Service Specification No.	
Service	Integrated Prevention Services
Commissioner Lead	Mark Roscoe, Commissioning Manager, Commissioning Centre of Excellence
Provider Lead	TBC
Period	1st January 2017 to 30th June 2019

1. National Context and local Need

The need to invest in preventative services to delay people's need for social care and health services and to promote the wellbeing of our community is widely recognised. A shared preventative approach across organisations in the public, voluntary, community and private sector to deliver services to a changing and ageing population is required if health and social care services are to be sustainable

Universal prevention services are targeted towards citizens who fall below the eligibility threshold for assessed care and support. The aim is to provide support to enable citizens to live independently for as long as possible within their own homes and reduce the demand on more expensive adult social care by managing health and wellbeing through early intervention. The Care Act 2014 places a new duty on Local authorities to ensure the provision of preventative services that help prevent, delay or reduce the development of care and support needs.

Older Adults – Primary prevention services offering community based day opportunities to reduce isolation and keep citizens engaged in their community. 6000 people per year have access to a service. A high percentage of these citizens will become isolated as these services provide their only contact on a regular basis. There is also potential for an even greater percentage to develop critical/substantial needs sooner than necessary due to their isolation The centres provide services at a significantly subsidised rate to people with assessed eligible care and support needs in most cases due to personal choice, and others who could be deemed to have high care needs but have not yet been identified.

The Care Act 2014 brings a significant reform in care and support, putting those with care needs and their carers in control and at the heart of their care to improve independence and wellbeing. The Care Act introduces new responsibilities for local authorities. It also has major implications for adult care and support providers, people who use services, carers and advocates.

The Act defines the primary responsibility of local authorities as the promotion of individual wellbeing. There is a shift from the duty to provide services to meeting needs. A key part of the Act is a focus on preventing or delaying the need for more complex adult social care. This requires investment in preventative services and fully utilising any existing community resources, facilities and assets to prevent people's needs escalating unnecessarily. The focus should be building community resilience and providing flexible support that does not create long term dependency.

It also states that Local authorities must:

- Establish and maintain an information and advice service.
- Facilitate a diverse, vibrant and sustainable market for care and support services that benefit the whole population.
- Focus on wellbeing, workforce development, pay and appropriate pricing of services when commissioning.
- Promote integration with the NHS and other key partners.

The Local Authority also has a commitment to provide provision that addresses the Public Services (Social Value) Act 2012.

The Act gained Royal Assent in March 2012 and was implemented in January 2013. It requires local authorities at the pre-procurement phase of commissioning services to consider how what is being procured might improve the economic, social and environmental wellbeing of an area and how the authority might secure that improvement in the procurement process itself. There is also a requirement that authorities consider whether to consult on these matters. In essence it is about factoring in 'social value'. Social Value is imbedded into all contracts.

A series of local policies have been developed in support of the Social Value Act 2012:

- Birmingham Business Charter for Social Responsibility 2013;
- Social Value Policy 2013; and
- Living Wage Policy 2013.

All areas of the public sector, particularly health and social care, face significant budget pressures, alongside pressures on existing services from an increasing, ageing population.

Citizen pathway

This service has been commissioned as part of the pathway (see appendix A), which aims to ensure that vulnerable people are able to access, pass through and exit services at the right points in their journey towards achieving or maintaining independence. Therefore, providers will maintain and retain effective working relationships with other providers at the relevant parts of the pathway and create a holistic package of care, so that citizens are able to access services without difficulty. The ultimate aim is to ensure that there is the best use of services available within the universal space (see appendix A), which in turn avoids unnecessary dependences elsewhere within the pathway and avoid duplication.

Support Services

Outside of the statutory requirement enshrined in the Care Act 2014, the Council is committed to supporting preventative and early intervention services, given their contribution to the Future Council's Vision of a sustainable model of demand management which not only improves the quality of life for citizens, but also reduces the escalation of need into more expensive statutory interventions. The services being procured through this process will support this future vision by making prevention an integral part of the Council's offer to all citizens; We will continue to measure this against the outcomes defined in the Adult Social Care Framework (ASCOF) and the locally derived prevention outcomes.

