Swindon Borough Council

Adults with Needs
Emerging Market Position Statement

2017 – 2022

Contents

1. Purpose of the document, who it is for and what it will support
2. National policy context and The Care Act
3. Local policy context
4. Swindon and its people, the vision of adults with needs
5. Health and social care integration
6. Commissioning principles and standards
7. The voice of Adults with Needs in commissioning services
8. Market Shaping and Oversight
9. Contingency planning for business failure
10. Partnership working and collaboration
11. Key messages for the social care market
12. The voluntary and community sector
13. Older People
14. Physical Disabilities and Sensory Impairment
15. Learning Disabilities
16. Transitions – Children's and Adult Services working together
17. Substance Misuse
18. Supported Housing
19. Direct Payments
20. Support for Carers
21. Support for Providers
22. Adults with Needs Commissioning Priorities 2017 – 2020
23. Glossary of terms

1. Purpose of the document, who it is for and what it will support?

The purpose of this market position statement is to provide the market, both currently commissioned by Swindon Borough Council and that interested in being commissioned, with key market intelligence. It is intended that it will support the market to make business and investment decisions, as well as being the basis for discussions and collaborative working between Swindon Borough Council and the provider market.

It also sets out the direction of travel and approach to commissioning that the Council intends to take between 2017 and 2020. It is recognised that this may change and flex during this period and therefore the intention is that the market position statement will be refreshed annually to reflect any changes. It will also only be available electronically so

The document includes information on the following:

- The current and anticipated future demand of services for Adults with Needs
- The quality, performance monitoring and models of care that the Council prefer
- Opportunities resulting from the use of personal budgets and the take up of direct payments.

As the demand for care being provided by the Council has increased in recent times, so too has that being funded by people themselves. Over the period of this document we would hope to have an increasing understanding of the data and information available to us and this would include information about people who fund care themselves.

We recognise that care and support providers are an important source of intelligence about the size, capacity, capability and characteristics of the local market. We would like service providers to maximise the use of this intelligence and their experience to work collaboratively with commissioners and Adults with Needs to create new and innovative solutions to the challenges and opportunities that are faced by the Council, and the provider market, in providing care and support for Adults with Needs.

2. National Policy Context

The dual public policy drive to encourage greater personalisation and the integration of health and social care will continue. This largely began with the new Care Act duties and integration requirements that came into effect from April 2015.

Care Act 2014

National policy is a significant driver of local authority commissioning intentions. For a number of years public policy has encouraged greater personalisation and the integration of health and social care support for adults and carers in need. This dual policy drive will continue, particularly in light of new Care Act duties and Integration requirements that came into effect from April 2015.

The Care Act 2014 represented the most significant change to adult social care in the last 50 years, and pulls together a number of different pieces of legislation into a single, modern framework for care

and support in England.

From 2015, the Act fundamentally reformed the law on adult social care, placing a stronger emphasis on prevention and wellbeing, information and choice, support for carers, and market oversight. The Act also outlines the 'portability' of care provision for people who move from one area to another and places a new duty on public agencies to co-operate in these circumstances.

However, these changes are happening at a time when all local authorities face significant reductions in funding from central government. These reductions, coupled with a rising demand for services mean that we have to fundamentally consider the way we operate if we are to fulfil our statutory duties as a local authority and our desire to provide high quality care services to borough residents. In response to these challenges Swindon's Health and Wellbeing Board aims to ensure that Council departments and local agencies work closely together to improve the health, care and wellbeing of the local population. As a result Adults' Services are working with colleagues from NHS Swindon Clinical Commissioning Group (CCG), and Great Western Hospital NHS Trust to integrate health and social care to deliver better co- ordinated models of care and support for the people of Swindon.

Implications arising from the Act

- **Wellbeing**
  The Act places a duty on every council to have regard for the wellbeing of people in its area. Councils must promote wellbeing when carrying out their care and support functions. Wellbeing cannot simply be achieved through crisis management, it must include a focus on delaying and preventing future care needs and support people to live as independently as possible, for as long as possible. Therefore councils need to look at a person's life holistically, considering their care and support needs in the context of their skills, assets and ambitions.

- **Prevention**
  Councils must provide or arrange resources that prevent, delay and reduce an individual's need for long-term care and support, and consider the needs and support of carers.

- **Information and advice**
  Councils need to meet duties that include, but are not limited to:

  - housing and housing-related support for those with care and support needs;
  - effective treatment and support for health conditions;
  - availability and quality of health services;
  - availability of services that help people remain independent such as handyman services;
  - availability of befriending services and other services to prevent social isolation;
  - availability of intermediate care entitlement such as aids and adaptations;
  - eligibility and applying for disability benefits and other types of benefits;
  - availability of employment support for disabled adults;
  - children's social care services and transition;
  - availability of carers' services and benefits;

  - sources of independent information, advice and advocacy;
  - raise awareness of the need to plan for future care costs;
  - practical help with planning to meet future or current care costs.

- **Independent Advocacy**
  From April 2015 councils must provide advocates where it is determined that a person has 'substantial difficulty' in understanding, retaining or using information; or in communicating their views, wishes or feelings; where there is nobody else willing or appropriate to do so.

- **Services for Carers**
  Includes providing or arranging for the provision of services in their area which will prevent or delay the development of, or reduce the need for, support by carers.

- **New market management oversight duties**
  Have been introduced that underpin market-shaping and commissioning activities by:

  - focusing commissioning arrangements on outcomes and wellbeing
  - promoting quality services, including workforce development
  - ensuring that services are appropriately resourced
  - supporting sustainability
  - promoting greater choice
  - enabling co-production with partners and service users

- **Provider business failure**
  Councils (and NHS commissioning bodies) are required to develop robust contingency plans to manage the business failure of providers of regulated activities.

- **Integration and partnerships**
  Local agencies and organisations must work in a joined-up way to eliminate disjointed care which can often result in a negative impact on a person's health and wellbeing. The vision is for integrated care and support that is person-centred, reflects the preferences of those needing care and support, and includes the views and needs of carers and families.

Councils must work to ensure integration of care and support with health and health-related provision (in this context Housing is defined as health-related provision) where this promotes (or contributes) to the prevention or delay in the development of future needs, or where it will improve the quality of care and support to people in need and their carers.

3. Local policy context

This market position statement both links to and underpins local strategic plans as listed below with their links:

Document or information title	Synopsis and links
Health and Wellbeing Strategy 2017 - 2011	Statutory Plan to improve the health and well-being of the people in Swindon http://ww5.swindon.gov.uk/moderngov/documents/s87831/Appendix%201%20-%20Swindons%20Health%20and%20Wellbeing%20Strategy%202017%20-%202022.pdf

JSNA 2013-2022	Joint Strategic Needs Assessment for Swindon http://www.swindonjsna.co.uk/
One Swindon	The Community Strategy and Vision for Swindon http://www.oneswindon.org.uk/cs/Pages/default.aspx
Adult Care Strategy	Our strategy for managing demand for adult services http://ww5.swindon.gov.uk/moderngov/mgConvert2PDF.aspx?ID=46045
CCG One Year Operational Plan 2017/19	Swindon CCG Operational Plan http://www.swindonccg.nhs.uk/index.php/about-us/download-our-plans-and-publications/317-swindon-ccg-2-year-operating-plan-2017-19
Sustainable Transformation Plan	Bath and North East Somerset, Swindon and Wiltshire's Sustainability and Transformation Plan (STP) A short guide: http://www.wiltshireccg.nhs.uk/wp-content/uploads/2016/04/STP-short-guide.pdf

4. Swindon and its people, the vision for Adults with Needs

The joint vision of Swindon Borough Council and Swindon Clinical Commissioning Group for people in Swindon is enshrined in the Health & Wellbeing Strategy.

To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities

Swindon is a single unitary local authority (Swindon Borough Council), one CCG (Swindon CCG, representing 26 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust, who have established a clinical directorate that just serves Swindon), one emergency patient transport provider (South Western Ambulance Service NHS Foundation Trust) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

Swindon Borough Council is the Local Housing Authority.

Swindon will have grown substantially by 2020 with a population of over 250,000 by 2026 (including Shrivenham) from a current population of 220,000.

Living in Swindon in 2020 will mean that you can expect to live longer than the English average, with less risk of avoidable death, in better health and with the support of your neighbourhood and community.

We recognise the ongoing cost pressures on Older People services, especially in relation to nursing home placements. Despite more people requesting services, and people over 85 years of age suffering from complex and multiple health problems, we aim to deliver £1.2m through more preventative care and finding new ways to meet people's needs.

Local analysis of need has identified:

- The most deprived areas of Swindon have the highest prevalence of chronic conditions (such as heart disease, diabetes and cancer) in the local population, the highest rate of emergency hospital admissions (after allowing for age), and the highest rate of death before 75 years of age

- 12,123 people are living with diabetes in Swindon which is projected to be 13,422 people by 2020, which represents a 10.7% rise (1,299 people). Currently there are 2,000 people in Swindon with dementia and the prevalence is projected to increase with age being the biggest risk factor. In 2014/15, there were 6,301 people with diagnosed Coronary Heart Disease in Swindon CCG (2.75%) and 3,372 people with diagnosed stroke.

- Over 120 languages are spoken in schools in Swindon and an increasing number of children are arriving from minority ethnic communities who will have parents and grandparents with increasing needs for health and social care. This also means that our advice and information needs to be in simple language and staff need to be well trained to provide a service to diverse communities. Given the number of languages spoken, we access services such as language line to offer a wide range of translation services.
- Geographical mapping has shown that more older people who are financially supported by the local authority live in areas of deprivation. Currently there are people living in areas of Swindon such as Penhill, Pinehurst, Parks, Toothill, Gorse Hill and Moredon with high levels of poor health and needs with little access to advice and information. From our data we know that many people in those areas prefer information given to them face to face. We know that the number of older people with long term conditions will rise substantially from 35,000 now to approximately 40,000 by 2020.
- An annual survey of service users gives us data about user satisfaction with local services. In all areas Swindon scores better than the national average.
- Swindon has an increasing number of people from minority ethnic communities and backgrounds. 25% of school age children are from BME backgrounds. Citizens Advice Bureau reports that 24% of its customers and service users are from BME backgrounds.
- Population estimates in Swindon show numbers are increasing and are currently around 220,000 of which 14.9% (32,237 people) are aged 65 or older. Projections indicate that almost half (25,900 people) of the population growth between 2011 and 2031 will be in the 65 plus age group. The increase in population is being driven by people living longer and (net) internal migration.

