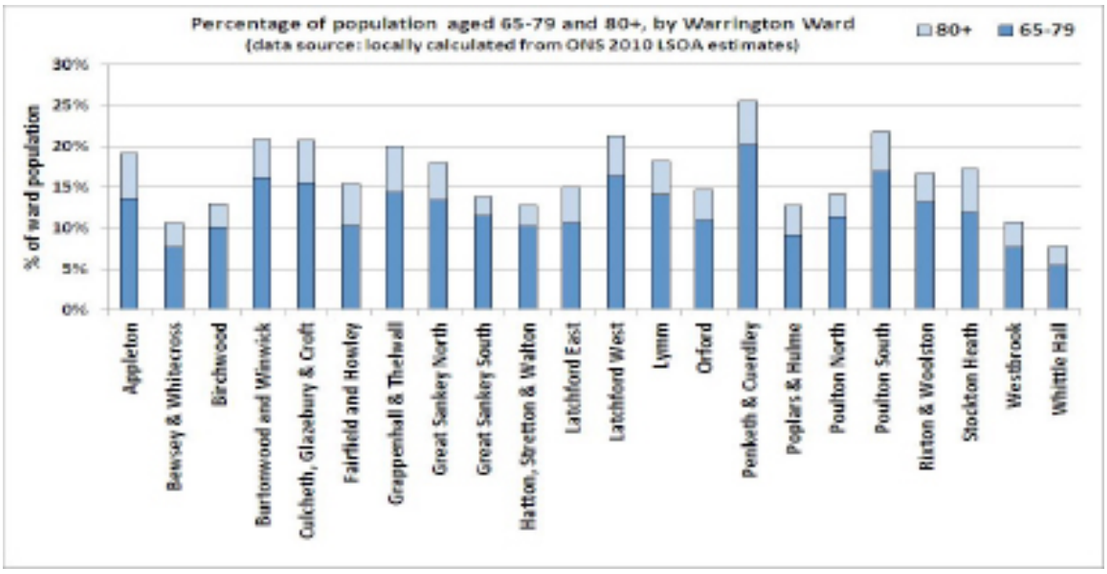
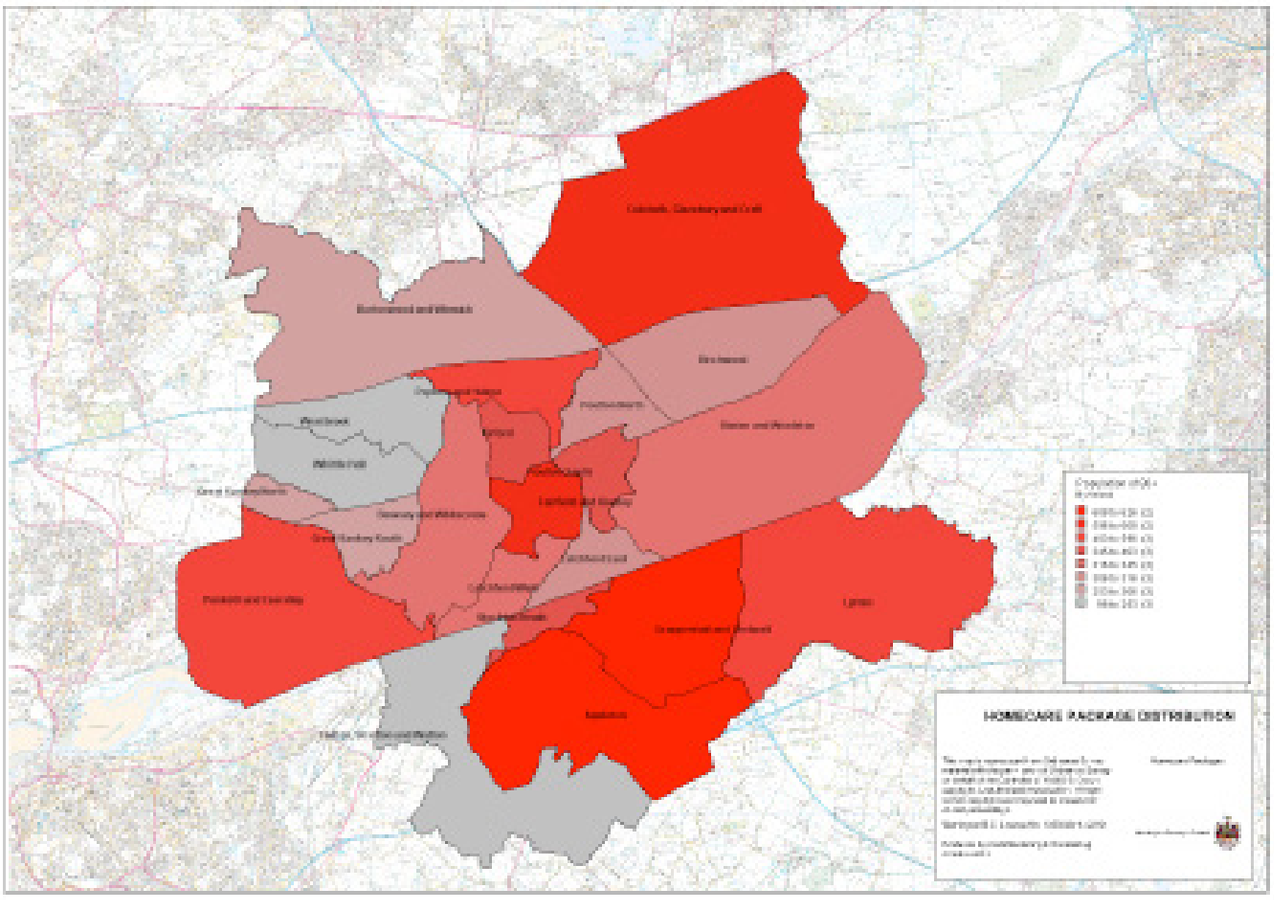


