

Future care needs and services for 18-64 year-olds in Herefordshire with physical disabilities

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Summary

Working together and with their partners, Herefordshire Council and the Herefordshire Primary Care Trust are committed to maximising the independence, well-being and choice of people with physical disabilities. In doing this, they face a major double challenge: despite additional investment and service improvements in recent years, in important respects they still lag behind what is achieved by high-performing authorities serving comparable areas; and the costs of services have continued to escalate.

Currently there are an estimated 4,600 people aged 18-64 with moderate disabilities who are likely to require personal care at some time. This number is expected to increase by no more than 5% (250 people) by 2012, and 8% (350 people) by 2021.

An estimated further 950 people with serious disabilities currently are likely to require care at some time; a figure expected to increase by 5% (50 people) by 2012, but not further by 2021.

The principal driver of these increases in need is the projected rise in the number of people aged 55-64, of 7.1% by 2012 and 20.6% by 2021; this is because a number of the most common physical disabilities are more often found in this age-group than amongst younger adults.

The prevalence of physical disability is much higher than the number of people who need services: in March 2007 328 people were receiving core social care services, while a further 293 were being helped by means of information, advice and annually serviced equipment. During 2006-07 as whole, there were 650 users of core social care services.

Between five and seven young people with physical disabilities a year are likely to be in transition from children's to adults' services.

It would appear appropriate to plan to provide care and other support for 5% more people by 2012. This would equate to an additional 37 users of core social care over the year as a whole; and, at any one time, an additional 16 users of core social care and 15 additional users of less intensive services.

Major gaps in current data need to be filled, which means that these estimates will need to be kept under review. Even so, it is possible to be reasonably confident about the needs estimated for 2012.

Users and carers want much better communications with staff, and also between professionals; more consistent support from social workers and occupational therapists, with reduced waiting times for services; better, clearer information about services; more local, flexible day opportunities; more opportunities for self-assessment, housing and employment; the extension of direct payments and individual budgets; and better services for those with

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acquired brain injury. The Government and the inspectorates have similar expectations.

Compared with generally high-performing North Somerset, Somerset and Shropshire, Herefordshire is slower to begin and complete assessments; much slower to deliver care packages; quicker to deliver equipment but much slower in carrying out major adaptations; provides less home care overall because of its low level of intensive home care, and does so at a relatively high unit cost; provides much more residential care; provides more of its day care in buildings-based settings rather than in local and generic facilities; does less to help people into employment; has fewer people in receipt of direct payments; doesn't provide a single point of access for users and carers; does less to support carers; and does less to enable users and carers to shape the planning and development of services. It incurs higher gross and net costs, attracting proportionately less than half the external income secured by Shropshire.

To achieve high-performing, cost-effective services by 2012 Herefordshire needs to do much more to support people, including those with intensive care needs, in their own homes and communities, placing much more influence and control in the hands of users and carers. This will require the cost-effective, local replacement of the current out-of-county provision and, more generally, a significant reduction in the use of residential care. There is an urgent need to emulate the high-performers by integrating the county's occupational therapists into single community teams under common line management.

Considering together the expected 5% increase in demand for services over the medium-term, the need for new forms of services to meet this cost-effectively, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas and the manifest inefficiencies in the current pattern of services, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council in 2006-07 (i.e including the over-spending against budget of just over £1 million), maintained in real terms and with the proceeds of efficiency savings reinvested in the new services will be needed recurrently until 2012, but that annual savings of some £209K a year should be possible by 2012-13.**

In addition, to establish the more efficient and effective new pattern of services, non-recurrent bridging funding for social care of between £200K and £250K a year will be required through to 2011-12.

Limitations of currently available information about PCT funding mean that there is no basis for comparisons with other areas in respect of health expenditure. The prudent assumption for now, pending the further work that will be done to develop the joint commissioning plan to deliver the improved pattern of services, is that at least the current level of expenditure, maintained in real terms, will be required.