We understand the population of Swindon at a locality/ward area and at GP practice level. We have some preventative and self-help services in place such as a third phase of community navigators and befriending support for a small number of older people.

The growth in people from BME Communities to 15% places even greater emphasis on the development of approaches to healthcare design and delivery that reach out to and are guided by our new communities. The greatest growth has been in communities who are also vulnerable to diabetes and cardiovascular disease in the Asian community,

By 2020 preventative and self-help integrated services will be in place locally to engage and support individuals. Swindon is in the process of developing an Accountable Care system. Accountable Care sits across several organisations: Swindon Clinical Commissioning Group (CCG), Swindon Borough Council (SBC), Great Western Hospital NHS Foundation Trust (GWH) and Avon and Wiltshire Partnership Trust and Primary Care. The aim is for everyone to work together to provide high-quality

care for patients. Accountable Care makes the system less complicated, less fragmented, and reduces hospitals delays. Each organisation providing care to the local community will pool resources to support the joint commissioning and delivery of health and social care for everyone. This is to benefit both patients and staff, as well as make better use of resources across the health and social care system.

- Our vision is to support Adults with Needs to live life to the full within the community despite long term conditions thus avoiding institutionalised care in a community setting.
- We will offer a genuine choice of care setting for those whose mobility, functionality or health is impaired or for those with serious and terminal illness who are preparing for death.
- Home will mean people's own home, where we will be using new practice and technology that enables people to be and remain at home.

5. Social Care and Health Integration

We have a long history of joint commissioning and integrated working for health and social care. Our future plans have now been revised in light of the Five year Forward plan next Steps and the Sustainable Transformation plan as well as the refresh of the Health and Wellbeing Strategy 2017 - 2022

Our track record in providing integrated commissioning and delivery has been recognised in Swindon becoming one of 10 members of the national Public Service Transformation Network Areas.

We have aligned our joint resources through a section 75 agreement to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations.

We have jointly commissioned services through National Health Services Act 2006 Section 75 Agreements since 2008. The Agreement renewed in 2015 comprises total funding of £47m from the CCG and £89m Swindon Borough Council (SBC), a total of £136m. Services are commissioned through the Joint Commissioning Group with representation of the Executive Nurse of the CCG, the Director of Adult Social Care and Director of Children's Services. For 2017 – 19 services are commissioned against the Better Care Fund Plan and monitored by the Joint Commissioning Group reporting to the Health & Wellbeing Board. The Better Care Fund is a separate pool within the S75 of £17.4m, with the balance of funding being within aligned pools.

The Better Care Fund Plan is a summary of jointly agreed areas of priority and serves as our plan for integrated working and joint commissioning.

Service users stated that their priorities are:

- Improved advice and information about services for carers and parent carers
- A simplified assessment process for service users and carers
- Community support for people discharged by specialist mental health services and a seamless link between voluntary and third sector providers and specialist services
- Support for older people who are isolated
- Improved patient flow within the hospital discharge process

We recognise that our demographic challenges as an expanding town with an ageing population. Following a detailed diagnostic by Newton Europe in 2015, the community health services and

community equipment services were tendered in 2016 with the aim of improving independence, reducing emergency admissions and improving the health and wellbeing of the population. The contract was successfully awarded to Great Western Foundation Trust who we are working with to develop a new model of care in line with the Five Year Forward View.

On 1 October 2016, 400 staff that had previously provided care services in Swindon on behalf of SEQOL (the independent employee-owned social enterprise company) transferred to the Council following financial difficulties experienced by SEQOL. A new management structure has been established and we have successfully recruited to a Head of Transitions post, Head of Commissioning, Head of Social Work and Regulated Services Manager. In light of the strategic direction and the Special Educational Needs Reforms, Swindon Borough Council transferred Learning Disability social work services from SEQOL to the Council in October 2015.

There are strong links between the provider of integrated community health and social care services and all partners, particularly the local hospital, care homes, voluntary sector and primary care. We have invested in My Care, My Support website at http://www.mycaremysupport.co.uk/ giving advice and information about health and social care as well as a community based advice service. We have also worked to improve urgent care, however there is more to do.

Our vision is that by 2020 everybody in Swindon will work together with a common set of values and principles based on respect, giving people choice, collaboration and innovation, where people are encouraged to think what they can do themselves, what help they have within their family and community and what they still need help with. When people need help it will be personalised, offering choice and control.

Outcomes for Adult with Needs will improve by 2020 in line with the Better Care Fund (BCF) and Swindon's vision for integrated health and social care:

- Emergency hospital admissions will be avoided for specific groups of patients, particularly those suffering from diabetes and heart conditions
- More patients will be able to leave hospital without delay and three or more long term conditions
- Fewer older people will be admitted to residential care, through support provided at home and flexible housing with care, reducing isolation amongst older people
- Reablement will be an integral part of all domiciliary care and will mean that fewer patients will be re-admitted to hospital
- More people with a learning disability will be able to find employment through support commissioned from the voluntary and third sector and in partnership with our Skills for Employment.

Our commissioning intentions

Swindon's commissioning intentions are covered in The Better Care Fund 2017 which includes a detailed action plan. The Better care Fund for Swindon is also seen as Swindon's commissioning strategy.

Also see Bath and North East Somerset, Swindon and Wiltshire's Sustainability and Transformation Plan (STP) A short guide: http://www.wiltshireccg.nhs.uk/wp-content/uploads/2016/04/STP-short-guide.pdf

6. Commissioning principles and standards

Swindon's Market Position Statement incorporates published commissioning standards developed by the University of Birmingham, Think Local Act Personal (TLAP), and the Department of Health, published by the Local Government Association. The framework consists of twelve standards, grouped into four domains that underpin effective commissioning and set out what good commissioning looks like. There is an emphasis on effective commissioning not being able to be achieved in isolation and without collaboration.

Domain	Description	Standards
Person-centred and outcomes-focused	This domain covers the quality of experience of people who use social care services, their families and carers and local communities. It considers the outcomes of social care at both an individual and population level.	1. Person-centred and focuses on outcomes 2. Promotes health and wellbeing 3. Delivers social value
Inclusive	This domain covers the inclusivity of commissioning, both in terms of the process and outcomes.	4. Coproduced with local people, their carers and communities 5. Positive engagement with providers 6. Promotes equality
Well led	This domain covers how well led commissioning is by the Local Authority, including how commissioning of social care is supported by both the wider organisation and partner organisations.	7. Well led 8. A whole system approach 9. Uses evidence about what works
Promotes a sustainable and diverse market place	This domain covers the promotion of a vibrant, diverse and sustainable market, where improving quality and safety is integral to commissioning decisions.	10. A diverse and sustainable market 11. Provides value for money 12. Develops the workforce

These standards underpin Swindon's future social care commissioning and procurement practice:

1. **Person-centred and focuses on outcomes**
   Good commissioning is person-centred and focuses on what people say matters most to them. It empowers people to have choice and control in their lives and over their care and support.

2. **Promotes health and wellbeing for all**
   Good commissioning promotes health and wellbeing, including physical, mental, emotional, social and economic wellbeing.

3. **Delivers social value**
   Good commissioning provides value for the community not just the individual, commissioner or the provider.

4. **Co-produced with people and their communities**
   Good commissioning starts with an understanding that the people using services, and their communities, are experts in their own lives and what good outcomes look like for them. Good commissioning creates

meaningful opportunities for the leadership and engagement of people and communities in decisions that impact on the use of resources and shape of services locally.

5. **Promotes positive engagement with providers**
   Good commissioning promotes positive engagement with all providers of care and support. This means market shaping and commissioning should be collective endeavor's, with commissioners working alongside providers and people with care and support needs, carers, family members and the public to find shared and agreed solutions.

6. **Promotes equality**
   Good commissioning promotes equality of opportunity and is focused on reducing inequalities in health and wellbeing between different people and communities.

7. **Well-led by local authorities**
   Good commissioning is well led within Local Authorities through the leadership, values and behaviour of elected members, senior leaders and commissioners of services, underpinned by principles of co-production, personalisation, integration and the promotion of health and wellbeing.

8. **Demonstrates a whole system approach**
   Good commissioning convenes and leads a whole system approach to ensure the best use of all resources in a local area through joint approaches between the public, voluntary and private sectors to improve outcomes.
9. **Uses evidence about what works**
   Good commissioning uses evidence about what works; using a wide range of information to promote quality outcomes for people and communities, and to support innovation.

10. **Ensures diversity, sustainability and quality of the market**
    Good commissioning ensures a vibrant diverse and sustainable market to deliver positive outcomes for citizens and communities.

11. **Provides value for money**
    Good commissioning provides value for money through identifying solutions that ensure a good balance of quality and cost to make the best use of resources and achieve the most positive outcomes for people and their communities.

12. **Develops commissioning and provider workforce**
    Good commissioning requires competent and effective commissioners and facilitates the development of an effective, sufficient, trained and motivated social care workforce. It is concerned with sustainability, including the financial stability of providers and the coordination of health and care workforce planning

European Union (EU) procurement regulations apply to all public procurement exercises started after 26 February 2015. Under the new rules means Part B services have either been abolished or replaced by a new Light Touch Regime. Procurement for those services above the value £625,050 (over the contract period) must be tendered via OJEU and comply with new EU transparency and equal treatment principles, and publish contract award notices. Whereas the award of any contract over £25,000 up to the OJEU threshold must be published in Contracts Finder (the UK Governments' procurement web portal).

7. The voice of Adults with Needs in commissioning services

We are committed to hearing the voice of the adults with needs and their carers throughout the commissioning process. Therefore we will adhere to the following;

- Ensuring that the voice of people using services contribute to our JSNA
- Ensuring that we meet with adults with needs/their families when conducting annual monitoring visits
- Request satisfaction surveys from providers and action plans in response to these
- Ensure that we co – produce the development of new services with adults with needs and their carers
- Ensure that the communication from user forums is fed into provider forums and that actions are monitored and fed back to the user forums on what has changed.