Chart 3. Distribution of People aged 80 plus



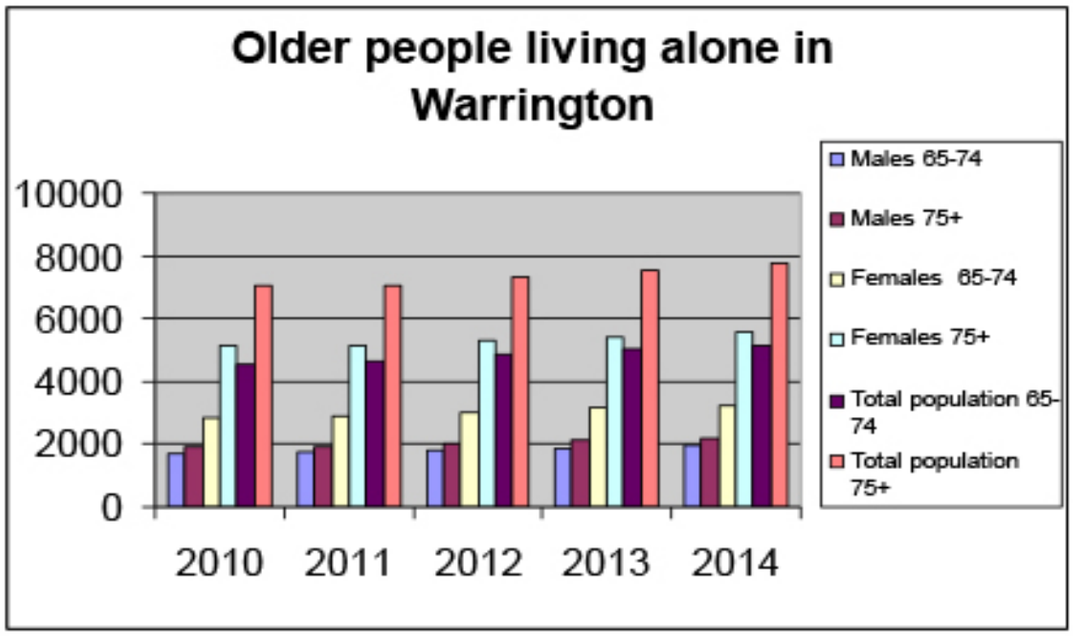
Population by ward data will assist both commissioners and providers in identifying those areas in Warrington where resources might best be targeted around local communities and needs.

Social Isolation

Approximately 1 in 10 older people report loneliness, although levels are much worse in communities with high multiple deprivation. Living alone may exacerbate the likelihood of social isolation.

We know that the social and environmental factors that influence mental health and wellbeing can impact heavily on older people as they potentially become less active and less mobile and potentially have less disposable income due to welfare reforms, reduced pensions, increased living costs etc. Social isolation, access to services, staying active, eating well, fuel poverty and fear of crime are all identified as important issues for older people. These wider determinants of wellbeing are all particularly important because levels of mental health and wellbeing affect physical health and the ability to remain independent. Chart 3 demonstrates the predictive number of older adults that are anticipated to be living alone and at most risk of social isolation.

Chart 4. Living Alone – People aged 65 and over living alone in Warrington by age and gender, projected to 2014



Domestic Tasks

This area is defined by the Living in Britain Survey 2001 as 'People aged 65 and over unable to manage at least one domestic task on their own, by age and gender, projected to 2030. Tasks include: household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities' (Office of National Statistics, 2002).

In Warrington in 2011 there were estimated to be 12,922 older people who are currently unable to manage at least one domestic task on their own (POPPI2). This will not necessarily indicate the need for formal care but support from family, friends and volunteers could be envisaged in supporting this type of low level need in order to support independence and individuals may wish to self fund a range of low level daily living tasks that will enable them to remain independent which service providers may want to be in a position to provide.

Table 1: Rates for Men and Women Unable to manage at least one Domestic Task on their Own

Age Range	% Males	% Females
65-69	16	28
70-74	21	40
75-79	36	52
80-84	41	67
85+	68	82

(Source: ONS Table PEEGC163, Ethnic group of adults by custom age bandings, mid-2007)

Self-Care

Table 2: Rates for men and women unable to manage on their own at least one self care activity

Age Range	% Males	% Females
65-69	18	21
70-74	19	30
75-79	29	39
80-84	33	53
85+	51	74

(Source: Living in Britain Survey 2001 (ONS, 2002))

Dementia

Prevalence models suggest there may be current widespread under-reporting of dementia. At the moment around 1,000 people are reported as living with dementia in the Warrington population but modelling techniques suggest that the actual figure may be more like 2,100. The projected number of older people in Warrington with dementia is expected to increase from 2,100 to 4,100 in 20 years, which is almost a 100% increase. In the next 5 years alone, the number of older people with dementia is expected to increase by 300 (14%). This will have a significant impact on the number of carers who will require support and also significant impact upon services in relation to capacity, service redesign and workforce development

Table 3. Older People Predicted to have Dementia

Age	2010	2015	2020	2025	2030
65-69	120	145	133	148	175
70-74	224	245	295	274	302
75-79	346	417	465	562	521
80-84	519	550	694	791	979
85-89	528	567	639	878	1,017
90 and over	360	477	594	770	1,066
Total aged 65 and over predicted to have dementia	2,097	2,401	2,820	3,423	4,060

(Source: POPPI[1])

Caring responsibilities and provision of unpaid care

The 2011 census determined that there are 21,843 carers in Warrington, 5,144 care for over 50 hours per week. There are a significant number of older people providing unpaid care either to a partner, family member or another person. The population aged over 65 in Warrington is set to increase by 60% by 2030 - including a 110% rise in the population aged over 80 (Warrington Wellbeing Strategy). As the older population increases, and people live longer, this may lead to an increase in the number of informal carers and a rise in the number of carers who require support in their role. In July 2013 there were 3179 carers recorded on Warrington Borough Council database. In 2012-13, 2,215 carers received an assessment. 16 carers declined an assessment, compared to 96 carers declining an assessment in 2011/12. Warrington Borough Council provided 31,410 days of day care to 418 service users and 9,227 nights of respite care was provided to 347 service users where they had a carer.