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To avoid a vicious circle of decline, the transformation plans to bring about the new pattern of services must be fully integrated with the steps taken to manage current in-year over-spending against budget.

Moreover, these resources will not do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT.

It will also require the large-scale extension of direct payments and individualised budgets; better support for carers; maximising the contribution and effectiveness of GP-based commissioning; adjusting the balance of PCT and Council funding to achieve a single, shared set of commissioning targets; attracting significant additional funding from external sources; and working closely with the third sector to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines.

The new services will only work if all those caring for and supporting people with physical disabilities are developed to have the right skills and behaviours. This will need to be done as part and parcel of the introduction of the streamlined processes and ICT-based systems being put in place under the *Herefordshire Connects* programme, buttressed by strong, disciplined performance management at all levels.

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Section 1: Introduction

- 1.1 Working together and with their partners, the Council and the Herefordshire Primary Care Trust (PCT) are committed to maximising the independence, well-being and choice of people with physical, including sensory disabilities.
- 1.2 Despite additional investment over previous years, and changes aimed to enable people to lead safe and fulfilled lives in their own homes and communities rather than in unnecessary residential care, the Council's and PCT's current patterns and levels of services are not, in important respects, achieving as much and providing the same value for money as are the highest performing comparable areas.
- 1.3 In addition, the costs of services in Herefordshire have risen substantially in recent years and continue to do so, to the extent that expenditure has significantly exceeded budgets.
- 1.4 This is taking place against the background of the ambitious developments in Government policy for health and social care set out in the White Paper of January 2006, *Our health, our care, our say: a new direction for community services*. This calls for a fundamental shift in services to local communities, to be developed by local partners in ways that better meet the needs of individual people. It sets four main goals:
- a. **better prevention and earlier intervention** – reducing the chances of people becoming ill or dependent in the first place;
 - b. **more choice and a louder voice** – ensuring that people are in control of the services they receive, through involvement in the planning and development of services, and by means of self-directed care, including direct payments and budgets for individuals;
 - c. **tackling inequalities and improving access to a wider range of community services** – ensuring that the areas, groups of people and individuals with greatest need get the services they deserve;
 - d. **more support for people with long-term needs** – better integration of services and joint planning across health and social care for those who make the most intensive use of services.
- 1.5 These goals are developed in more detail for physical disability services in other authoritative publications, including *Improving Life Chances for Disabled People* (PM's Strategy Unit 2005); *Long-Term (Neurological) Conditions* (NSF, DH 2005); and *Supporting People with Long Term Conditions to Self Care* (DH 2006). They are expressed most concretely in the seven outcomes for people used by the CSCI in their assessments of care: *Improved health and emotional well-being*;

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Improved quality of life; Making a positive contribution; Exercise of choice and control; Freedom from discrimination and harassment; Economic well-being; and Personal dignity and respect.

- 1.6 The goals are underpinned by national consultation showing strong support for more community services. That is reflected in the consistent findings of public consultation in Herefordshire, including that carried out with users and carers specifically to inform this assessment (details are given in section 3 below). The Council, the PCT and their partners in The Herefordshire Partnership have made *Healthier Communities and Older People* one of the *Herefordshire Community Strategy's* four priorities for better outcomes.
- 1.7 In the light of these considerations, the Council and the PCT are committed to work with their partners, service users themselves and their carers and representatives to develop and deliver better, sustainable services for the future. They want, in particular, to strike the right balance between preventative services and the provision of more intensive support and care.
- 1.8 In all of this, the Council and PCT are particularly conscious not only of the inter-dependence of health and social care one upon the other in achieving the best outcomes for people, but also of the vital contribution that needs to be made by housing, employment services, education, welfare benefits, generic community-based opportunities (such as cultural and leisure services), the voluntary and community sector, and, not least, by users and carers themselves and by their advocates.
- 1.9 Crucial too are effective links to ensure smooth transition between the services provided for children and young people and those for adults; and between services for 18-64 year-olds and those for older people.