8. Market Shaping and Oversight

Market Development

Swindon Borough Council will support the care market development through:

- Adopting an outcome based approach to commissioning services and working with providers to develop and deliver person centred services
- Working with providers to ensure they offer continuously improving, high-quality and innovative service provision supported by a highly-trained workforce
- Ensuring that local commissioning practices and services delivered comply with the requirements of the Equality Act 2010
- Working with providers and wider stakeholders to develop a sustainable market for care and support
- Encouraging a diversity of providers and different types of services to deliver a range of outcomes
- Having due regard to the sufficiency of provision, in terms of capacity and capability, to meet anticipated needs for people requiring care and support
- Understanding the market through a increased knowledge, understanding and awareness of providers' businesses

Quality assurance

The provision of high quality social care and support is a key outcome for adults in need, carers, service providers and commissioners alike, and it is important, particularly at a time when financial pressures are increasing, that the issue of quality is not overlooked.

We recognise that the financial climate is a challenge too for providers and therefore we are committed to working collaboratively with providers to build relationships and trust in which honest and open support and challenge can take place. We will actively work with providers through our commissioning arrangements to strive for the highest standards of services.

We will build on the existing Provider Forums that are in place for Residential and Nursing Homes, Learning Disability and Domiciliary Care whereby they increasingly promote and develop quality and standards.

We will continue to build on our existing relationship with CQC locally, with the CCG, to further develop a coordinated response to quality matters as they occur. Our approach to quality monitoring will be to openly challenge and to also offer support. We will develop a virtual quality support team with partners that can be called upon to aid providers requiring support in a variety of aspects.

Performance Framework for Contract Management

1. Robust governance arrangements in place

Evidenced by contract documentation outlining:

- Robust governance structures & arrangements – role of Members in management & scrutiny of contracts
- Contract has clear objectives, purpose or outcomes
- Clear roles & responsibilities of all parties
- Performance targets, reporting requirements and review timescales in place
- Identified key risks, equality issues and legal terms & conditions
- Clear contract payment terms
- and timescales

2. Appropriate reporting requirements

Evidenced by:

- You can easily see if the contract is meeting and progressing the expected outcomes
- There is a mixture of performance, financial and risk data regularly provided
- Customer feedback information is available – surveys, compliments and complaints
- Performance and financial data can be externally benchmarked
- The contract driving the right behaviours without creating perverse incentives

3. Effective monitoring of the contract

- The provider supplying timely and accurate performance and finance reports
- Monitoring the service against measures/standards/targets set out in contract documentation
- Early identification and resolution of delivery failure/declining performance
- Spot check or audits of provider information to confirm accuracy and progress
- Annual review of progress and agreement of next year's targets
- Regular review meetings involving all relevant people

4. Additional questions to consider

- Is the process for making variations and amendments clearly stated in key documents?
- How do our costs compare to other areas?
- Are we getting value for money?
- Do we need to re-negotiate any targets?
- Are the right support services involved at the right stages?
- Should we use the break clause in the contract?

9. Contingency planning for business failure

The Care Act 2014 sets out duties that require Councils to act should a regulated care provider business fail. Under the Act, Councils have a temporary duty to meet people's needs where a care provider is unable to continue to operate due to a business failure. The duty applies to all people receiving care from registered care providers providing regulated care activities who are registered as operating in the borough, whether or not the local authority organises or pays for that care.

The duty aims to ensure people's needs are met where a business has failed and services can no longer be provided. However, in most cases where a business fails administrators will be in place and continue to run the business until it can either close in a planned way or a buyer found – in these planned cases the duty would not be triggered.

In cases where there is an imminent failure then Councils will have a duty to act. The Act outlines that Councils must meet the needs for care and support which were being met immediately before the business failure for 'as long as it considers necessary' and 'as soon as they become aware of the failure'. The temporary duty also extends to where the person is a self-funder. The Council can charge for meeting care and support needs (except for the provision of information or advice) that it arranges in response to a business failure. However, the Council has no powers to intervene for those people placed who in receipt of NHS funded Continuing Healthcare, these cases remain the responsibility of the NHS.

As a consequence of these duties Swindon will develop:

- A 'Business Continuity Plan for Business Failure'
- The establishment of incident response teams consisting of social work, commissioning and finance lead officers to respond to individual provider business failure events – the incident teams will include NHS colleagues where the failure involves NHS funded placements

Swindon will also ensure:

- The maintaining of resident / service user registers by Swindon's care and support providers
- Robust financial checks in all tendering activity
- The proportionate financial 'health-checks' of regulated care and support providers in Swindon
- Maintaining up to date provider information including vacancy and capacity information.

Under the Act the Care Quality Commission has a prescribed duty to assess and monitor the sustainability of those "hard to replace" regulated care providers and as such is required to share business intelligence with the relevant local authorities.

10. Partnership working and collaboration

Swindon will promote and develop greater links with other public agencies as part of its duty to co-operate. We partnership working and collaboration as key to successful commissioning and therefore we will:

- Work with NHS Swindon CCG colleagues to promote greater integration with the NHS and other health- related services and to ensure an integrated response to the Council's prevention and wellbeing duties
- Work strategically with local and regional and sub-regional partnerships to learn, share and collaborate across our commissioning and care and support functions
- Work in partnership with other local authorities, in particular those bordering Swindon, on individual care and support need matters as they arise.

11. Key messages for the social care market

- Swindon is committed to the principles of promoting wellbeing and prevention, and in helping people to achieve the best outcomes that matter to them in their life.

- Our approach will promote practices and interventions that delay and prevent long-term or future care needs, and which support people to live as independently as possible for as long as possible; and that also support the needs of carers.

- Through the BCF Plan the Swindon Borough Council and Swindon CCG are also similarly committed to delivering integrated community based health and social care services that are:

  - person-centred
  - of the highest quality
  - safe, sustainable and affordable
  - co-designed with professional and voluntary groups, and patient representatives
  - focused on the needs of the individual and local population
  - continuously improving based on the "learning from experience approach"
  - designed to facilitate greater self-care for those for whom it is appropriate
  - innovative in their design and delivery and apply best practice

- The Council will actively embed the prevention and wellbeing principles throughout all adult social care commissioning and procurement processes.

- We will continue the trend toward outcome-based commissioning, working with providers to build trust and relationships to empower them to deliver individual outcomes through a person centred approach.

- People often only need limited assistance at times of crisis or when events cause short-term difficulties as a result we will further invest in preventative and early intervention services in the borough and work with NHS partners to promote access to universal services that support prevention and promote wellbeing and which encourage a culture of self-care.

- We will further develop and maximise the use of local housing support services to maintain and promote independence

- We know that alternate solutions such as equipment and assistive technology can have a significant impact enabling people to live independently. As a result we will continue to invest in this area as we know that these solutions are vital in supporting independence, dignity and

wellbeing.

12. Older People

Population Profile

Population Projection	2011	2016	2021	2026	2031
People aged 65+	29,069	34,009	39,504	46,458	54,976

Source: SBC population projections: http://swindonjsna.co.uk/Files/Files/Population-Projections-to-2031.pdf

The largest increase in persons in the population growth will be in the 65 to 74 age group, projected to be 12,900 more by 2031. However, the 85 plus age group will have the largest growth rate at approximately 136%. By 2031 the population aged over 65 is projected to grow by 25,900 persons to reach a total of about 55,000 by 2031, accounting for 46% of total population growth.

In Swindon, in 2013-15, life expectancy is 79.6 years for males and 82.8 years for females, which is similar to England. Males in Swindon will spend 80.5% of their lives in good health, around 64 years, whereas women will only spend 74.4% in good health, around 62 years. At age 65, life expectancy for males in Swindon is an additional 18.5 years compared to 20.9 years for females. However, there is little difference between sexes in the remaining length of time spent in good health (12.2 years compared to 11.2 years). Causes of premature mortality in Swindon are changing. In 2001-03, 36% of deaths under 75 were from cancer and 30% from cardiovascular disease (CVD) but by 2012-14, 41% were from cancer and 23% from CVD.

Meanwhile, the gap in life expectancy between the least and most deprived has reduced significantly amongst the female population but risen slightly amongst the male population. In the most deprived areas of Swindon, men die on average 9.7 years earlier and women 4.0 years earlier than those in the least deprived areas.

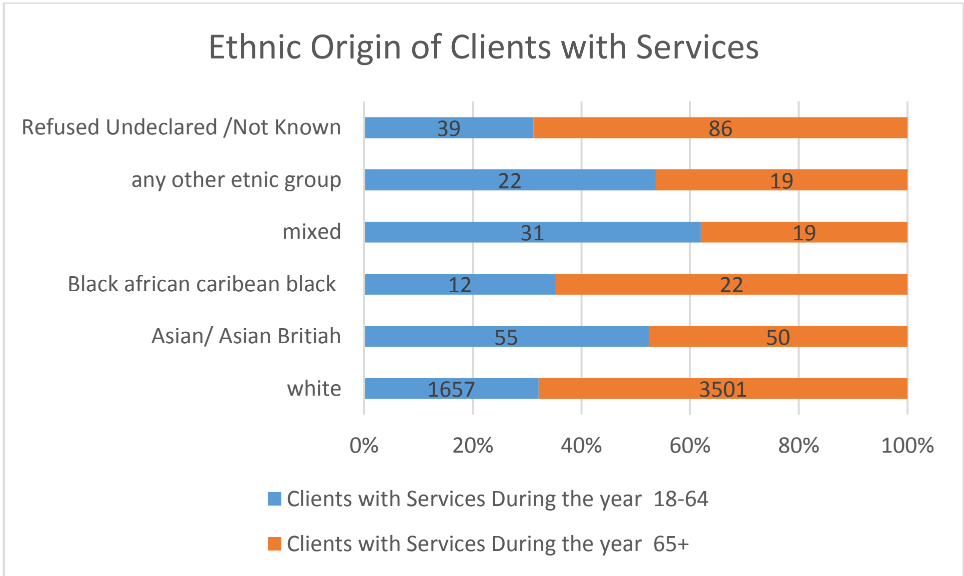
Based on national population projections, which show less growth in Swindon's elderly population because they don't take new housing into account, the following projections of the number of over 65s projected to have certain conditions or limitations have been calculated. These numbers can be regarded as conservative estimates if the prevalence of these conditions remains unchanged in future years. Many elderly people will have more than one of these conditions or limitations.