Wired Adult and Young Carers Services (wired.me.uk, 86 Sankey Street, Warrington) provides services such as advocacy, GP liason/hospital discharge service, signposting, drop in sessions within local communities, counselling, amongst other services. As of August 2013 Wired had 1278 Adult Carers and 142 young carers registered with their service.

Table 4: People aged 65 and over providing unpaid care to a partner, family member or other person, by age, projected to 2030

Age of Carer	2010	2015	2020	2025	2030
65-74	2,688	3,077	3,211	3,241	3,749
75-84	994	1,163	1,372	1,620	1,710
85 and over	130	150	181	239	294
Total population aged 65 and over providing unpaid care to a partner, family member or other person	3,812	4,390	4,764	5,100	5,752

Figures may not sum due to rounding (Source: Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S025 Sex and age by general health and provision of unpaid care. Crown copyright 2010)

4. Current Supply

This section will outline the key resources currently developed that support older adults in Warrington.

Table 5. Numbers of residential/ nursing beds Older Adults

	Residential	Residential Elderly mentally ill (EMI)	Nursing	Nursing EMI	Total
Number of beds currently purchased by Warrington Borough Council	245	190	267	139	841
Predicted required number of beds required by 2015	282	219	307	160	968
Predicted required number of beds required by 2020	306	237	333	173	1051
Predicted required number of beds required by 2025	327	254	357	185	1125

(The table above assumes that WBC will continue to support the same percentage of older people. The above table does not account for changes to the WBC eligibility criteria or changes to the wider policy frameworks, such as the drive to help more people to live at home for longer. Such policy changes may have the effect of offsetting the increase in the demographic profile of over 65's and would result in people being admitted later to residential care. This may reduce the length of stay and increase the turnover of beds).

The total Warrington Borough Council spend on residential / nursing placements for the year 2013/14 was £12,754,000. The current supply of residential and day care services is not sustainable to meet the longer term changing demand in Warrington. Current costs of services will reduce in response to the diminution in Government spending. However there may be a requirement for additional EMI nursing and specialist dementia care and support models that are able to support the individual from early diagnosis through to complex care offering continuity in support and environment. Residential and nursing homes could also support the re ablement agenda by offering a range of services including short term placements aimed at supporting the individual to increase confidence and independence to enable them to return home where appropriate.

Domiciliary Care

Chart 5. Distribution of domiciliary care hours by ward 2012/13

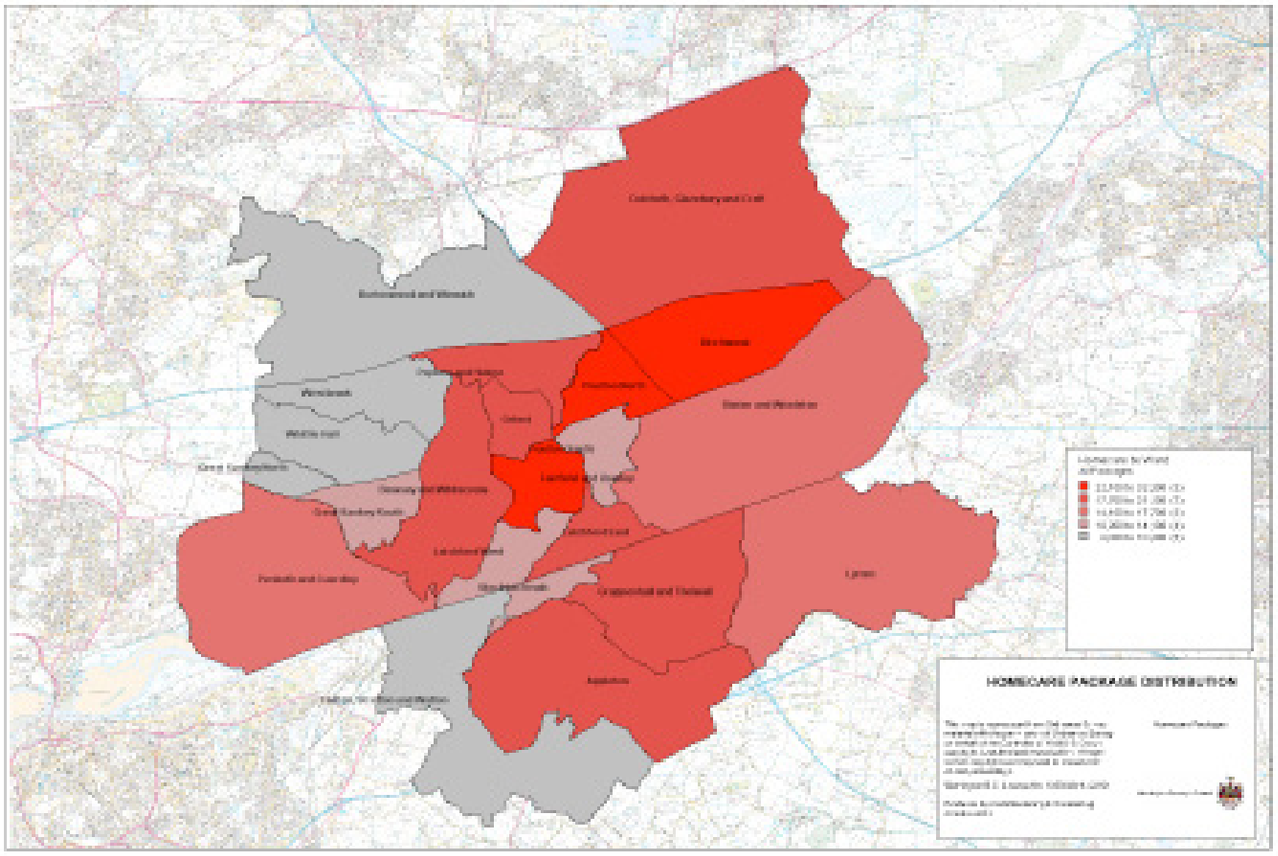
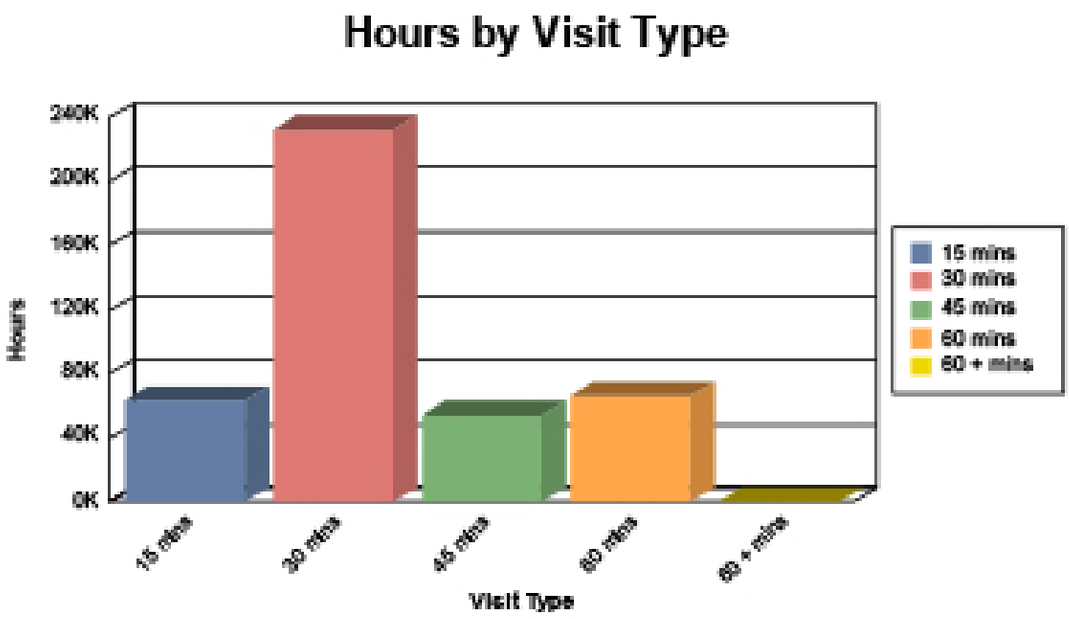