The purpose of this report

- 1.10 Having last year assessed future needs for older people and adults with learning disabilities, and agreed how services would be developed to meet them, the Council and the PCT decided to carry out, with the *Herefordshire Alliance*, a thorough assessment of future needs of 18-64 year-olds with physical disabilities; of the services needed to meet those needs; and of the costs involved in doing so, taking into account the scope for greater efficiency in moving from the present services to a new, more effective pattern.
- 1.11 This report has been prepared under the leadership of the Council's Corporate Policy and Research Team, working with staff in the PCT, in the Council's Adult Social Care Department and Resources Directorate, and with *The Herefordshire Alliance* and *The Herefordshire Centre for Independent Living*. The membership of the Steering Group is at Appendix 1.

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- 1.12 The Steering Group has been advised by distinguished experts in the field, Professor Gerald Wistow and Eileen Waddington. Further information about the expert advisers is at Appendix 2.
- 1.13 The first stage of the project was to estimate the need for care of 18-64 year-olds with physical disabilities through to 2021. This was to provide the long-term context for the second stage: the assessment of what patterns and levels of cost-effective services would be needed to meet expected needs in 2012.
- 1.14 Rather than conduct a theoretical assessment of the services that will be needed, the best possible comparator areas were identified; that is those with high-performing services in areas with broadly similar settlement patterns and demographic characteristics to those found in Herefordshire. The selected areas were North Somerset, Somerset and Shropshire.
- 1.15 Through analysis of comparative data about services and costs, of inspection reports, and by visiting the authorities, we established what patterns and levels of services they provide; how they intend further to change and improve them to meet future challenges; and, crucially, how they manage and deliver them successfully. These findings were then applied, having regard to the distinctive needs and circumstances of Herefordshire and to wider relevant comparisons.
- 1.16 The final stage was to translate these findings into costed proposals for the development of high-performing services through to 2012.

The structure of the report

- 1.17 Section 2 of the report examines future needs to 2012 and 2021. Section 3 describes what pattern and levels of services will be needed to meet those needs in 2012. Section 4 looks at the capacity needed to develop and deliver these services successfully. Section 5 sets out the estimated costs of doing so, comparing them with current costs.

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Section 2: Assessment of future needs

2.1 The full assessment of future care needs for 18-64 year-olds with physical disabilities is at Appendix 3. It begins with a summary.

2.2 The crucial points are:

- an estimated 13,200 people between the ages of 18 and 64 in Herefordshire have **some kind of physical disability**, meaning one that reduces the person's locomotion, sight, hearing, communication and/or ability to wash, dress, feed, go to the toilet, or get in or out of a bed or a chair
- of these, an estimated 3,200 have a **serious disability**
- by 2012 the numbers with moderate disabilities are expected to grow by 5%, as are the numbers with serious disabilities
- however, the current estimated number with **moderate disabilities who are likely to require personal care** at some time is much lower, at 4,600; a figure that is expected to increase by no more than 5% (250 people) by 2012 and 8% (350 people) by 2021
- the estimated current number with **serious disabilities likely to require personal care** at some time is fewer still, at 950; a figure that is expected to increase by a maximum of 5% by 2012 (50 people) but not further by 2021
- almost all people with a personal care disability are likely to have a **locomotor disability**
- within these totals, 1,450 are estimated to have a **sight disability**, which is serious for an estimated 250; these numbers are not expected to change by 2012, but they are expected to increase by 50 for people with serious disability by 2021
- an estimated 3,000 people have a **hearing disability**, but for only 100 people is this serious; that 100 is expected to increase to 150 by 2012, and to remain at this level in 2021
- an estimated 1,250 people have a **communication disability**, which in 300 cases is serious; the maximum expected change in the number with a moderate disability is an additional 50 by 2012, but no change is expected in the number with a serious disability
- the **principal driver of these increases** in need is the projected rise in the numbers of people aged 55-64, of 7.1% by 2012 and