Given the climate of reducing resources it is essential that projects work to deliver effective services along the pathway model (Appendix A), so that vulnerable citizens, access, pass

through and exit the commissioned services in an appropriate and timely manner so as not to generate unintended demand elsewhere within the pathway or create long term dependency.

This approach will require multi agency collaboration across the sector to ensure appropriate expertise available to support the most vulnerable citizens.

The commissioning of universal services will help some of the most vulnerable and sometimes most excluded people to remain independent with choices over how much they contribute to their community and wider society. The primary target audience for this specification is vulnerable adults. For the purpose of this specification a vulnerable adult has been defined as a person over the age of 18 who is or may be in need of community care services by reason of mental or other disability, age or illness; and/or who is or may be unable to protect him or herself against significant harm or exploitation in any care setting. This includes individuals not in receipt of social care services, but may include those in receipt of other services such as health care (Department of Health and Home Office, 2000).

Through this specification we will continue with our commitment to purchase universal services that improve and maintain the health and wellbeing of citizens, with a clear focus on activities that will deliver measurable benefits to vulnerable adults across the City. We want to do this through an outcome based approach that delivers on the priorities in:

- the Leaders Statement: For a fair, prosperous and democratic city ;
- The Health and Wellbeing Strategy: Improve Health and wellbeing of most vulnerable adults; Improve the resilience of our health and care system; and
- the Adult Social Care Market Position Statement: SAFEGUARDING – Protect most vulnerable in the city; QUALITY LIFE – Enhancing quality of life for people with care and support needs; RESIDENTIAL CARE - Delaying and reducing need for residential care and support and through the procurement of services that can deliver results against the outcomes listed below.

The aim of preventative services is to promote independence by reducing negative dependency and empowering citizens to do as much as they can for themselves for as long as possible. One way of doing this is to keep them active and engaged within their own communities and neighbourhoods.

This could include but is not limited to:

a) Activities/events organised, led and run by users that help them to feel valued appreciated and enable them to re-engage with the community within which they live.

b) Befriending services that allow for development of community and peer networks.

c) Activities that support citizens in their home for example through the provision of volunteer floating support services that are not housing related.

d) Services/activities that will build on new and existing community hubs and groups to leave a lasting impact or legacy for the community

e) Day opportunities that provide access to a range of activities and services for individuals that they are able to actively engage with as users and/or organisers.

Through this process we aim to commission services that facilitate access and support vulnerable adults into preventative services as and when they feel the need too.

In developing universal provision, providers need to be conscious of the diverse needs of citizens who access services and ensure the support is flexible in a way that it manages the demand, builds resilience and does not create dependency. There is an acceptance that the level of support and interventions for citizens will vary as a person centred approach is applied. For some citizens, prevention may mean maintenance to stop their condition or situation from deteriorating further; it is therefore reasonable for citizens to have an individual agreement in place when they join a service that details their expectations and outcomes.

The delivery of such services must adopt a Asset Based Community Development (ABCD) approach.

Asset Based Community Development (ABCD) is a *strategy* for sustainable community-driven development. Beyond the mobilization of a particular community, ABCD is concerned with how to link micro-assets to the macro-environment. The appeal of ABCD lies in its premise that communities can drive the development process themselves by identifying and mobilising existing, but often unrecognised assets, and thereby responding to and creating local economic opportunity.

ABCD builds on the assets that are already found in the community and mobilizes individuals, associations, and institutions to come together to build on their assets Such assets should be matched with those in need to build resilience in the community. The key is to begin to use what is already in the community and not parachute in expertise that is no longer sustainable under the existing financial pressures.

In the past when a person had a need they went to their neighbour for assistance. But this has shifted today to the belief that the neighbour does not have the skills to help them, therefore we must go to a professional for assistance.