Chart 6. Domiciliary Care hours by visit type 2012/13



Domiciliary based services over 65 +

Number of Older People receiving a service	3,044
Number of Older People receiving a Community based service	2,075
Number of Older People Home Care	1,527
Number of Older People Day Care	570
Number of Meals (in day care)	97
Number of direct payments	100
Amount of equipment loaned	1,068
Number of Older People Professional Support	30
Number of Other Services	375
Number of Domiciliary care hours	10,959
No of people in receipt of Assistive Technology (Carecare, Telecare & Sensory Loss Equipment)	2,853
Number of people in receipt of Continuing Health Care funding in 2012/13	455
Number of people in receipt of Intermediate Care services (bed based) in year	391
Number of people in receipt of Intermediate Care services (home based) in year	544
Average length of stay in intermediate care service (bed based)	27 days
Number of people in receipt of re ablement services	84
Number of re ablement hours accessed (per week)	685

5. Measuring quality

We have entered into partnership arrangements with the Warrington Clinical Commissioning Group whereby resources can be pooled through Section 75 Health Act Flexibilities and will continue to develop further opportunities for pooling budgets to ensure resources are used effectively and efficiently when commissioning support services. To support the pooling of funds an Integrated Commissioning structure has also been established with the intention that services will be commissioned jointly based on Warrington's Joint Strategic Needs Assessment.

In the future it is our intention that contracts will contain joint health and well being indicators of quality and performance. This is a major step towards ensuring that services are not duplicated across health and social care ensuring the rights skills, at the right time, in the right place and that resources are effectively and efficiently commissioned and that those services understand and support the Health and Well Being priorities locally.

Appendix A shows the national requirements in respect of outcomes that health and social care are required to address. These indicators will start to be reflected in local contracts from April 2013 and commissioned services will be asked to report on them regularly to demonstrate how their services are having a positive impact on individual's health and wellbeing.

6. Finance and funding

This section is concerned with identifying key areas of spend in relation to older adults based on Warrington Borough Council spend currently.

Table 6. WBC Community Care Budget Net Expenditure 2013/2014 - Older People

Financial Year	2013/14 £000
Assessment & Care Management	4,820
Older People Dom/ day care/ intermediate care	3,573
Older People Res	5,587
Older People Nursing	7,167
Older People Supported Accommodation (Shared Lives , Extra Care etc)	1,523
Older People Direct payments	385
Meals	24
Equipment & adaptations	3
Other services (transport , miscellaneous)	808
Total Older People	**23,893**

7. Developing services based on best evidence

This section identifies the key interventions based on best evidence that will support the development of prevention and early intervention services.

Assistive Technology/ Telecare

Assistive Technology (AT) is any product or service designed to enable independence for disabled and older people. There is mounting evidence to suggest that assistive technology/ telecare can make a difference to individuals and their carers, and to the health and social care system as a whole. It can help to improve people's independence, relieve stress on informal carers and improve clinical and care outcomes. (Care Services Improvement Partnership, 2006).