Number of over 65s in Swindon projected to have certain conditions or limitations

	2015	2020	2025	2030	% increase 2015 to 2030
Dementia	2,280	2,727	3,259	3,979	75%
A long standing health condition caused by stroke	766	890	1,042	1,228	60%
A long-term illness limiting day to day activities a lot	7,745	9,005	10,694	12,653	63%
An admission to hospital because of a fall	677	792	957	1,124	66%
A BMI of 30 or more	8,683	9,927	11,398	13,272	53%
Type 1 or Type 2 diabetes	4,135	4,787	5,525	6,494	57%

Source: Projecting Older People Population Information System (POPPI)

The graph below shows the ethnic origin across the age groups of people who received a funded social care services during 16/17



Demand and supply profile

During 2016/17 Swindon supported 3697 older people aged 65+ with funded support services. This is a 2% increase on the previous year equating to an additional 69 older people.

Older People 65+ who received funded support services during 16/17 by primary support reason

Adults 65+ who received funded Services	16/17
Physical Support	3210
Sensory Support	109
Mental Health Support	118
Memory and Cognition	181
Learning Disability	79

Those services are broken down into 4 key types to support the different care pathways, shown as follows:

- Services to help maintain mobility and independence such as equipment, adaptations, telecare /home alarms and sensors. In 16/17 1904 older people aged 65+ received equipment services which is an increase on the previous year of 4.5%

- Preventative support services to support people out of crisis and help remain at home such as rapid response services to reduce the risk of hospital admission, hospital discharge homecare to support those who are more vulnerable following a hospital episode, reablement services to help people retain and regain skills and independence. In 16/17 1162 older people aged 65+ received preventative services which is an increase of 3.7% on the previous year.

- Community support services to help individuals remain living in the community, these services are aimed at promoting independence, improving quality of life, reducing social isolation and to help people help themselves to continue living fulfilled lives. These will include day opportunities, personal budgets & direct payments, short term breaks and homecare services. In 16/17 1245 older people aged 65+ received community support which is 2.7% increase on the previous year.

- Care Home Placements for when individuals are no longer able to maintain their independence t home. In 16/17 481 older people aged 65+ were in a permanent placement during the period, which is a reduction of 4% on the previous year, reflecting our aim to reduce long term placements for as long as possible by using more appropriate community support

The activity data for last year is indicated below;

Number of service users receiving Community Services in Swindon between April 16 to March 2017

Primary Support Reason	Services to help users maintain mobility & independence; Adaptations, Equipment, & Telecare (e.g. home alarms & sensors)		Preventative services to support users during crisis & help remain independent; Crisis support, hospital discharge services & reablement		Community Services to help users remain independent & living in the community; Homecare services, day care support, direct payments, short term breaks		
	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17	
Learning Disability Support	53	68	17	12	480	499	
Mental Health Support	5	5	4	3	84	87	
Physical Support - Access & Mobilty only	416	476	3	5	11	15	
Physical Support - Personal Care Support	232	199	78	92	266	293	
Sensory Support - Support for Dual Impairment	2	1	0	0	4	8	
Sensory Support - Support for Hearing Impairment	14	7	1	0	0	0	
Sensory Support - Support for Visual Impairment	24	11	1	2	8	5	
Support with Memory & Cognition	3	1	0	0	11	9	
18 -64 Year Old Total	**749**	**768**	**104**	**114**	**864**	**916**	
	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17	Apri Nov
Learning Disability Support	11	13	5	2	42	47	
Mental Health Support	14	13	13	4	43	45	
Physical Support - Access & Mobilty only	865	1239	61	45	21	24	

Physical Support - Personal Care Support	760	550	978	1071	972	1037
Sensory Support - Support for Dual Impairment	29	10	11	4	18	12
Sensory Support - Support for Hearing Impairment	46	23	17	9	6	7
Sensory Support - Support for Visual Impairment	56	35	17	14	22	13
Support with Memory and Cognition	40	21	19	13	88	60
65+ Year Old Total	**1821**	**1904**	**1121**	**1162**	**1212**	**1245**

Care Home Provision

Admissions to residential and nursing care have being effectively managed and remain below target for both younger adults (aged 18-64) and older adults (aged 65 and over). During 2016/17, 192 older people have been admitted to permanent care: 102 to a nursing home placement and 90 to residential care. Amongst these first time permanent admission to care**,** 21 people were admitted with mental health needs, one with a learning disability and 170 people with personal care/physical support needs (older people). The target for the year was to admit no more than 228 older people (a rate of 689.52 per 100k population). Current performance is 580.65 per 100k population aged 65 and over which puts us ahead of our year-end target. During 2016/17, nine younger adults were admitted to permanent care: two to nursing care placements and seven to residential care. Amongst these new admissions to permanent care, three are people with physical care needs, three people have mental health needs and three people have a learning disability. Our rate for first time permanent admissions for younger adults is 6.66 per 100k against a target of 8.89.

Number of service users receiving Permanent Nursing & Residential care in Swindon between April 16 to March 2017

	18-64 Year Olds				65+ Year Olds			
Primary Support Reason	**Nursing Care**		**Residential Care**		**Nursing Care**		**Residential Care**	
	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17
Physical Support: Access and Mobility Only	0	0	0	0	4	0	3	3

Physical Support: Personal Care Support	3	5	13	19	221	298	287	297
Sensory Support: Support for Visual Impairment	0	0	0	0	3	1	5	4
Sensory Support: Support for Hearing Impairment	0	0	0	0	1	1	2	1
Sensory Support: Support for Dual Impairment	0	0	0	0	2	1	5	2
Support with Memory and Cognition	2	2	4	4	63	48	124	88
Learning Disability Support	6	3	165	171	8	9	38	40
Mental Health Support	3	4	38	39	7	17	37	46
Totals	**14**	**14**	**220**	**233**	**309**	**375**	**501**	**481**

Dementia Care

Dementia is a key priority for Swindon in the context of an increasingly older population and likely demand on health and social care services. It is estimated over 2,300 people in Swindon have dementia (based on the Joint Strategic Needs Assessment) and most people wait on average 3 years before reporting symptoms to their GP. People live on average 7-10 years with dementia once diagnosed but this varies by person. Different types of dementia produce different symptoms, depending on which part of the brain is affected and services and support need to reflect an understanding of this. The latest published data (2015/16) records prevalence for dementia in Swindon is 0.62% for all ages and 4.04% for age 65+. This compares to 0.76% and 4.31% for England. March 2017 data for NHS Swindon CCG shows an estimated diagnosis rate of 62.5% compared to a national estimate of 67.6%.

Projected growth in numbers of People aged 65+ in Swindon Borough with dementia:

Swindon Borough	2011	2016	2021	2026	2031	2036
People aged 65-69	107	131	138	166	194	215

People aged 70-74	183	220	273	288	346	386
People aged 75-79	330	351	431	537	568	628
People aged 80-84	517	557	614	760	955	1064
People aged 85-89	532	600	687	775	985	1099
People aged 90+	353	514	718	943	1198	1409
Total population aged 65+	**2022**	**2372**	**2861**	**3469**	**4246**	**4802**

Source: Family Resources Survey 2015/16 available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600465/family-resources-survey-2015-16.pdf

Work continues to develop a clear community pathway for dementia led by the Dementia Steering Group. Great Western Hospital launched a dementia strategy in 2017 and held a successful event in Steam on 18th May to coincide with National Dementia Awareness Week which SBC were involved with. A Dementia Friendly Swindon Co-ordinator (funded by One Swindon) started on 24th April to work with businesses and others in the community to make Swindon dementia friendly. Swindon has guidance for dementia friendly housing provision and is drafting a specialist housing supplementary planning document (SPD) which is relevant for dementia care.

Extra Care and Day Support

There are currently four Extra Care settings who have commissioned care provided by Swindon Borough Council; there are a number of private Extra Care settings in Swindon run by housing providers. Some of the care packages are privately funded. The four Extra Care settings include one where the building is owned by Swindon Borough Council; the other three are owned and supported by three different housing providers.

There is day support provided on all four Extra Care sites providing a range of support.

	Maple Court	The Ridings	Newburgh	Harry Garrett
No of flats	51 with 21 receiving care/support	30 with 14 receiving care/support	47 with 32 receiving care/support	41 with 25 receiving care/support
% /no of residents with general needs	0%	29%	31%	0%
%/ residents with medium needs	83%	64%	53%	60%
% residents with high needs	17%	7%	16%	40%
% residents with diagnosed dementia	23%	21%	9%	27%

% residents with signs of dementia without a diagnosis	29%	36%	31%	36%

Commissioning Activity for Older People:
• During 2017/2018 we will commission a residential and nursing home framework with Swindon CCG. We will work with the market to shape levels of care and an outcome based framework to include in the tender. • During 2017/2018 we will jointly commission Extra Care and Day Support following a review and reshaping of both services including a change to the referral process into Extra Care • A key task of the Health and Care community is to help older people to move into the "Ageing Well" segment (while remaining there as long as possible), and to prepare middle-aged people for a later life which builds on "Ageing Well" principles. This task involves mental health as much as physical health. People in deprived areas have the most to gain from such initiatives. • Work is ongoing to develop community initiatives and awareness of existing activities focused on ageing well including keeping people active, promoting balance and strength, reducing loneliness and social isolation and encouraging social engagement. • By 2020 Swindon will be a dementia friendly community. Older people suffering from dementia have good diagnosis in place with support groups operated in the community and more use of dementia cafés and activities. Community and social care providers support people suffering from dementia and are skilled and sensitive to their needs.

13. Domiciliary Care and Care at Home

Population Profile

Domiciliary care plays an important part in the enablement of adults with needs particularly in the discharge from hospital and in the avoidance of delayed discharge. The link of domiciliary care with occupational and physiotherapy is crucial in the delivery of sustained outcomes.