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20.6% by 2021 (compared with 3.7% and 5.5% for England and Wales as a whole); this is because a number of the most common physical disabilities are more often found in this age-group than amongst younger adults

- it is not possible at present to estimate the numbers of people in **different ethnic groups** in the county with physical disabilities; nor to produce estimates of the numbers of people likely to have these in **different parts of Herefordshire**
- it is estimated that between five and seven young people with physical disabilities a year are likely to be in **transition from children's to adults' services**
- the prevalence of physical disability is much higher than those who need – or probably want – social or most other forms of care and support; this underlies the huge disparity between some of the numbers above and the **number of people aged 18-64 known to services**. In March 2007, 328 were receiving core social care services, while a further 293 were being helped less intensively by means of information, advice and annually serviced equipment. During 2006-07 as a whole, there were over 650 users of core social care services; the large difference between this figure and the snapshot figure for March is accounted for by the turnover of people receiving short-term services, such as intermediate care and welfare benefits
- taking into account the estimated increases in physical disabilities in the population summarised above, **it would appear appropriate to plan to provide care and other support for an additional 5%. This would equate to an additional 37 users of core social care over the year as a whole; and, at any one time, an additional 16 users of core social care and 15 additional users of less intensive services**
- there were, in 2005, an estimated 14,100 people in the county aged 18-64 acting as unpaid **carers** for at least one hour a week, of whom 3,600 were providing care for 20 hours or more; we have no reliable basis on which to estimate the number of these caring for someone with a physical disability, but it would seem safe to assume that the number is substantial; and it would also seem safe to assume as likely a modest increase in this number to reflect the expected growth in the number of younger people with physical disabilities
- although we do not have detailed information about either the **incomes or accommodation** of people with physical disabilities, there is enough evidence nationally and locally to

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assume that they are likely to have lower than average incomes and to be more likely to live in social rented accommodation

- 2.3 In considering these estimates, it is important to bear in mind the paucity of reliable data currently available nationally, regionally and locally as regards both present and future levels of need. A study for the Department of Work and Pensions concluded in 2004 that, *“there is no single ‘gold standard’ measure of disability. The multi-dimensional and dynamic nature of disability makes it inherently difficult to measure.”* And a 2007 study of possible future trends by the Institute of Public Policy Research for the Disability Rights Commission, based on self-reporting of long-term health problems and disability, qualified their finding that there could be substantial increases with the words, *“..the fact that a pattern has occurred between 2001 and 2004 is not a guide to the pattern over the next four years, much less over the next 15 years.”*
- 2.4 It has been suggested that the substantial rise in obesity will lead eventually to higher levels of a range of disabilities, for instance those associated with diabetes, stroke and coronary heart disease. On the other hand, intensifying health promotion together with legislation, such as the ban on smoking in public places, may result in improved diet and health. It is not possible at the present time to be clear about even the broad net effect of these and other factors that may give rise to either more or fewer physical disabilities in the future.
- 2.5 Within Herefordshire difficulties arise because data have not been collected and because the various separate data-bases maintained by the Council and the PCT about individuals mean that there is likely to be extensive double-counting or more. On the other hand, some things are probably not being counted at all. These deficiencies will need to be addressed to provide a sound basis for the future monitoring and planning of services, as well as to meet fully statutory requirements in respect of equalities and those to come requiring a Joint Strategic Needs Assessment for health and social care.
- 2.6 It is of great importance that we rectify these deficiencies as quickly as possible. Much of this will be made possible by the introduction of a single user data-base and other improvements under the *Herefordshire Connects* programme, including the development of shared systems between the Council and PCT within the Public Service Trust. The longer-term estimates in this report should be reviewed as these improvements bear fruit.
- 2.7 That said, the present estimates are the best possible current basis for planning and delivering improved services to 2012, in respect of which it is possible to be reasonably confident about the extent and nature of future needs.