The Whole System Demonstrator (WSD) programme was launched in 2008 by the Department of Health (DoH) to show what Telecare and Telehealth are capable of. In December 2011 the findings were published in Whole System Demonstrator Programme: Headline findings (DoH, 2011b). The programme was the largest randomised control trial of telecare and telehealth in the world, and involved over 6,000 patients and more than 200 GP practices. Early indications show that, if used correctly, telehealth can deliver a 15% reduction in Accident & Emergency (A&E) visits, a 20% reduction in emergency admissions, a 14% reduction in elective admissions, a 14% reduction in bed days, and an 8% reduction in tariff costs. More strikingly, they also demonstrate a 45% reduction in mortality rates.

Re ablement

Re ablement services support individuals who have or are recovering from poor physical or mental health and enables them to accommodate their illness by learning or re-learning the skills necessary for daily living. Re ablement improves outcomes, particularly in terms of restoring people's ability to perform usual activities and improving their perceived quality of life. From a social care perspective, there is a high probability that re ablement is cost effective (Francis et al., 2011). Research evidence demonstrates that re ablement improves independence, prolongs people's ability to live at home, and removes or reduces the need for commissioned care hours (in comparison with standard home care). The best results (McLeod et al., 2009) show that up to 62% of re ablement users no longer need a service after 6/12 weeks (compared with 5% of the control group), and that 26% had a reduced requirement for home care hours (compared with 13% of the control group).

Intermediate Care

Intermediate care is defined as a range of integrated services designed to promote faster recovery from illness, prevent unnecessary admissions to hospital and long term care, support timely discharge and maximise independent living. It is a vital component of the programme to improve the health and well–being of older people. Intermediate care services can be based within a community based specialist building or delivered in an individual's own home and has the following aims:

- are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care;
- are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- have a planned outcome of maximising independence and typically enabling patient/users to resume living at home;
- are time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less; and
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Housing and support

Good housing conditions impact positively on health and well being. Poor housing exacerbates the burden of ill-health and disability:

- Older people spend between 70-90% of their time in their homes, much more than any other age group.
- Older people have been indentified by Government research as the main group needing adaptations to their homes in order to live independently.
- Mainstream housing often presents a challenging environment in which to age, exacerbating otherwise manageable illnesses and disability. For example, older people may be at increased risk of home accidents where homes have poor lighting.
- Unsuitable housing has direct and proven linkages with ill health, including pneumonia, asthma, mental health, and falls and hip fractures.

For example, there is good evidence that cost-effective housing-based interventions can reduce accidents, falls, hospital admissions and promote independence.

> *Falls amongst older people have been estimated to cost the state well in excess of £1 billion per year. Some 1 in 4 falls are from stairs and the majority take place in the home.*

Extra care housing is a form of housing, care and support which can successfully promote independence, and tackle social isolation, in ways which reflect local circumstances and the needs and expectations of local populations. It is also capable of contributing to savings across health and social care, as well as providing wider benefits to the local housing market. The articulation and promotion of a vision of what is to be provided, and what it will achieve, whether by the commissioner or provider, will significantly improve the chances of delivering the outcomes successfully.

“When matched with a group of equivalent people moving into residential care, costs were the same or lower in extra care housing. Better outcomes and similar or lower costs indicate that extra care housing appears to be a cost-effective alternative for people with the same characteristics who currently move into residential care” Personal Social Services Research Unit (July 2011). Improving Housing with Care Choices for Older People: An Evaluation of Extra Care Housing.

When developing future housing for older adults providers should consider best practice as described in Dementia: Finding solutions- National Housing Federation (2013) which looks to integrate housing, care and support.

Home safety programmes

This can include medicines reviews and environmental risk assessments to minimise the risks of falling, the provision of small aids and adaptations and ensuring good lighting and that the home is warm. Warrington in partnership with the voluntary sector are currently delivering a small pilot joining local community pharmacist’s review of medicines alongside a home safety screening checklist for frail elderly housebound delivered by the voluntary sector. It is anticipated the screening checklist will be expanded to incorporate other early intervention and prevention actions that can support older adults to age healthily.

Dementia Services

Evidence shows that early diagnosis and intervention in dementia is cost-effective (Philip, 2007), yet there is a significant diagnosis gap and only a third to a half of people with dementia ever receive a formal diagnosis.

Memory services are recommended by the National Institute for Health and Clinical Excellence (NICE) and Social Care Institute for Excellence (SCIE) guidelines as the single point of referral for all cases of suspected dementia. Memory services can provide a cost-effective way of significantly increasing the number of people seen for early diagnosis and intervention and breaking down the stigma associated with dementia by avoiding labels, such as “mental health” or “old age psychiatry” (Banerjee et al., 2006).

Diagnosing more people and doing so earlier may be cost-effective as more can be done to delay progression of the disease. Having a clear diagnosis could also reduce the number and length of acute hospital episodes and delay the need for more expensive long-term care. In addition, using therapies that reduce behavioural problems is known to reduce carer stress, which is often the trigger for unplanned entry into care homes.

The Dementia strategy (DOH, 2009) identifies the following additional objectives for enabling people to live well with dementia:

- Improving public and professional awareness and understanding of dementia
- Good quality information for those diagnosed with dementia and their carers on their illness and services available
- Easy access to care, support and advice following diagnosis
- Development of structured peer support and learning networks
- Improved community personal support services that are flexible and reliable ranging from early intervention to specialist care homes

Carers Services

Warrington has a carers strategy which identifies four priority areas that agencies need to work on together to continue to improve outcomes for carers. These are:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
- Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Personalised support both for carers and those they support, enabling them to have a family and community life.
- Supporting carers to remain mentally and physically well.

Home respite care takes the form of sitters and other types of home care relief services, which provide alternative care for the older person at home and enable the carer to take a break. One reason for their popularity is that they are often more acceptable to the older person than day care outside the home. Respite provided in this way offers, potentially, the least disruptive form of service. This is true, both for the dependent person who is not required to go into a strange environment, and for the carer who is not required to organise and get their dependent out of the house.