Total Number of New Homecare Clients Split by Age Band, Category and Number of hours per week. Period 2016/17					
Client Category	**Less than 5 Hrs per Week**	**Greater than 5 - 11 Hrs per week**	**Greater than 11 - 18 Hrs per week**	**Greater than 18 Hrs per week**	**Total**
Personal Care Clients aged 18-64	10	30	8	4	52
Personal Care Clients aged 65+	116	170	80	63	429
Mental Health Support /Memory & Cognition 18-64	3	1	3	1	8
Mental Health Support /Memory & Cognition 65+	2	6	3	2	13
Total	**131**	**207**	**94**	**70**	**502**

65+ Group	Homecare Clients during 16/17
Physical Support /Sensory	1555
Mental Health	30
Memory and Cognition	35
Learning Disability	22
Total	**1642**

Demand and supply profile

Population Projection	**2010**	**2015**	**2020**	**2025**	**2030**
Total population aged 65 and over unable to manage at least one domestic task on their own	13,011	13,323	15,541	18,269	21,623

Source: www.poppi.org.uk (based on national not local population projections). 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

There will be a new domiciliary framework in place from 1st July 2017 which will develop the journey further with providers to move to outcome focused, person centre delivery. This will be built on in the commissioning of master vendor(s) for the north and south of Swindon in 2017 which will move from time and task to outcome focused delivery.

Commissioning Activity for Care at Home:
• During 2017 we will commission a domiciliary care framework. These providers will maintain the packages of care they deliver when the master vendor(s) contract is awarded. • Also during 2017 we will commission one or two master vendor(s) to deliver domiciliary care across Swindon.

14. Physical Disabilities and Sensory Impairment

Population profile

Using the provisional outturn 2014/15 data, Swindon is spending £508.55 per older person on Physical Support and Sensory Support (PS&SS) 65+ social care. This is in line with the South West average of £508.38. The actual proportion of Adult Social Care (ASC) spend on PS&SS in Swindon at 25% is lower than the South West average at 31% but this is due to Swindon having a smaller 65 plus population. The actual amount we spend per person on the 65 plus population is in line with the average.

Population Projection	2015	2020	2025	2030
People 18-64 predicted to have a moderate physical disability	10,592	11,258	11,650	11,751
People 18-64 predicted to have a serious physical disability	3,093	3,347	3,511	3,542

Source: Source: www.pansi.org.uk (based on national not local population projections).

Population Projection	2015	2020	2025	2030
People 18-64 predicted to have a severe visual impairment	89	92	94	95
People aged 65+ predicted to have a moderate or severe visual impairment	2,891	3,341	3,957	4,652
People 18-64 predicted to have a moderate or severe hearing impairment	5,259	5,780	6,059	6,075

People 65+ predicted to have a moderate or severe hearing impairment	13,805	16,084	19,291	22,752

Source: www.pansi.org.uk (based on national not local population projections).

Demand and supply profile

During 2016/17 Swindon supported 1816 younger adults aged 18-64 split across the following categories of support need.

Adults 18 – 64 who received funded Services	16/17
Physical Support	896
Sensory Support	29
Mental Health Support	238
Memory and Cogition	15
Learning Disability	638

During 2016/17, nine younger adults were admitted to permanent care: two to nursing care placements and seven to residential care. Amongst these new admissions to permanent care, three are people with physical care needs. Our rate for first time permanent admissions for younger adults is 6.66 per 100k against a target of 8.89.

15. Mental Health

Population Profile

Mental health is an essential component of a persons' health and has an impact on every aspect of life, including how people feel, think and communicate. It impacts on physical health, lifestyle choices, and behaviour. It enables people to manage their lives successfully and live to their full potential. Mental ill health is the largest single source of ill-health in the UK. No other health condition matches mental illness in terms of prevalence, persistence and breadth of impact. In Swindon it is estimated that between 22,600 and 29,000 individuals have a common mental health disorder such as anxiety, depression, phobias, panic and Post Traumatic Stress Disorder. The number of people with mental health conditions looks set to rise over the next couple of decades. Much of this is to do with demographic changes rather than a particular expected increase in prevalence.

Population Projection	2015	2020	2025	2030
People aged 18-64 predicted to have a common mental disorder	22,084	22,819	23,302	23,584

People aged 18-64 predicted to have two or more psychiatric disorders	9,896	10,220	10,436	10,565

Source: www.pansi.org.uk (based on national not local population projections).

Population Projection	2015	2020	2025	2030
People aged 65+ predicted to have depression	2,853	3,277	3,791	4,446
People aged 65+ predicted to have severe depression	905	1,036	1,229	1,445

Source: www.poppi.org.uk (based on national not local population projections).

Swindon GP registers indicate that Swindon's population has slightly higher rates of depression than the national and regional average. Particularly pertinent is the expected increase in the numbers of those over 65 years expected to develop depression. Planning for later life and initiatives to ensure that older people protect themselves from depression should be developed.

We already achieve the 50% IAPT recovery targets and are piloting the national model to support patients identified with LTCs. We will increase baseline mental health spend to facilitate delivery of the Mental Health Investment Standard.

We are working closely with our partners in the STP so that our developments are tied into the workstreams and project plan being developed through the STP as well as the BCF plan. This will ensure that mental health services operate at scale across the STP to deliver system wide pathways of care.

Current demand and supply profile

During 2016/17 Swindon supported 356 adults with mental health support services split between 238 younger adults aged 18-64 and 118 older adults and 65+. This is a 13% drop on the previous year. We know that some of the reasons for this drop has been that some peoples care needs are changing so their care needs now out weighing their mental health needs and therefore those people have changed from having a primary need of mental health to that of physical support need.

Number of service users receiving Community Services in Swindon between April 16 and March 2017

Primary Support Reason	Services to help users maintain mobility & independence; Adaptations, Equipment, & Telecare (e.g. home alarms & sensors)		Preventative services to support users during crisis & help remain independent; Crisis support, hospital discharge services & reablement		Community Services to help users remain independent & living in the community; Homecare services, day care support, direct payments, short term breaks	
	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17	April-Mar 16	April-Mar 17
Mental Health Support 18 – 64 year olds	5	5	4	3	84	87
Mental Health Support 65 + year olds	14	13	13	4	43	45

Commissioning Activity for People with Mental Health:

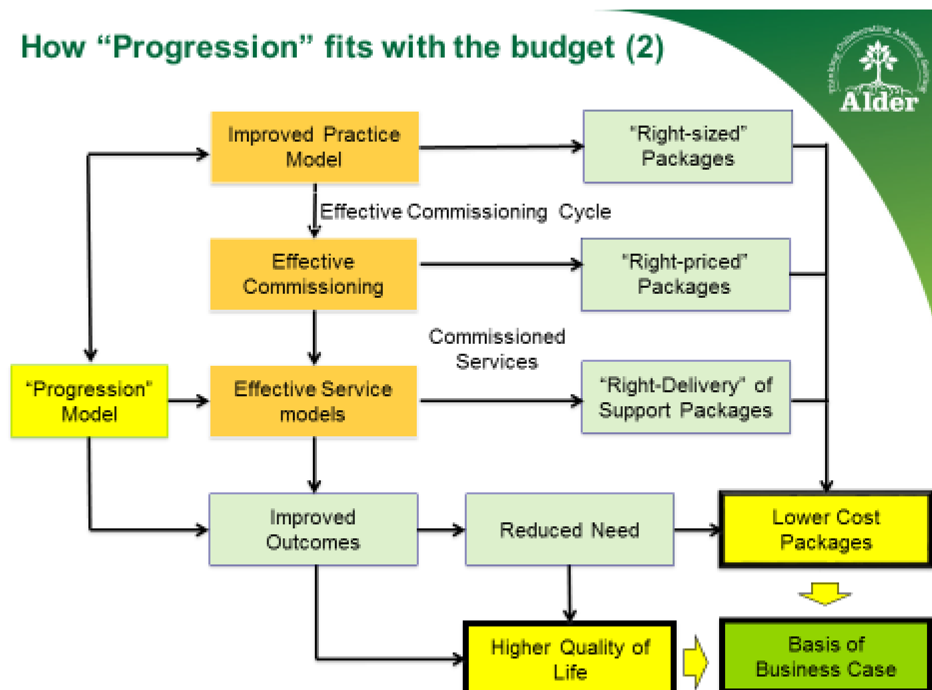
- By 2020 we will have reduced the number of people with mental illness being admitted to an acute ward when presenting with mental health problems and we will have built on the many services in the local community that are amongst the best in the country and need to continue to be supported. Mental health services will be delivered locally with a strong focus on early intervention and recovery. We will have wellbeing coordinators working in voluntary organisations, bringing together specialist and community services for people being discharged and those at risk of mental illness and learning disability
- With Swindon CCG we will develop an Implementation plan for the Mental Health Five Year Forward View for all age groups alongside access and quality standards so there is genuine parity of esteem within our services.
- A joint service commissioned across the STP footprint, enabling more joined up approaches through joint commissioning arrangements of one provider. The contract starts in April 2018.
- Implementation of a single point of access in place for TAMHS/CAMHS services to ensure a seamless service provision. For Eating Disorders, the CAMHS service accepts direct referrals from any professional or parent/carers.

16. Learning Disabilities and Autism

Population Profile

We support in the region of 680 people with a learning disability through social care. 192 of those live in residential care, a proportion higher than in other areas**.** The number of people with a learning disability is expected to rise by 30 people each year as life expectancy rises and a larger number of young people become the responsibility of adult social care each year.

Swindon has a higher number of people with a learning disability living in residential care and high costs supported housing. Our analysis of social work assessments and plans has also found that there is a need to be outcome and progression focused so that people learn new skills. A pilot has been undertaken with Wiltshire, with consultant Alder, on the implementation of progression planning.



Key to this work has been the higher quality of life, through delivery of sustainable outcomes, and also lower cost packages. With both of these comes the opportunity to innovate across the market.

Population Projection	2015	2020	2025	2030
People aged 18-64 predicted to have a learning disability	3,344	3,451	3,529	3,585
People aged 65+ predicted to have a learning disability	687	797	923	1087

Source: www.pansi.org.uk and www.poppi.org.uk (based on national not local population projections).

Demand and Supply Profile

During 2015/16 Swindon supported 717 adults with learning disability support needs split between 638 younger adults aged 18-64 and 79 adults aged 65+. This is an increase of 4.2% on the previous year.

The Swindon and Wiltshire Transforming Care Plan (TCP) is in its first year of implementation. There is multiagency responsibility for delivery and robust governance and performance structures in place to ensure this is successful. A SMART project plan with milestones is in place which will be monitored over its 4-year period by a multiagency project team and the NHS E LD Assurance Manager. Our Transforming care Plan interprets the local actions required to ensure the national requirements for Transforming Care for people with LD and/or Autism are delivered.