Section 3: The pattern and levels of services to meet needs in 2012

3.1 Drawing on the views expressed by users and carers in Herefordshire, on Government and other authoritative national requirements and guidance regarding physical disability services, together with the evidence about high-performing services gathered from the comparator areas – North Somerset, Somerset and Shropshire – this section describes what needs to be done, to what extent, to achieve services that will meet the needs identified in section 2.

The views of users and carers

3.2 The views on present and future services of users and their carers and personal advocates were sought at a forum in July 2007. 26 took part, expressing clearly and forcefully what they want from services.

3.3 Their main points were:

- communications between staff and those receiving assessments and care need to improve a lot
- as do communications between professionals about individuals' care
- especial concern about the need for better, more consistent communications and support from social workers and occupational therapists, with a particular need to reduce waiting times for assessments and occupational therapy services
- the need for better, clearer information about services
- a need to increase opportunities for self-assessment
- the need to eliminate delays in the provision of equipment, in the carrying out repairs and, especially, in making major adaptations
- a need for improved housing opportunities
- the need to increase employment opportunities, including through avoidance of the benefits trap
- the majority wanting more community-based/generic day opportunities, but a minority concerned about the possible loss of valued current buildings-based services
- on the back of a perception that those in receipt of them are

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living more independently than others, the importance of increasing the number of people receiving direct payments or individual budgets

- the need to improve services for those, often younger people, with acquired brain injury

Government and inspectorate requirements

3.4 The improvements users and carers want to see reflect key elements of the national requirements and guidance on good practice. Other key elements expected by Government and the inspectorates are:

- the fullest possible participation in society being the touchstone, including meaningful employment
- advocacy and other help for individuals to promote their social inclusion
- user and carer involvement in service planning and development
- the fullest possible integration of the commissioning and provision of services across health and social care
- a single point of contact and continuity for users and carers across agencies
- the systematic and effective management of the transition of young people from children and young people's services to those for adults
- the provision of information, advice and, where appropriate, assessment to the whole population, including self-funders

Comparing with high-performers

3.5 In comparison with the relatively high-performing North Somerset, Somerset and Shropshire, Herefordshire:

- is slower to begin assessments (88% of contact within 48 hours, compared with an average of over 96%, with Somerset achieving 99%)
- is slower to complete assessments (83.6% within 28 days, compared with an average of 89%, with Somerset achieving 94.9%)

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- is much slower to deliver care packages (76% within 28 days, compared with an average of 92.5%, with Shropshire achieving 96%)
- the proportion of its total net social care expenditure classified as assessment and care management is the lowest (6%); substantially lower than the average (18%); and massively lower than Shropshire (26%)
- is much slower in carrying out major adaptations (average waiting time 39 weeks, compared with 33 in Shropshire and 16.5 in Somerset)
- is best at delivering equipment within seven working days (96%, compared with an average of 93%)
- helps a slightly higher proportion of 18-64 year olds with physical disabilities to live at home (6 per 1,000 population, compared with an average of 5.5)
- but provides less intensive home care for all adults (6.7 per 1,000 population, compared with an average of 9.4)
- despite this lower level of intensive home care, its unit costs for home social care as a whole are much higher than the average (£295 per person per week, compared with an average of £160)
- provides substantially more residential and nursing care than two of the three comparator areas (32 per 1,000 population, compared with an average of 24 in North Somerset and Shropshire, and 57 in Somerset); most dramatic is the comparison with Shropshire: whereas 32% of Herefordshire Council's total net expenditure is on these forms of care, Shropshire spends only 14%.
- most of its day care is buildings-based as opposed to being shaped around the needs of individuals, with an emphasis on community-based and generic facilities; this is reflected in a social care cost per user per week that is higher than the average for Shropshire and Somerset (£102, compared with £83; with Shropshire alone £69)
- does less to enable people to gain or retain employment
- all Herefordshire's occupational therapists are employed by the PCT and, unlike the comparator areas, are not integrated into single community teams under common line management; this is a principal cause of our relatively poor performance, including delays in assessments, the delivery of care packages and major adaptations