Buildings based respite care is used by carers of older people, particularly those with dementia, to give them an overnight break from caring. Evidence collected since the community care reforms were introduced suggests that, with regard to caregiver burden, respite care has substantial effects for caregivers in some circumstances. Davies and Fernandez (2000) found that respite care, which was defined as overnight care in institutions, was found to have the largest marginal productivities (involving reductions in levels of carer stress associated with increases in use of respite care) where the care manager perceived the user to have cognitive impairment.

There is a need to improve the offer to carers in respect of what support they require in order for them to continue in their caring role, whilst providing them with opportunities to have their own needs met whether that be by respite or through supporting carers in accessing culture, leisure and work opportunities.

8. Opportunities for business change

Prevention and early intervention

To address the changing demands placed upon Adult Social Care, the methods by which services are provided must evolve. Formerly care service delivery centred on the provision of continued care following a period of deteriorating health. However, the emphasis is now on the prevention agenda with earlier and more intensive short-term interventions, which increase the long-term independence of service users and reduce the need for dependence on long-term care. We are currently undertaking service developments in partnership involving the voluntary sector, neighbourhood teams and adult social care teams via the 'Integrated Care Communities' project focused initially on the Bewsey & Dallam areas that will support new integrated person centred approaches across agencies and pathways that aims to provide seamless care to the individual. The project will be achieved by developing facilitated networks across partners which is an approach we hope to utilise on a wider scale around all service delivery.

We wish to encourage providers that can demonstrate that their services are able to diversify into areas of provision to maintain people at home living healthy lives for longer. This will be the core customer base in the future and the area that represents the most opportunities for success and continued business. Additional capacity may be required to meet the expected rise in demand for care and support services. We do not wish to see an increase in traditional models of care such as residential or nursing home care over and above that which is predicted demand based on demographic changes. However there may be a requirement for additional EMI nursing and specialist dementia care and support models that are able to support the individual from early diagnosis through to complex care offering continuity in support and environment. Residential and nursing homes could also support the re ablement agenda by offering a range of services including short term placements aimed at supporting the individual to increase confidence and independence to enable them to return home where appropriate.

Our view is that investment and growth in prevention, early intervention and social capital is vital. This means delivering a range of preventative services from lower level community planning and involvement to higher level housing related support needs such as telecare, falls prevention and working with carers. We want to encourage alternative models of housing that offer integrated care and support services into the marketplace that promote independence and wellbeing for people with housing and support needs. The extent of such development will depend on available land and investment and continued stimulus of the independent sector. This may require us to review the distinction between sheltered housing and extra care housing. In respect of residential and nursing homes focus will need to shift from permanent placements into shorter-term placements providing rehabilitation and a return home with appropriate levels of support. Permanent placements will be appropriate for those with the highest and most complex needs where it is acceptable to the individual and represents a cost effective way of meeting their needs.

A wider range of home-based volunteer services will be needed to maintain people staying healthy and with a sense of wellbeing at home for longer such as sitting services, befriending services, time banking, good neighbour schemes etc. Supporting older adults to engage with their local community, helping them to maintain and develop social networks and access social activities will help to reduce their sense of social isolation.

We would wish to see increased and improved access to information, advice, advocacy and brokerage services that are able to demonstrate confidence to customers. The Health and Wellbeing Board will be responsible for ensuring there is sufficient provision of this type of service borough wide and in ways that are easily accessible to the community.

There is a need to further develop the use of Assistive Technology and Telehealth care to support independence and positively manage risks.

Re ablement and floating support models will need to be designed to respond to need as opposed to providing a fixed number of visits/hours per week. We want to work with providers that can provide flexible support arrangements and evidence that they are helping people to achieve independence.

Dementia

As partners we need to ensure that people suffering from dementia are diagnosed early and receive appropriate services. This will require all partners to:

- Improve public and professional awareness and understanding of dementia
- Improve the range and offer of personal support services to individuals with dementia and their carers
- An informed and effective workforce for people with dementia

Specialist providers will need to demonstrate:

- Enable easy access to care, support and advice following diagnosis
- Develop good quality early diagnosis and intervention
- Develop good quality information for those with diagnosed dementia and their carers
- Develop services that are able to support the individual and their carers through the continuum of needs they may experience

Promoting lifestyle changes

In order to realise our Healthy Ageing Strategy we need to fully develop and enhance the whole of the health and social care workforce across all partners and we will do this by rolling out the "Making Every Contact Count (MECC), Prevention and Lifestyles Behaviour Change Competence Framework "currently being developed through Public Health. Over the next three years the MECC training will be offered to all commissioned services in order to develop wider workforce competencies. We would anticipate that 80% of the wider workforce will have accessed MECC training over the next three years and that we are able to evidence how that training has been utilised to make a positive difference to individual's in that they support lifestyle change.

Self funders

People who do not require the local authority to fund their care, should still benefit greatly from improved health and social care information and expertise e.g. the alternatives to care homes, maximising independence, managing risks and supporting carers. More people will want to choose these types of services from a provider that they trust and that has a good reputation. Systems need to be accessible and in place where by individuals and their families are able to access information about individual providers to help them make informed decisions about which provider they choose based on quality and trustworthiness. Support planning and brokerage will take a new shape with the aim to broker short-term packages of care and support with the focus on re ablement rather than setting up longer term packages of care. This may involve the model of floating support and mobile nights, particularly in the private housing market and offering a wider choice of supportive activities that relate to maintaining a good quality of life in one's own home.

As a provider you may want to think about how your services / staff are able to connect the individuals they are supporting into their own local community to reduce social isolation. Involvement in networks via the culture and leisure opportunities that the council and its partners develop (see Active Warrington Strategy and the six area plans developed by the Neighbourhood Area Board's available). This will create and help to grow the social infrastructure that supports and sustains healthy communities and will demonstrate that provider organisations understand and are supporting the development of the local community infrastructure.