The Plan encompasses actions to ensure processes are in place to support unnecessary hospital admissions and lengthy hospital stays; embed workforce development to ensure staff have the right skills in the right place; ensure people and their families have more choice and more say in their care with options for accessing innovative i.e. through Personal Health Budgets; ensuring more care can be provided in the community (including positive daily activities e.g. employment) and in providing more intensive support for those who need it, so that people can stay close to their home.

Work is ongoing to reduce spend on Learning Disability services. Spend per service user in Swindon remains high compared to other authorities. We continue to work with housing colleagues to commission a greater variety of supported living accommodation to reduce the need for care home provision. This year's performance shows more adults with learning disabilities are supported to live in more stable and appropriate settings compared to last year (74.7% vs 71.3%) and take up of paid employment has improved from 3.6% to 5.4% but remains below our target of 6%.

Work opportunities

Access to employment and training is a corporate priority and the multi- agency Transitions Programme will continue to drive improvement over the coming year.

Commissioning Activity for People with a Learning Disability:
• There will be an innovation pilot working with a small number of providers across neighbouring authorities to embed outcome based working • During 2017 we will commission a Supported Living Framework working with providers to create a specification that is outcome based and person centred that promotes progressive support planning. We will also make sure that we work with adults, young people and their parents /carers in the shaping of the specification. • In 2017/2018 we will commission a Learning Disabilities Residential framework, again working with providers and adults with needs and their families to shape the specification. • Implementation of progression and strength based social work assessments

- Development of new housing and support for people with a learning disability
- Case reviews and collaboration with other local authorities and CCGs to reduce the number of people in residential care where appropriate
- Understanding the position of people with autism who have received a health check and have a health action plan in place. This will include assessing current rates of health screening and local mortality rates
- By 2020 if you have a learning disability and are supported by social workers you will have a personalised plan and personal budget in place. You and your carers have fully participated in the plan and own the outcomes to be achieved. You will be supported to be the best you can be with skill development, education, training and employment opportunities identified and pursued. Where possible you are living within the community in supported housing with local support. Community support through volunteers and wellbeing coordinators will support you if you do not require specialist social work support.

17. Transitions – Children's and Adult Services working together

Population Profile

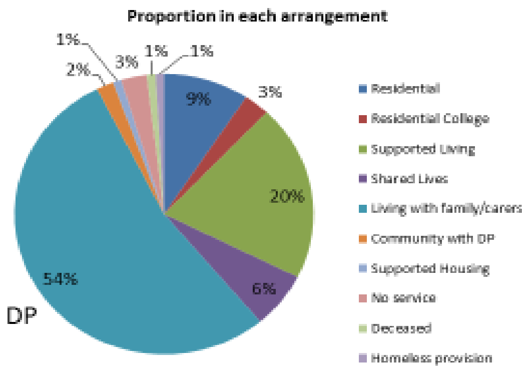
A major focus of work is the Transitions Programme on improving the experience and outcomes for young disabled people making the transition from children's to adult services. We are seeking to identify and achieve savings through changes to the way we work with parents/carers with children with a disability and young people across the 0-25 age range. This includes maximising, where possible, young disabled people's ability to find paid work on leaving school or college and as well as making plans for independent living.

- 30-35 service users transition from Children to Adult Social Care each year
- 60% are 18 years old, and a further 30% are 19 or 20 when they transition
- Looking at the current proportions of recent transition cohorts, the following **new demand** is likely each year, 16-21 who will continue to live with family or carers and 12-15 who will require supported living

Population Projection	2010	2015	2020	2025	2030
Young people who 18 + will transition to Adult Services					

2013-2015 Transitions Cohort

- Between 2013-2015 there were 108 new service users aged 18-25
- Current arrangements are:
  - 10 in residential
  - 3 in residential college
  - 7 in shared lives
  - 22 in supported living
  - 58 living with family or carers
  - 1 in supported housing
  - 1 in homeless provision
  - 2 living in the community with DP
  - 3 with no current service
  - 1 deceased



Demand and Supply Profile

The main aim of the Transitions Programme is to develop a good service user experience that identifies those likely to transfer at an early age and that makes the best use of resources to develop independence wherever possible.

Commissioning for Transitions will be improved through the following actions/outputs:

- Define the market place in the broadest sense, including what is commissioned across the Council and partners
- Learning from other local authorities and work with bordering local authorities
- Understand the whole life costs across a spectrum of need through case investigation
- Co- production with the provider market to shape needs led, outcome focused provision
- A market position statement including transitions
- A Joint Commissioning Transitions Strategy across health, education and social care

Commissioning Activity for Transitions:
• The Transitions Programme will drive improvement in helping more people with a learning disability into paid employment and live independently. Work is underway to support a number of young people aged 16-25 years with Education Health and Care Plan to participate in supported internships. The aspiration is for the young people to complete these courses and for them to be skilled to enter employment. • Work will be undertaken in 2017 with providers to agree an outcomes framework for transitions, develop a move from the current residential/supported living model,

exploration of other models of support, alignment of outcomes with the voluntary and community sector and to reduce costs for general and complex levels of need.

18. Substance Misuse

Population Profile

Population Projection	2015	2020	2025	2030
Adults aged 18-64 predicted to have alcohol dependence	8290	8552	8732	8846
Adults aged 18-64 predicted to be dependent on drugs	4691	4841	4943	5007

Source: www.pansi.org.uk and www.poppi.org.uk (based on national not local population projections).

In 2015/2016, it is estimated that there are 1,147 Opiate and Crack users in the local area, which is equivalent to eight in 1,000 people. 53% of the estimated number of OCUs in Swindon were engaged in structured treatment, which is 2% lower than the national average of 55%. (Source: Swindon JSNA http://www.swindonjsna.co.uk/dna/Substance-misuse-needs-assessment) More men than women engage with treatment services locally compared to the national average. Between September 2015 and August 2016 there were 165 clients presenting with opiate and /or crack use which has increased by 8% from last year.

Between September 2015 and August 2016 CGL had engaged 1,250 clients in drug or alcohol treatment. In line with national profile the age of clients accessing treatment is rising. Over half of those entering treatment with CGL in Swindon were over 35 years of age. 27 clients reported that their problematic drug use had started before the age of 18. Many of these clients have long term health problems as well as their addiction issues. 744 clients were effectively treated.

Alcohol

According to the North West Public Health Observatory (NWPHO) alcohol profiles and the Department of Health's Alcohol Learning Centre (ALC), Swindon has an estimated 31,000 hazardous drinkers, 7,500 harmful, 4,046 dependent and 25,000 binge drinkers.

The total number of alcohol specific admissions has risen from 996 in 2013/14 to 1,174 in 2014/15. Numbers have increased for males and females by similar amounts. There are approximately twice as many admissions for males than females. The number of admissions peaks for males and females between the ages of 41 and 50. Admissions have risen in most age groups for males and females with the notable exception of the under 21 age group.

For alcohol, Swindon's treatment population age profile is broadly similar to that seen in treatment services nationally, although the profile is narrower with fewer clients from both younger and older age cohorts and a higher proportion of 40-49 year old clients than seen nationally.

Dual Diagnosis

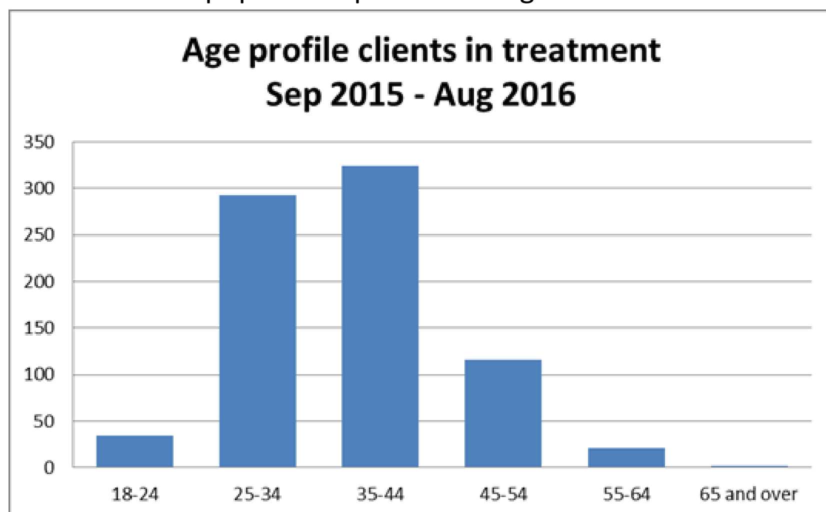
CGL, Swindon's local substance misuse treatment service, report that just over 13% of their current clients have been identified as have a significant mental health problem, while the higher number are within the drug treatment service (113 clients, 13% of drug treatment population) a slightly higher proportion with a dual diagnosis are within the alcohol service (56 clients, 16% of alcohol treatment population). A third of clients across drug and alcohol treatment services with dual diagnosis are female, with a higher proportion of these accessing drug treatment. The age distribution of dual diagnosis also mirrors the general age profile of services with the drug service treating a greater proportion of younger clients compared with the alcohol service.

BME Communities

There has been a substantial improvement in reporting of ethnicity as previously 98% of clients in drug treatment services identified as White, which now stands at 92%, with the general Swindon population in the 2011 census being 89.8% White.

Age Profile

The treatment population profiles for age is shown below:



Demand and Supply Profile

There is one provider for the drug and alcohol service for adults in Swindon Change, Grow, Live (CGL).

The current substance misuse treatment services provided in Swindon includes;

- Alcohol liaison nurses at GWH
- Criminal justice workers

- Street drinkers outreach
- Shared care – GP practices
- Needle Exchange Pharmacies, specialist provision (including image and performance enhancing drugs) available at Temple Street.
- Naloxone widely available
- Tele Health online support
- Hep C positive support group
- U-turn - young people's treatment
- Prevention campaigns
- SUST – Service User representatives
- Non-commissioned services – 9 mutual aid services, viewable on MyCare MySupport
- Families and carer support group – Time4Us and CGL
- Residential Rehabilitation
- Liaison with midwifery, NSPCC (support for parents)
- Dual diagnosis
- Licensing and trading services

Most substance misuse treatment interventions in Swindon are delivered in the community. For those that demonstrate higher levels of risk and need a residential placement may be considered. In order to access such a placement service users need to demonstrate they are ready for active change and a higher intensity of treatment. Inpatient/residential placements are considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example, housing) problems.