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- doesn't provide a single point of access across health and social care for users and professionals
- does less to support carers (services provided to carers in respect of 10% of service users, compared with an average of over 12% and North Somerset's nearly 14%)
- does less to enable users and carers to make an influential contribution to the planning and development of services
- has improving, but still weak and inefficient, systems for the collection and analysis of data, on the basis of which the performance of services can be continuously monitored and improved
- overall, incurs higher social care gross costs (£47 per head of the 15-64 population per annum, compared with an average of £42; and with North Somerset's figure of only £34)
- attracts about the same level of income as the average of the comparators per head of the 15-64 population from charging service users for social care, but this will rise under the new fairer charging arrangements
- generates about the same level of other external income for social care per head of the 15-64 population, but under half of that secured by Shropshire (£1.46 compared with £3.16)
- limitations of currently available information about PCT funding mean there is no basis for comparisons with other areas in respect of health expenditure

The new pattern of services required

3.6 This analysis leads to our recommending the following principal changes to achieve the modern, cost-effective patterns of services that would meet future needs in Herefordshire.

3.7 The fundamental strategic shifts needed are to do much more to support people, including those with intensive care needs, in their own homes and communities; place much more influence and control in the hands of users and carers; and integrate fully the planning, commissioning and delivery of care and support across the Council and the PCT.

3.8 The specific changes to achieve this should be:

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- commissioning cost-effective services within the county to replace current out-of-county placements and avoid them in the future, wherever this is in the interests of users
- developing own-home and community-based services so as to reduce to the absolute minimum the use of residential and nursing home care
- maximising the targeted use of telecare, so that people are able to live safely in their own homes
- moving away from traditional, buildings-based services by developing and enhancing access to community-based, often generic opportunities
- working closely with the third sector to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines.
- enhancing recovery and rehabilitation services, particularly for people with acquired brain injury; these improvements should include home support, housing, education, training and employment opportunities, and support, where necessary, to access general community facilities
- the maximum possible number of people securing their own care with direct payments or individual budgets
- securing effective, independent advocacy for individuals
- providing better, clearer information about services, tailored to meet the needs of different groups of users
- securing services to support carers to continue in their role and improve their own health and well-being, including, where necessary, help to retain or gain employment
- systematic, continuous user and care involvement in the planning and development of services, including financial assistance and capacity-building to make this possible; with regular surveys of users' and carers' views about services and the quality of their lives, and the systematic use of complaints to improve services
- developing a shared philosophy and approach across children's and adults' services, reflected in fresh protocols, to ensure a smooth and successful transition for young people moving between them

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- identifying the needs of ethnic minority groups and then tailoring services to meet them
- as a pre-condition for the necessary service improvements, and therefore as a matter of urgency, putting in place a single set of arrangements across the Council and the PCT for the planning, commissioning, delivery and performance management of health and social care
- as an essential part of this, creating wholly integrated community-based teams including the occupational therapists, under single line-management
- establishing a single point of contact for users, carers and professionals, buttressed by shared business processes and information systems
- improved preventative and intermediate care services for people with chronic conditions by means of joint management of health and social care
- doing all this in partnership with GP practices to achieve effective integration between community teams, therapy services, GPs and practice and district nurses, and to maximise the effectiveness of GP-based commissioning

3.9 A number of the necessary improvements are already beginning to happen or are planned. These include:

- the expert patient programme, which helps people with long-term conditions to improve their quality of life, delivered by volunteers who themselves have long-term conditions
- chronic back-pain classes and insulin management groups for insulin-dependent patients and their carers
- two well-being co-ordinators promoting targeted preventative services with GP practices to avoid inappropriate hospital and care home admissions
- the initial roll-out of telecare, with over 97% of service users feeling that this has increased their independence
- the appointment of a Physical Disability Co-ordinator to identify opportunities for young people in residential care to live with support in the community
- intermediate care flats to enable people to undertake daily living activities and increase their independence

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- working in partnership with voluntary bodies to maximise the take-up of direct payments and, through welfare rights information and advice, people's income

- the temporary appointment of an officer to draw up the joint commissioning strategy that will secure the improved pattern of services

3.10 The overall pattern and levels of high-performing services proposed are set out in Appendix 4, which also explains the underlying assumptions.