This leads to isolation, lack of community integration and reliance on more expensive care. Those less affluent begin to see themselves as people with special needs that can only be met by professionals; this can be changed through the ABCD process.

Secondly, ABCD is found in the local associations who drive effective community development and leverage additional support and entitlements. These associations are the vehicles through which a community's assets can be identified and then connected to another in ways that multiply their power and effectiveness. ABCD draws out strengths and successes in a community. Among all the assets that exist in the community, ABCD pays particular attention to the assets inherent in social relationships, as evident in formal and informal associations and networks.

It is a strategy directed towards sustainable, economic development that is community-driven. Most communities address social and economic problems with only a small amount of their total capacity. Much of the community capacity is not used and is needed. This is the challenge and opportunity of community engagement. Everyone in a community has something to offer.

Five Key Assets in ABCD

Communities can no longer be thought of as complex masses of needs and problems, but rather diverse range of assets. Each community has a unique set of skills and capacities to channel for community development. ABCD categorises asset inventories into five groups:

• Individuals: At the centre of ABCD are residents of the community that have gifts and skills. Everyone has assets and gifts. Individual gifts and assets need to be recognised and identified. In community development you cannot do anything with people's needs, only their assets. Deficits or needs are only useful to institutions.

• Associations: Small informal groups of people, such as clubs, working with a common interest as volunteers are called associations in ABCD and are critical to community mobilisation. They don't control anything; they are just coming together around a common interest by their individual choice.

• Institutions: Paid groups of people who generally are professionals who are structurally organised are called institutions. They include government agencies and private business, as well as schools, etc. They can all be valuable resources. The assets of these institutions help the community capture valuable resources and establish a sense of civic responsibility.

• Physical Assets: Physical assets such as land, buildings, space, and funds are other assets that can be used.

• Connections: There must be an exchange between people sharing their assets by bartering, etc. These connections are made by people who are connectors. It takes time to find out about individuals; this is normally done through building relationships with individuals by individuals.

Outcomes

All elements of the service must deliver in line with the strategic objectives of the Council Business Plan and Budget 2016+ and the Health and Wellbeing Strategy. **ASCOF outcomes see Appendix B**

Each outcome is stand alone and it is expected that providers will demonstrate how their service provision achieves a positive impact. In addition all should demonstrate and provide evidence of how their service will deliver against **Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm**. The provider should deliver against the following:

1. Enhancing the quality of life for people that are just below the assessed care and support needs eligibility threshold;
2. Delaying and reducing the need for care and support
3. Ensuring that people have a positive experience of care and support;
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm;
5. Support Citizens to Self-manage and maintain Independence;
6. Reducing Social Isolation;
7. Health and Wellbeing (including the five ways to wellbeing);
8. Living Safely at Home;
9. Remaining Independent;

10. Reduce demand on Carers;
11. Build community resilience;

Social Value

In relation to this service, the service provider will deliver the following "social value requirements" through an agreed Action Plan

1. Payment of the Birmingham Living Wage
2. Adherence to the Birmingham Business Charter for social responsibility including:
    a. Local Employment
    b. Buy Birmingham First
    c. Partners in Communities
    d. Good Employer
    e. Green and Sustainable
    f. Ethical Procurement
3. Supplier innovation relevant to and proportionate to the contact value.
4. A robust evidencing and evaluation methodology

3. Scope and service description

Aims

This prevention model aims to provide an integrated prevention service that offers flexible support that reflects the individual needs of vulnerable adults with a goal to build community resilience and promote independence. This would result in citizens living independently in their own home over the long term and reducing the demand on adult social care. This will be in line with the Care Act (2014) and Council and CCG priorities, to provide a shift in service provision, with an increasing focus upon preventative services with the aim of preventing, reducing and delaying the need for care. This should allow us to reach our goal of providing people with adequate information and advice, thus enabling them to access high-quality services at an early stage to aid their independence for as long as possible in their community and own homes.

It has been decided that we will not be commissioning information and advice services as discreet stand-alone provision. However there is a requirement for all services to offer access to high quality information and advice that supports and empowers citizens to know their rights and responsibilities. This is integral to all service provision.