Swindon has a well-established targeted residential treatment pathway which has been recently reviewed, to now include review of community detox and support options. 58 referrals were received for consideration by the panel in 2016/17, compared with 41 in 2015/16. In 2016/17 12 rehab placements have been made with 9 admissions for inpatient detox.

Commissioning Activity for Substance Misuse:
• During 2017 we will commission a new substance misuse service to be in place by 2018. This will be undertaken with Wiltshire and be a combined tender for combined services across both Swindon and Wiltshire.

19. Supported Housing

Population Profile

Supported Housing provides accommodation based services with housing related support. These schemes enable individuals to develop the skills needed to live independently. We also have services

which support people who are living in their own accommodation who need to develop skills to maintain this going forward.

These services often accommodate individuals who do not meet the Adult Social Care threshold however need support to live independently. In doing so, this may prevent individuals requiring services from Adult Social Care in the future. These services can also be used as a step down option when people no longer need involvement from Adult Social Care, but are not yet ready to live independently.

Number of People accessing Supported Housing in 2015/16 and 2016/17

Client Group	2015/16	2016/17
Domestic Abuse	84	92
Homelessness	538	582
Learning Disabilities	42	40
Mental Health	63	64
Young People and Young Families	362	344
Total	**1089**	**1122**

Demand and Supply Profile

Across Swindon, there are 403 units of Supported Housing and two Floating Support teams providing support to 167 people in their own home. 1122 people accessed supported housing services in 2016/17. This was an increase on the number of people accommodated in 2015/16 (1089).

There were 991 new referrals made to the supported housing services in 2016/17. Of the 1030 people supported, 94% were from the Swindon area. The average stay in supported housing is 15 months, however this does vary depending on the client group. There were 88 people in 2016/17 who had been in a supported housing scheme for longer than two years. The journey towards independence will be different from person to person and this will be part of the discussion from the point an individual moves into supported housing. These services are temporary accommodation services and we have been working with providers to ensure that there are no barriers to stop individuals moving onto more independent living when they are ready.

In 2016/17, 533 people left the supported housing schemes or ceased their involvement with the floating support teams. Of these, 65% of people made a positive onwards step on their journey to independence. This is a small decrease on the positive move on rate for individuals that left the schemes in 2016/17 (74%).

One of the key outcomes in helping individuals on their journey towards more independent living is assisting people into work or education. The aim is for 60% of people to be supported into education, employment or training (EET) within six months. 36% of individuals who left the schemes in 2016/17 were recorded as being in education, employment or training. This will continue to be a key focus within the schemes going forward and we are working with providers, colleagues and stakeholders to develop opportunities and training for the benefit of service users. In particular we work closely with the Routes to Employment Team to look at ways of supporting service users in this area.

Recently we have facilitated GOALS training (Gaining Opportunities and Living Skills) to assist individuals in setting and reaching achievable goals.

Commissioning Activity for Supported Housing:
• The learning disabilities and domestic abuse supported housing services were re commissioned in 2016/17. • The young persons and mental health supported housing services are being re commissioned in 2017/18. • The homelessness supported housing services are due to be re commissioned in 2018/19. • The re commissioning across all supported housing services is outcome focused. • In all re commissioning projects, we have been, and will continue to work with service users, stakeholders, current providers and the wider market when defining the specification.

20. Direct Payments

Our aim is to support independence, and promote choice and control, for people facing difficulties due to disability, mental health issues, effects of age and other circumstances. Through personalisation, people have the opportunity to manage their own resources and determine how their needs will be met by organising their support and services themselves. The national target is for 100% of clients receiving community based long term support to have a personal budget. This year, 1312 of long term community service users have been allocated a personal budget equating to 88%. 362 of these clients (24.3%) are receiving their personal budget through a direct payment. Although performance is below the targets we set ourselves at the beginning of the year, we have increased the percentage of users with personal budgets from 83% (1184) in 2015/16, although direct payments has remained static. The 2015/16 national average for personal budgets was 86.9%. It is pleasing to see that 92.2% (413) of clients with a learning disability have a personal budget and 34.2% (153) are accessing it through a direct payment. Commissioners continue to work closely with providers, especially Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) who have only 45% of clients with a personal budget, to improve access to self-directed support.

18 – 64 group	
Physical Support / Sensory	112

Mental Health / Memory & Cognition	6
Learning Disabilities	152
65+ group	
65-74	27
75-84	29
85+	36
Total	362
Carers one-off	170

21. Support for Carers

Population profile

National evidence shows that carers providing regular and substantial care are at greater risk of poverty, poor health and loss or inability to secure or maintain work. Carers UK report that people caring for more than 20 hours per week are twice as likely to have poor mental health. In Swindon the Carers Centre membership data indicates that the most common relationships to the cared for person were as follows:

- Parent 31%
- Partner 34%
- Son/daughter 11%
- Sibling/other family member 21%
- Friend/neighbour 1%

	18-64	65-84	85+
No of Carers	871	649	108

Current demand and supply

We recognise carers provide regular and substantial support for service users and it is encouraging that we are exceeded our annual target of 70% with over 82% of carers (1342) having an assessment or review of their needs. It is particularly pleasing to see improved access for learning disability carers to annual reviews which suggest long term planning and carer needs around ageing well are becoming embedding in support planning. 130 carers of clients with a learning disability have received a review of need compared with 103 at the same point last year. We have not met our annual targets for the proportion of carers with self-directed support and the proportion of carers receiving support through direct payments. 32% of carers have personal budgets (177 carers) against the annual target of 36%, and 30.9% (170) have a direct payment against the annual target of

34%. Swindon continues to be an outlier compared to the 15/16 England average (77.7%) and South West average (55.4%). We will continue to work with the Swindon Carers Centre to address the shortfall in personal budgets and progress will be monitored regularly.

Although the recent survey we have undertaken has shown more carers are reporting satisfaction with their quality of life and social contact, it has also identified a number of areas for improvement. Compared to the previous survey in 2015/16, recent findings have highlighted a slight reduction in the overall satisfaction of carers with social services, there were fewer carers reporting that they have been included or consulted in discussion about the person they care for, and there was a reduction in the proportion of carers who reported they find it easy to find information about services.

Commissioning Activity for Carers:
• A JSNA for Swindon carers has been completed in 2017 • During 2017 we will commission a new carers contract to commence in January 2018. Work will be done with carers to coproduce the shape of the specification.

22. Prevention and the Voluntary and Community Sector

Population Profile

We currently have a diverse sector of voluntary and community groups meeting a variety of needs across Swindon. A small number of these organisations are directly commissioned by SBC to provide support to people focussed on maintaining independence and increasing wellbeing in order to try to prevent or delay the need for more intensive support.

In 2020 we will have reduced the number of people with mental illness being admitted to an acute ward when presenting with mental health problems and we will have built on the many services in the local community that are amongst the best in the country and need to continue to be supported. Mental health services will be delivered locally with a strong focus on early intervention and recovery. We will have wellbeing coordinators working in voluntary organisations, bringing together specialist and community services for people being discharged and those at risk of mental illness and learning disability.

Demand and Supply

Number of service users/clients worked with 2016/17

Name of Provider	Service Users/Clients worked with or supported in 2016-17
Age UK	173
Alzheimer's Society	112
Cruse – Bereavement Care	71

DHI (Developing Health & Independence)	573
Harbour	337 current registered clients
Headway	65 in Swindon 23 from surrounding areas
Open Door	93 in last workbook
Red Cross	31
SAM (Swindon Advocacy Movement)	222
Swindon MIND	423
Stroke Association	27
Swindon Carers Centre	2322 adult carers registered
TWIGS (Therapeutic Work in Gardening in Swindon)	230 in workbook

Information/Signposting services

Name of Provider	Service Users/Clients worked with or supported in 2016-17
CAS (Citizens Advice Swindon)	9,116 clients presented 16,437 advice issues
Healthwatch	1,167 contacts received
VAS (Voluntary Action Swindon)	n/a – provide support to organisations, not individuals

There are currently 15 voluntary and community sector organisations commissioned to deliver services, on behalf of Swindon Borough Council, to support adults in the community, in addition to the Carers Support contract. The contracts have an emphasis on engagement with local communities, developing community based activities and a focus on encouraging adults into employment.

Sanford House occupies a central location in Swindon and houses several key charitable organisations. This colocation is convenient for people accessing the services and has encouraged joint working across organisations. Citizen's Advice Swindon (CAS) provide a reception service to greet people and answer general queries, including the provision of information from computer stations (including MCMS) and leaflets. Voluntary Action Swindon manages the building.

Citizen's Advice Swindon (CAS, formerly Citizen's Advice Bureaux) provides a range of specialist welfare advice covering: Debt, Benefits, Housing, Immigration, Employment, Family & Relationships, Consumer, Legal rights & processes, Health etc. Provision is a statutory legal requirement for the council to provide for advice and information under the Care Act.

Healthwatch Swindon, provided by The Care Forum, is an independent consumer champion for patients, carers and all those using health and social care services, as well as the wider public. Provision is a statutory legal requirement for the council to provide. We are providing the minimum required. Healthwatch Swindon undertakes the following core functions: Gathering views; and understanding the experiences of patients, carers and the public

The Harbour project has dealt with an increasing number of asylum seekers and refugees over the past year and has, at the same time, engaged more women and children in their support plans.

Swindon Advocacy Movement (SAM), deliver an Advocacy Service that encompassed Independent Mental Capacity Advocacy (IMCA)/Independent Mental Health Advocacy (IMHA) and Care Act statutory requirements. SAM has supported 501 clients during 2016/17

Swindon MIND offers a service for adults aged 18 (16 for the Self-Harmony Counselling service) and above who are experiencing poor mental health, including those who may also have a learning disability diagnosis. Providing early support to prevent escalation of poor mental health services, and support to those stepping down from statutory mental health services, bridging the gap between primary and secondary services. In addition, TWIGS delivers a therapeutic gardening project for adults with poor mental health and CRUSE provides bereavement counselling.

The Home from Hospital provision provided by Red Cross and Age UK has supported service users who are discharged from hospital. This work is designed to give a much more holistic and responsive service to individuals needing support to return home. The service is designed to engage early with patients during their stay in hospital, and provide support to avoid hospital re-admission and ensure reintegration into their community.