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Section 4: The capacity needed to deliver the Improvements

- 4.1 Achieving successful change on the scale necessary to meet future needs cost-effectively requires not only careful, detailed planning across health and social care (and beyond) but also a firm, co-ordinated grip on all aspects of managing projects, finance, human resources and performance.

Funding

- 4.2 Overall and pro rata to the 15-64 population, the current level of social care **gross funding** is almost 12% above the average for the comparator areas. It is, however, only marginally above that for Shropshire, which provides the closest match to Herefordshire's circumstances.
- 4.3 However, the **net cost** to the Council is a significant 4% higher per head of population than Shropshire. Since Shropshire raises less per head of population from charges to users, this is entirely because Shropshire raises more than twice as much external income per head.
- 4.4 Considering together the expected 5% growth in the need for services, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas, inefficiencies in the current pattern of services, and on the basis that Herefordshire should be capable of generating proportionately equivalent levels of external income to those achieved by Shropshire, in addition to the additional income that would result from the proposed new fairer charging arrangements, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council in 2006-07 (i.e including the over-spending against budget of just over £1 million), will be needed recurrently until 2012.**
- 4.5 **This would hold true only if this level of spending were to be maintained in real terms and if the efficiency savings that would be secured under the new pattern of services were retained for investment in those new services.**
- 4.6 **Moreover, although the reduction in services no longer required, for example expensive out-of-county residential placements, should be expected to pay the recurrent costs of the new pattern, this can only happen if there is targeted, time-limited, non-recurrent funding to develop the new services, such as for reablement, advocacy and carers.**
- 4.7 The PCT has not hitherto been required to collate expenditure figures in respect of care for particular age-groups. For the purposes of this assessment, it has estimated that its total costs of commissioning

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services and directly providing physiotherapy and occupational therapy for 18-64 year-olds with physical disabilities were £1.16 million in 2006-07 and are likely to be some £1.22 million in 2007-08. Despite this initial estimate, **there is no basis currently for comparisons with other areas in respect of health expenditure. The prudent assumption for now, pending the further work that will be done to develop the joint commissioning plan to deliver the improved pattern of services, is that at least the current actual level of expenditure, when it has been determined, maintained in real terms, will be required.**

4.8 The assumption that the current real levels of recurrent funding should be an adequate basis for emulating the achievements of the high-performing comparator areas rests on six crucial additional provisos:

- that the large-scale extension of direct payments and individualised budgets will be managed in such a way that significant efficiency savings are generated for recycling in physical disability services
- that support for carers will be strengthened (recent research by the University of Leeds estimates that the average carer saves the nation more than £15,000 a year)
- that the contribution and effectiveness of GP-based commissioning will be maximised
- that the balance between PCT and Council funding will be adjusted, where necessary, to achieve a single, shared set of commissioning targets
- that we will attract significant additional funding from external sources (such as Government grants, including Supporting People, charities, private business and the National Lottery)
- that this and wider benefits will be achieved by working in close partnership with the third sector, so as to provide access to wider sources of external funding and, even more important, to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines; this may include the development of user-led organisations as service providers

4.9 Moreover, the plans for radical transformation that will produce sustainable, affordable and cost-effective services must be fully integrated with the steps taken in response to the current over-spending. Unless this is done, on the basis of establishing an agreed programme of change for the coming four years, underpinned by the necessary minimum recurrent and targeted non-recurrent funding,

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services will deteriorate in a vicious circle of ad hoc cuts and retrenchment that will render them incapable of meeting future needs .