Access to this high quality information and advice must be a fair and equitable service for all citizens. To meet the requirements for the provision of information and advice at the required level, providers can choose to develop partnership/consortia or sub-contracting

arrangements with advice agencies or resource centres.
The service offered should be delivered flexibly to address the needs of the following vulnerable adults:

1. Those at risk of entering adult social care
2. Mental health
3. Learning disabilities
4. Poor health and wellbeing
5. older adults,
6. adults with autism,
7. adults with Sickle cell
8. adults with learning disabilities

The specification is broken down into three Lots. A provider may wish to tender for one or more Lots. The Lots are as follows:

1. **Centralised Hub**
2. **Community Brokerage**
3. **Primary Prevention services** (applicants must clearly indicate which vulnerable groups the service will support and how it is tailored to address their needs)

All providers, including all consortia with nominated lead or single providers should be able to deliver a simple package of care that meets the varied needs of the population. Whether the lots are awarded to a single provider or a separate providers, they will be required to work together to deliver an integrated system to vulnerable adults.

The Centralised Hub Overview:

- Create an information platform that will ensure that both the public and professionals are aware of the services available to support their needs to improve their health.
- To provide information and advice service
- Signposting or referral to support services
- Access to training
- Access to day opportunities
- Support and manage the co ordination of service provision
- to support vulnerable adults and professionals throughout the citizen pathway and ensure that the customer journey, choice and options is easy to understand, access

and use, with key information in one place.

- Establish and develop a wide network of sub-contracted community organisations across Birmingham to provide support planning and related practical support to vulnerable adults

- Provide support and guidance to community organisations within the network to ensure they understand their role and how it fits within the wider Citizen Pathway

Provide and deliver training/support opportunities to community organisations within the network to ensure they have the necessary knowledge, skills and abilities to provide any sub-contracted support to vulnerable adults The Service Provider will work in partnership with the Council and other stakeholders to provide an intergraded hub , the hub will form the central element of the new prevention service and will be part of an integrated approach that provides clearer and holistic pathway for citizens accessing prevention services. The hub should not be one individual centre that is accessible from across the city and instead should form a multitude of access points within local communities as well as virtually, that is coordinated centrally to deliver a city wide holistic package of care for vulnerable adults that are at risk of entering adult social care.

The hub will be managed and coordinated by a service provider(s) that will work with all community and partner organisations locally that offer support to ensure:

1. The needs of citizens are met and communicated within vulnerable communities

2. A simple referral pathway is maintained to access services

3. Communication of how citizens exit support that would instil independence, develop community resilience and reduce risk of relapse

4. Provide onward referral to specialist services where necessary

The service will enable vulnerable adults to access services within the universal space and therefore facilitating their independence longer term.

Community Brokerage Overview:

- The provider will support vulnerable adults to move through the system- citizen pathway thus avoiding blocking the system

- The provider will assist citizens assessed by the Council as eligible for Direct Payment to develop their own Support Plan.

- The Provider will assist self funders to develop their own Support Plan

- Actively promote the Community Brokerage model to Personal Budget Holders/self funders, their families, friends and the wider community.

- Develop and co-produce effective IT e market approaches that enables those with a Direct Payment and self funders to make informed choices about which community organisation within the network they would wish to choose for the provision of

support.

- Develop effective governance arrangements, processes, information transfer and management arrangements, and communication interfaces to manage and deliver Community Brokerage services.

- Develop peer support networks to support Personal Budget Holders and self-funders to both undertake their own support planning activity and manage their Personal Budgets**.**

Community brokerage will manage demand and support citizens to move through the citizen pathway with a focus on providing flexible care that moves citizens through the pathway as effectively and efficiently as possible, whilst focusing on building independence and community resilience. The priority is to instil the necessary skills, support and expertise where necessary to enable citizens to live independently in their own homes for as long as possible.