In our commissioning approach we are moving towards a model of integrated health and social care outcome based commissioning and performance management that aims to deliver greater flexibility and improved outcomes rather than the former block contracting of services. This process will commence in 2014. We also want to do business with providers that can demonstrate a more person centred and integrated approach to social care and housing delivery, recognising that a one-size approach is no longer suitable.

We seek to do business with providers who can demonstrate their ability to offer high quality care and support, underpinned by person-centred values and approaches whilst offering value for money. A repeated message from the national voices coalition is that what matters most is the quality of the individual providing the care and support and their punctuality and flexibility to go the extra mile.

We want to work collaboratively and in partnership with providers to diversify the level of competency and range of duties that care/support workers can provide to meet the rising demand for home based and re ablement services. This includes skills development in areas such as falls risk assessment, early intervention and prevention and supporting individuals to manage long-term conditions.

9. Supporting businesses to develop

New methods of developing and facilitating the social care market are required which can build on the Council and NHS Warrington Clinical Commissioning Group's unique position of co terminosity. Via the Joint Strategic Needs Assessment and the Health and Well Being Board we can bring information we know about the local population and demand of our customers and carers into a dialogue with providers about investment and risk. We aim to encourage and support providers to shape their services towards prevention, re ablement and personalisation, demonstrating good outcomes and improved models of practice, and to explore further ways in which providers can complement these approaches and be acknowledged and rewarded for doing so.

We recognise that to deliver change, providers will need to invest. This might include providing new types of services, redesigning services, training staff to improve the quality of care and support or spending time engaging with and listening to customers in order to plan and tailor services both at an individual level or strategic level.

If we wish to see small and medium-size providers in the market we must consider their capacity to invest money and take risks and support them. Larger providers should not be overlooked either, but they generally have more capacity to take risks and to allow demand for services to build up over time and increase plurality of the models of care and support available.

There is an existing third sector policy group that operates in Warrington and commissioning intentions are to further develop and enhance the voluntary sector locally, recognising the importance of the sector in regard to their local knowledge and significant contribution to our communities. The development of the Voluntary sector, including new models such as Community Interest Trading Companies and Social Enterprises will help to develop the local community infrastructure and increase social capital that will play a significant role in the prevention agenda. We can provide support in accessing alternative available funding specifically aimed at developing innovative services.

We recognise the need to foster a supportive environment of shared positive risk taking across the board from assessment and support planning, through to brokering services, frontline service delivery and reviews. Shared positive risk taking in terms of the packages of support that people are given will promote independence and reduce dependency. We want to work with service providers that can provide effective short-term interventions and collaborate with us during the review process in order to reduce support to reduce costs, which can then be reinvested into other service developments.

We aim to continue to encourage local people to help influence local commissioning decisions and will always consult with residents to shape the services they want and to do what is right for Warrington through initiatives such as the Older Peoples Partnership Group (OPEG) and through neighbourhood boards/ groups.

10. Next steps

This market position statement is the start of a process. It is intended to serve as an introduction to the many discussions that need to be had between the council and partners but also as a starting point for service providers within the Warrington Borough to think about their current business models and how they may need to change for the future.

It does not prevent providers seeking a competitive advantage through their own market research and other activities. The right kind of freely shared and published intelligence could lower barriers to market entry and prevent providers from wasting resources on poorly targeted initiatives.

As a commissioning organisation the council will continue to develop partnership networks to support market development and offer the opportunity to continue this dialogue in a meaningful and collaborative way. These individual networks will need to influence and shape:

- Person Centred approaches
- Integrated Care Approaches
- Integrated Workforce Development
- Sharing Best Practice
- Influencing delivery / commissioning

Future Market Position Statement for Older People

It is planned to produce an update for the Market Position during 2015. Consideration will be given to the key actions below, which derived from the partnership event held to discuss the current Market Position Statement.

Key Actions:

Theme	Key Actions
Person centred approaches	1) Establish a Market Development and Innovation Forum (MDIF) with partners to support transition and shared learning 2) Develop an older people's engagement strategy to support service redesign - Consider future services by engaging with younger adults (40 yrs+) - Consider views of the community who may not be accessing services 3) Incorporate all older people services into developed resource directory 4) MDIF to engage all stakeholders with an interest in supporting Older People
Integrated care approaches	1) Clarify decision making processes across health and social care via MDIF 2) Develop a commissioning culture based on outcomes as opposed to outputs with commissioners being more flexible in how services are commissioned and delivered 3) Acknowledge role of voluntary and independent services in developing a prevention agenda 4) Clarify what prevention and early intervention and complex care models would look like - present new models in more detail at MDIF to raise awareness and understanding 5) Further consider the potential impact of national changes to social care 6) Improve knowledge of supply within Warrington including providers and housing – gap analysis to be undertaken. 7) Consider development of Market Position Statement and strategy in relation to housing
Sharing best practice	1) Further develop a more partnership approach to commissioning to deliver innovation and manage decreasing resources though the MDIF. 2) Undertake SWOT analysis of current position with stakeholders 3) Undertake more enhanced / detailed mapping via MDIF (consider voluntary sector provision in relation to prevention services). 4) Clarify role of strategic commissioning in relation to data collation and support to partners re information sharing 5) Support the development of integrated data collection across health and social care via integrated strategic commissioning 6) Incorporate further data on health and health service delivery