Open Door provides community to support to adults with a Learning Disability through a day centre and activities in the community.

DHI provides Support Planning and Direct Payment advice and support to adults with either a Personal Budget through social care or a Personal Health Budget for adults eligible for Continuing Health Care.

The Alzheimer's Society Dementia Advisers help people take control of their lives and make sense of what is happening. From understanding the benefits system to how dementia progresses and the importance of getting your financial affairs in order – Alzheimer's Society's Dementia Advisers can explain about the condition but also refer people to other support services available. The Advice and Information Service is for people with dementia and their carers.

Headway Swindon is a rehabilitation day centre for people with brain injuries, providing a tailored Cognitive Rehabilitation Therapy programme of exercises, tasks and activities for each attendee to help them reach their full potential. Headway also offers help, information and ongoing support to their families and their carers.

Stroke Association provide a communication support service for people who have had a stroke and have been left with aphasia. Carers also can be helped to learn improved communication skills/techniques. The service runs two groups – one which is run by service user volunteers with the support of the coordinator and one run solely by the coordinator. Service users are encouraged to become volunteers and take on roles/responsibilities for the group.

Commissioning Activity for Voluntary and Community Sector:
• During 2017 we have re -commissioned a Reducing Loneliness and Isolation Service. This work will replace the existing Home from Hospital service

- LD Community Support – LD Forum planned for July to consult with people with a LD. This will inform the new contract that needs to be in place by April 2018.
- Support Planning, DP Administration and Managed Accounts – consideration of alternative options (pre-paid cards, virtual accounts) to inform re-commissioning
- Voluntary sector infrastructure support – joint survey of sector needs completed to inform re-commissioning in 2017 for a start date of April 201
- Support for people with a brain injury or stroke – review of current contract with Headway and the Stroke Association to inform re-commissioning

23. Glossary of terms

Term	Definition
ADASS	Association of Directors of Adult Social Services
Advocacy	Supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need. Requirements of organisations and Independent Advocates are prescribed by the Care Act.
Assessment	The process of working out what your needs are. An assessment looks at how you are managing everyday activities such as looking after yourself, household tasks and getting out and about and is used to inform determinations of eligibility for social care services.
Authorised person	Someone who agrees to manage a direct payment for a person who lacks
Capital limits	Determines the extent to which a person with eligible needs could be charged for care and support in relation to their savings and other forms of assets. See upper and lower capital limits. Between the upper and lower capital limits means tested support is available.
Care account	From April 2016 everyone with assessed eligible needs will be entitled to a care account. This will keep track of what a person has accrued towards the cap on care costs.
Care and support plan	Sets out how a person's eligible needs are going to be met and provides information and advice about wellbeing.
Care cap	A cap on the eligible care costs which a person pays over their lifetime. How a person progresses towards the cap will be based on what the cost of meeting their assessed eligible needs would be to the local authority
Clinical Commissioning Groups (CCGs)	Groups of GP Practices that are responsible for commissioning most health and care services for patients. They are responsible for implementing the commissioning roles as set out in the Health and Social
Child or young person in transition	Anyone who is likely to have needs for adult care and support after turning 18.The transition period can start earlier however.

Commissioning	Commissioning is the local authority’s cyclical activity to assess the needs of its local population for care and support services, determining what element of this needs to be arranged by the authority, then designing, delivering, monitoring and evaluating those services to ensure appropriate
Cooperation	Public organisations working together in partnership to ensure a focus on the care and support and health and health-related needs of their local
Co-production	When an individual/ groups are involved as an equal partner(s) in designing the support and services they receive. Co-production recognises that people who use social care services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need social care
Deferred payment agreement (DPA)	People entering residential care can defer paying for their care costs, meaning that they should not have to sell their home during their lifetime. A deferred payment agreement enables a local authority to reclaim care costs through the sale of the person's property (or other security) at a later date
Deprivation of liberty	Restriction of a person’s liberty to the extent that they may be deprived of their liberty – provisions of the Mental Capacity Act 2005 must be applied
DH	Department of Health
Deafblind	The generally accepted definition of Deafblindness is that persons are regarded as Deafblind “if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss” (Think Dual
Direct payment	Payments made directly to someone in need of care and support by their local authority to allow the person greater choice and flexibility about how their care is delivered
Disposable income allowance	In a deferred payment agreement, the amount of income a local authority must leave the deferred payment holder with (unless the deferred payment holder decides to retain less than the allowance)

Term	Definition
Disregard	In a financial assessment, income and capital must be disregarded (ignored) in certain circumstances
Duty	This is something that the law says that someone (in this case, usually a local authority) must do, and that if they do not follow may result in legal
Eligible needs	Needs for care and support which result in an adult being unable to achieve specified outcomes and as a consequence there is or is likely to be a significant impact on the person's well-being
Equity limit	The maximum equity available in a deferred payment agreement from a person's chosen form of security
Financial assessment	An assessment of a person's resources that will calculate how much they will contribute towards the cost of their care and how much the local authority will. This covers both a person's income and capital.
Financial information and advice	A broad spectrum of services whose purpose is to help people plan, prepare and pay for their care costs.
Financial Threshold	Levels of assets set to determine if financial support can be provided by the Council to meet assessed eligibility needs. Until April 2016, if you have savings, investments or property worth over £23,250, you will be asked to pay for all your care.
Floating Support	Service that meets the housing related support needs of people living in their own accommodation within the boundaries of the borough – this is commissioned as a preventative service. It does not provide personal care.
Independent advocate	Someone appointed by the local authority to support and represent a person who has substantial difficulty in being involved with the key care and support planning (or safeguarding) processes, where no appropriate
Independent financial advice	Refers to regulated financial advice services.
Information and advice	Providing knowledge and facts regarding care and support, services available, and helping a person to identify suitable resources or a course of action in relation to their care and support needs.
Lower capital limit	A person with assets below this amount will not need to contribute to the cost of their care and support from their capital, they will only be charged from their income.
Market shaping	Local Authorities with their partners are expected to have an understanding of demand and supply for well-being, health and social care services. They are expected to intervene accordingly to ensure the right services are in situ for the specified population
Minimum income guarantee	When an adult contributes towards their care and support they must still be left with a certain amount of money for themselves after the local authority has charged them. The minimum income guarantee is the minimum amount of income a person must be left with after charging in all settings except a care home. The amounts are set out in regulations and are based on income support, plus any relevant premiums plus 25%.

Term	Definition
National eligibility threshold	This is the level at which a person's needs for care and support, or for support in the case of a carer, reach the point where the local authority must ensure they are met. The local authority has powers (but not duty) to meet ineligible needs, so the link between eligibility and 'council-funded care and
Needs assessment	The process of working out what your needs are. An assessment looks at how you are managing everyday activities such as looking after yourself, household tasks and getting out and about and is used to inform determinations of eligibility for social care services.
Outcomes	In social care, an ‘outcome’ refers to an aim or objective you would like to achieve or need to happen – for example, continuing to live in your own home, or being able to go out and about. You should be able to say which outcomes are the most important to you, and receive support to achieve them. Outcomes are prescribed within the Care Act for determinations of eligibility.
Personal budget	This is a statement that sets out the cost to the local authority of meeting an adult’s assessed unmet eligible care needs. It includes the amount that the adult must pay towards that cost themselves (on the basis of their financial assessment), as well as any amount that the local authority must pay
Person-centred approach	An approach that seeks to involve the person and ensure they can engage as fully as possible. The local authority must take a person-centred approach throughout the assessment and care planning processes, and in all other contact with the person (such as a review of their care and support package)
Preventative	Applies to the provision of services, facilities or resources that prevent a need from occurring, minimise the effect of a disability or help slow down any further deterioration for people with established health conditions, complex care and support needs or caring responsibilities.
Preventative services	An early intervention or activity that supports a person to retain or regain their skills or confidence. A service that prevents a need for care and support occurring, reduces an existing need or delays further deterioration
Prevention	A local authority must provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals’ needs for care and support, or the needs for support of carers
Resource Allocation System (RAS)	System used by Adult Services teams to calculate an estimated budget required to meet the customers care and support needs. Is used to guide the support planning process. The final costs of the care and support deployed are referred to as the Personal Budget.

Term	Definition
Reablement	A structured programme of care provided for a limited period of time, focusing on helping the person to regain skills and capabilities to reduce their needs
Regulated financial advice	Advice from an organisation regulated by the Financial Conduct Authority (FCA)
Review	A review of a person's care and support plans ensures that outcomes continue to be met. Can be planned, unplanned or requested by the person receiving care and support
Safeguarding	The process of ensuring that adults at risk are not being abused, neglected or exploited, and ensuring that people who are deemed unsuitable' do not work with them.
Self-funder	Someone who arranges and pays for their own care and support services and does not receive financial help from the local authority.
Signposting	Pointing people in the direction of information that they should find useful.
Substantial difficulty	The Care Act defines four areas in any one of which a person might have substantial difficulty in being involved in the care and support planning, or safeguarding, processes. This includes substantial difficulty in understanding relevant information, retaining that information, using or weighing that information, and communicating the individual's views, wishes or feelings (whether by talking, using sign language or any other means)
Support plan	A plan developed following assessment that says how customers will spend their personal budget to meet assessed needs/outcomes and stay as well as possible. The local council must agree the plan before it makes the money available.
Supported self-assessment	An assessment carried out jointly by the adult with care and support needs or carer and the local authority, where the adult or carer is willing, able, and has capacity or (in the case of a young carer) is competent.

Term	Definition
Top Up Fee	This is only relevant where a person has exercised their right to choice of accommodation. It means that where a person has chosen a more expensive setting than the amount identified in their personal budget, the top-up fee is the additional amount needed to meet the cost of that setting. This can be paid by a third party, or in limited circumstance, the person
Transition assessment	An assessment of a child or young person, young carer or child's carer that will inform a transition plan to receive care and support from Adults Services.
Transition plan	A statutory requirement for young people and carers if they are likely to need care and support when they turn 18
Wellbeing	Wellbeing is a broad concept, and it is described as relating to the following areas in particular: personal dignity (including treatment of the individual with respect); physical and mental health and emotional wellbeing; protection from abuse and neglect; control by the individual over day-to-day life (including over care and support provided and the way it is provided); participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal relationships; suitability of living accommodation; the individual's contribution to society