The community brokerage service will manage demand and support citizens to move through the system with a focus on reducing dependency and ensure citizens have the appropriate level of intervention that enables them to remain in their own home with limited support and care; therefore providing an effective primary prevention offer. It will also identify those who have an assessed eligible need for care and support and have chosen to take their personal budget as a Direct payment to avoid taking capacity from prevention services and instead ensure they receive the appropriate level of care.

This will be supported by the need to commission prevention services that have the ability to deliver a more flexible model of care that maintains a primary prevention model, but also has the capacity to increase resources and opportunities for other adults that may have more complex needs. This would in turn enable providers to draw on additional resources (i.e. direct payments) to develop a more sustainable business model that meets the demands for those that sit above and below the assessed care and support need eligibility threshold.

The service will provide access to a brokerage service to develop support plans for adults with an assessed eligible care and support need and self-funders . It will also facilitate access to a range of community based services to provide support for Vulnerable Adults. This element of the service will be linked to the Framework Agreement for Direct Payment Support.

The aim is to promote independence by providing support when needed and shifting towards independence as appropriate for the individual.

The approach should be flexible and reduce the support at the right time to ensure the need of the whole population is met. It should also provide high quality information and support for people about the range of services available, enabling them to manage their own care where appropriate.

Utilisation of new technologies and approaches to enable people to have more control and choice in their care is important and the focus across any support package should be more joined up to embed independence, community resilience and prevention in the need for

more expensive complex care.

Any approach should utilise community, environmental and individuals assets to promote and maintain independence and a healthy lifestyle.

Brokerage should develop partnerships to facilitate effective community resilience.

Primary Prevention Services

Prevention services will be delivered by a multitude of community and 3rd sector organisations that will be supported by the Community Hub and Brokerage roles. The intention is to ensure the approach delivered to enable citizens to maintain independence is coordinated and accessible to those with the greatest needs. The commissioning of these services will focus upon enabling organisations to deliver new, innovative programmes that improve health and wellbeing to instil long term community improvements in health and wellbeing

This will be a range of community services that will work as part of a consortium of delivery. The services may be managed by the lead agency as sub contracted organisations/partners.

Voluntary and community sector services are key to enabling people to live independently, be active in their community, create a local support network and help navigate the health and social care system should they need to.

These prevention service will :

1. Work towards increasing capacity in the system.
2. Work towards reducing demand for more expensive adult social care and reduce dependency.
3. Engage the local 3rd sector to support people to live as independently as possible in their local community and maintain their good health and wellbeing.

Prevention services will provide an innovative, person centred and cost effective support service, that utilises an asset- based approach to provide flexible care and support specific to the needs of different vulnerable adults. The prevention offer should only focus on providing support for those just below the assessed care and support needs eligibility threshold, that if a package of support was not offered, the citizens would progress to more expensive adult social care interventions.

Providers are also encouraged to develop a model that also has the capacity to increase the resources they have by utilising other funding streams i.e. direct payments. This would enable providers to maintain a primary prevention model funded by this contract that is not taken by those with more complex needs, whilst developing their individual support services that will enable citizens to utilise their direct payments to access the support they need; this would be supported by the brokerage role. This helps to reduce the increasing demand on adult social care in the long term whilst ensuring the resources are available to support those with more complex needs.

The model will develop community assets, whilst facilitating co-production and community

capacity building are therefore of paramount importance.

The provider will make the customer journey effective by developing pathways across the range of prevention services. This approach will assist service users to access, as required, a range of related services and provide an opportunity to offer appropriate early intervention if the support requirements of individuals changes or escalates.

It will enable the development of community resilience and remove independence on more expensive social care in the long term as citizens are supported to manage their own health and wellbeing for as long as possible.

It will facilitate the introduction of a more innovative, cost effective model that better manages demand for prevention services and adult social care.

Support the priorities of reducing dependency and creating community resilience.

Develop services that focus upon vulnerable citizens and are reflective of the local need and increased uptake of direct payments which will, in turn, help reduce demand on adult social care in the long term and manage more immediate pressures.