Integrated workforce development	1) Identify workforce development requirements across the health and social care workforce 2) All providers engaged in 'Making Every Contact Count' training via public health to support behaviour and lifestyle for individuals they support 3) All services to shift towards outcome focused delivery of service 4) Development of Integrated Strategic Workforce Strategy 5) Establish a Market Development and Innovation Forum to support transition, shared learning and improve cross sector working
Influencing delivery / commissioning	1) Develop a shared vision and strategic commissioning intentions particularly in relation to integration 2) Develop shared outcomes as part of commissioning intentions and contracts 3) Develop more proactive rather than reactive approach to taking forward change and clearly state the process. 4) Develop collaborative model of commissioning to support service redesign/innovation e.g. experience led commissioning 5) Support voluntary sector to access external funds via bidding process 6) Clarify role of council and CCG regarding support that can be offered to partners when developing bids/business planning via MDIF 7) Consider utilising lead provider commissioning arrangements/ collaborative approach (risk sharing and rewards) across providers. 8) Consider the development of longer term contracts to support voluntary sector development 9) Clarify financial and contracting decision making processes across health and social care via MDIF 10) Further development of Integrated strategic Commissioning across health and social care to support effective use of resources 11) Raise awareness and understanding of contracting processes

How to give your feedback on the Market Position Statement

We would be interested in gaining your views on this Market Position Statement and would welcome the continued involvement from service providers and customers in co-producing future Market Position Statements.

Telling us what you need in respect of planning information (e.g. what market information would be especially useful in the future or might be difficult to obtain independently) will assist in moving the Warrington health and social care community towards new fit for purpose business models

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Appendix A

Current national indicators for adult social care

Domain 1: Enhancing quality of life for people with care and support needs	• Social care-related quality of life • The proportion of people who use services who have control over their daily life • The proportion of people who use services who have control over their daily life • Proportion of people using social care who receive self-directed support and those receiving direct payments • Carer-reported quality of life • Proportion of adults with a learning disability in paid employment • Proportion of adults in contact with secondary mental health services in paid employment • Proportion of adults in contact with secondary mental health services who live independently, with or without support • Proportion of people who use services and their carers who reported that they had as much social contact as they would like
Domain 2: Delaying and reducing the need for care and support	• Permanent admissions to residential and nursing homes per 100,000 population • Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re ablement / rehabilitation services • The outcomes of short term sequel to service • Delayed transfers of care from hospital and those which are attributable to adult social care • Dementia- a measure of the effectiveness of post diagnosis care in sustaining independence and improving quality of life
Domain 3: Ensuring that people have a positive experience of care and support	• Improving people's experience of integrated care • The proportion of carers who report that they have been included or consulted in discussions about the person they are for • The proportion of people who use services and carers who find it easy to find information about services • Overall satisfaction of people who use services with their care and support • Overall satisfaction of carers with social services
Domain 4: Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	• The proportion of people who use services who feel safe • The proportion of people who use services who say that those services have made them feel safe and secure • Proportion of completed safeguarding referrals where people report they feel safe

Appendix B

Current national indicators for public health

Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest

Outcome 1: Increased healthy life expectancy taking account of the health quality as well as the length of life (Note: This measure uses a self-reported health assessment, applied to life expectancy.)

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities through greater improvements in more disadvantaged communities

DOMAINS

DOMAIN 1: Improving the wider determinants of health	Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities
DOMAIN 2: Health improvement	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
DOMAIN 3: Health protection	Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities
DOMAIN 4: Healthcare public health and preventing premature mortality	Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Appendix C

Current national indicators for health

CCG Indicators are structured around the five NHS Outcomes Framework domains.

Domain 1, Preventing people from dying prematurely **This domain captures how successfully the NHS is in reducing the number of avoidable deaths.**	• Potential Years of Life Lost (PYLL) from causes considered amendable to healthcare • Life expectancy at 75 for males and females • Under 75 mortality rate from cardiovascular diseases • Under 75 mortality rate from liver disease cancer • One and five-year survival from colorectal cancer • One and five-year survival from breast cancer • One and five-year survival from lung cancer • under 75 mortality rate from cancer
Domain 2, Enhancing quality of life for people with long-term conditions **This domain captures how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible.**	• Under 75 mortality rate from respiratory disease • Health-related quality of life for people with long term conditions • Proportion of people feeling supported to manage their condition • Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) • Enhancing quality of life for people with dementia
Domain 3, Helping people to recover from episodes of ill health or following injury **This domain captures how people recover from ill health or injury and wherever possible how it can be prevented**	• Emergency admissions for acute conditions that should not usually require hospital admission • Emergency readmissions within 30 days of discharge from hospital • Improving recovery from injuries and trauma • Improving recovery from stroke • The proportion of patients recovering to their previous levels of mobility/walking ability at 30 and 120 days • Proportion of older people (65 and over) who were still at home 91 days after discharge into rehabilitation and offered rehabilitation following discharge from acute or community hospital
Domain 4, Ensuring that people have a positive experience of care **This domain looks at the importance of providing a positive experience of care for patients, service users and carers.**	• Increase the proportion of NHS patients in Warrington who would rate their experience as 'good' • Improving people's experience of outpatient care, hospitals responsiveness to personal needs, accident and emergency services, access to primary care services, women and their families' experience of maternity services, care for people at the end of their lives and healthcare for people with mental illness
Domain 5, Treating and caring for people in a safe environment and protecting them from avoidable harm **This domain explores patient safety and its importance in terms of quality of care to deliver better health outcomes**	• Improve patient safety, reducing Quality Adjusted Life Years lost to NHS patients in Warrington through avoidable harm • Patient safety incidents reported • Safety incidents involving severe harm or death • Incidence of hospital-related venous thromboembolism (VTE) • Incidence of healthcare associated infection (HCAI), MRSA and C. difficile • Incidence of medication errors causing serious harm

Appendix D

Reference list

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13. Reablement: a key role for occupational therapists 2010

Websites

Warrington’s Health & Well Being Strategy 2012 to 2015

Warrington Health Ageing Strategy

Neighbourhood strategies

Appendix E

List of tables and charts



Market Position Statement

Older Adults

2014