4.10 These considerations underpin the costings in section 5 below.

Human resource, organisational and systems considerations

4.11 Developing and delivering the new pattern of services will require considerable, sustained management effort and a systematic approach to workforce planning and performance management, so as to ensure that all those providing care and other support to people with physical disabilities have the right skills and exhibit the right behaviours.

4.12 Elements of a good basic infrastructure have now been created in the Council and the PCT which, together with an increasingly productive relationship with both the third and private sectors, has the potential to bring about the necessary changes. Notably, this includes an Interim Head of Adult Social Care, a dedicated Head of Learning Disability, a Change Manager, the strengthening of the PCT and Council Planning and Change Team, including a Physical Disabilities Commissioning Manager, and additional appointments to the Council's contracts and adult safeguarding teams.

4.13 However, this strengthened capacity is already tackling a comprehensive transformation programme that includes the fundamental reshaping of older people's and learning disability services, and the development of wholesale new procedures and management systems; to which will now need to be added, as well as that in respect of physical disabilities, a similar reshaping of mental health services. These and other **existing resources will not be able to do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT**. In turn, this will require the putting in place of single procedures, processes and ICT systems as part of the *Herefordshire Connects* programme.

4.14 Physical disabilities planning and commissioning capacity will be needed; the present Commissioning Manager post is temporary, filled by a secondment and due to end in April 2008.

4.15 This will need to be funded either from existing budgets or, if that is not possible, from the first tranche of non-recurrent investment in 2008-09, with the recurrent costs absorbed as the new pattern of services produces off-setting savings.

4.16 Underpinning all of this, there will need to be a cross-agency development programme for all those caring for or supporting people with physical disabilities. A partnership workforce strategy for

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the whole of adult health and social care is already in the early stages of development. This will need to include a dedicated element to deliver the improvements in physical disability services.

- 4.17 Similar considerations apply to the rolling out of the communications strategy and action plan for the comprehensive transformation programme.
- 4.18 The new pattern of services should be subject to regular review and periodic formal evaluation, taking account of a progressively better understanding of the nature and level of need. This should include an external, independent element, if possible linked to national evaluation programmes.

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Section 5: The costs

- 5.1 Appendix 4 contrasts the proposed high-performing services in 2012 with the services in place in 2006-07.
- 5.2 Unless services are fundamentally reshaped along the lines proposed in this report, they would fail to meet the needs and wishes of users and carers, and also the expectations of Government and the inspectorates. Worse still, this would take place in a context where the performance of other areas can be expected, on average, to continue to improve year-on-year and in which Government and the inspectors are likely to have ratcheted up the minimum acceptable standard for services and, therefore, the threshold for intervention.
- 5.3 Additionally, the maximum possible sustainable improvements in efficiency can be achieved only if services are modernised as proposed. This is illustrated by the growth, from 16 in 2005-06 to 20 currently, in the use of residential care, with an increase to ten out-of-county placements, which are costing the Council over £500,000 a year. There is a substantial danger that, in the absence of adequate local, community-based services, this trend will continue, resulting in even greater spending pressure against budgets.
- 5.4 **The recurrent spending required annually on social care from 2008-09 through to 2011-12 is the 2006-07 expenditure of £4.826 million, maintained in real terms.**
- 5.5 **Pending the further work that will be done to develop the joint commissioning plan to deliver the improved pattern of services, the prudent assumption is that *at least* the current actual level of PCT expenditure, maintained in real terms, will be required recurrently.**
- 5.6 **In addition to these recurrent costs, non-recurrent investment of the following order will be required to put in place the new pattern of services :**

Year	£000
2008-09	200
2009-10	250
2010-11	250
2011-12	200

- 5.7 **Annual savings of some £209K a year in social care costs should be possible by 2012-13.**