Provide a central resource for vulnerable adults at risk of entering adult social care, autism, Sickle cell, Thalassemia, poor mental health and learning disabilities

Promote a no wrong door policy and act as a signpost to other local service, organisations, working with partners to identify and meet the needs of the vulnerable adults, building individual and community resilience and identifying /developing local assets to effectively meet need.

Demonstrate collaborative and coordinated working with a range of partner agencies (third sector, community, statutory) in order to achieve a support plan for individuals

Demonstrate effective engagement with the vulnerable communities through footfall, partnerships with organisations, community engagement

Develop and support the market to ensure a clear understanding is in place that meets the priorities set by the Council.

Seeks to capture innovative practices which address early intervention and prevention utilising the assets of both communities and individuals.

Promote independence for vulnerable people to reduce negative dependency and empower people to do as much as they can for themselves.

Support vulnerable people to exit or reduce their reliance upon statutory interventions and reduce the likelihood of re-entry into statutory services.

Enable vulnerable people to access universal services thus maintaining their independence.

To empower vulnerable people to do as much as they can for themselves

<u>The following applies to the three elements of the service</u>

1. Centralised Hub
2. Community Brokerage
3. Primary Prevention services

Capacity

The providers should state the numbers of people they propose to work with over the life of the contract and the numbers of staff to be deployed (FTE) to the service and their working hours.

It is expected that the numbers will vary throughout the period as people move out and new ones join. Prevention services are intended to empower and enable individuals to access services as and when needed. It is therefore, reasonable to expect citizens to have agreements in place upon joining a service with a clear exit expectation. On occasion there may be a need to re-engage with the service at a later date, each intervention should be clearly outcome focused

Management of Sub-Contracted Services

Develop and co-produce effective governance arrangements for organisations and all activity undertaken, including quality standards, measures and best practice guide lines for all key activity within the services

The lead organisation will take responsibility for the management , coordination of the hub brokerage service and prevention services

Financial and performance monitoring forms:

- Coordinate the collection/submissions of monitoring forms
- Monitor compliance and address performance to sub-contracted organisations
- Check and sign off forms submitted

Duration

It is intended that contracts will be available for up to two years and seven months subject to finance being available. This may be extended in exceptional circumstances but only with agreement of the authority;

Providers are required to state:

Networking/ Partnership working

The provider is required to demonstrate how he proposes to work in partnership/consortia with stakeholders, citizens, and other providers across the city.

Operational protocols must be agreed and implemented for the partnership/consortia, these should include but are not exclusive to:

- Data Security/sharing/retention and storage
- Compliance with safeguarding requirements and legislation to include appropriate

DBS clearance for staff and volunteers within all partner organisations

- Sub-contractor agreements that ensure their ability to comply with BCC contract requirements;

Monitoring and Data collection

Providers must ensure their polices comply with the requirements of the Equality Act 2010, and do not discriminate against people with protected characteristics, this should include monitoring delivery against the requirements of that Act and that Data collection must be sufficient to allow local authorities to meet their duties under the Equality Act 2010.

Providers will be a required to provide quarterly reports to demonstrate the availability and impact of their service against each of the protected characteristics of the Equality Act 2010. The provider must therefore be able to demonstrate and evidence in their application robust data collection systems that will enable them to produce information as determined by the authority against all 9 of the protected characteristics within the Equality Act 2010 and to proactively address and resolve any issues.

Confidentiality and Data Sharing

The Provider will be required to have a Confidentiality Policy that complies with the Data Protection Act 1998.

The Provider will be required to have written policies on information sharing, data protection and record retention that facilitate effective multi-agency working within the clear boundaries set by the *Data Protection Act 1998*.

The provider will be required to produce policies and procedures for making and maintaining records of contact with service users. The policies and procedures will be expected to detail standards for recording service users' information, internal audit, quality monitoring, storage, cataloguing, archiving, and destruction. There must also be a procedure for handling and storage of third party information.

The provider will be required to sign a data ownership and sharing agreement.

<u>The following applies to</u>

1. Centralised Hub and Community Brokerage

Management of Sub-Contracted Services

Develop and co-produce effective governance arrangements for organisations and all activity undertaken, including quality standards, measures and best practice guide lines for all key activity within the services

The lead organisation will take responsibility for the management , coordination of the hub brokerage service and prevention services

Financial and performance monitoring forms:

- Coordinate the collection/submissions of monitoring forms
- Monitor compliance and address performance to sub-contracted organisations
- Check and sign off forms submitted

Population covered

Older adults

There are a number of definitions of older people; the Census method of classification is any person age 50 years or more. Over 50 years there are separate classifications for older people and these classifications are as follows:

1. 50 – 65 years - new entrants to later life
2. 66 – 75 years - the 'young old'
3. 75 or more years - the old
4. 85 years and over - older old

Support services that are specifically designed for older people will primarily be accessible for people of 50 years and over. However the ethos driving the support agenda for older people is applicable across all client groups and the social care agenda.

Older people comprise a diverse group from all walks of life with a range of needs represented across vulnerable groups including disability, learning disability, mental health, sensory impairment, homelessness, offending and substance misuse. Services will be commissioned on the basis of old age being the primary indicator of vulnerability. The key to supporting older people successfully is to procure flexible, creative services. Service delivery will need to respond to each individual and their given circumstances such as income, culture, religion, gender and ethnicity.

Birmingham population

- Sum of population 1,1014000
- Population 65+ 140000
- Approx. 9% of population is 65+

Learning Disabilities

Disabilities Department of Health estimates for people with a learning disability suggest that 2.57% of adults in Birmingham were learning disabled in 2009. Approximately 29,000 people are recognised as having a learning disability with 4,000 being severe. The risk of dying under the age of 50 for someone with a learning disability is 58 times greater than the general population. Table eleven shows the number of people by age in Birmingham estimated to have a learning disability.

Table eleven – predicted learning disability

Predicted LD	2012	2015	2020	2025
18 to 24 years	3,643	3,601	3,412	3,530
25 to 34 years	4,273	4,624	4,848	4,738
35 to 44 years	3,226	3,166	3,524	4,037
45 to 54 years	2,899	3,019	2,948	2,794
55 to 64 years	2,101	2,170	2,411	2,618

65 to 74 years	1,509	1,555	1,633	1,694
75 to 84 years	959	973	995	1,088
85+ years	388	414	460	531
Total	**18,998**	**19,522**	**20,231**	**21,030**

Data source: PANSI & POPPI data 2012.

- 2.5% of the population were estimated to have a learning disability and numbers are predicted to increase
- *"13.8% of these people are recognised as having a severe learning disability"* Approximately 29,000 people are recognised as having a learning disability with 4,000 being severe
- Learning disabilities represents 69% of the disabilities client group

Disabilities client group expected to increase circa 7% by 2021

Sickle Cell

Specific data was unavailable for this group

Citizens suffering from Sickle Cell Anaemia and Thalassemia suffer discrimination and stigma due to cultural perceptions based on the belief that the illness is caused by faulty genes. The impact of social stigma means that sufferers often experience difficulties in disclosing their diagnosis within their communities leading to mental illness, depression and levels of vulnerability that require help and assistance to maintain independent living.

Due to the nature of the disease many sufferers have severe anaemia episodes: acute chest syndrome blocked blood vessels in the lungs, pain episodes due to blocked blood vessels in bones and are susceptible to certain types of bacteria which can cause pneumonia, meningitis and septicaemia. This creates life threatening illnesses including strokes or brain injuries; this affects not only adults but 1 in 10 children.

Our focus is to ensure that citizens suffering from Sickle Cell Anaemia and Thalassemia are enabled to live as independently as possible and to maintain quality of life irrespective of where they live – in supported accommodation or own their own home. This means securing services or activities with a focus on the promotion of inclusion and personalisation that allow individuals to do more for themselves, and enable their families and carers to support them to regain their independence.

Autism

Autism is a lifelong developmental disability and although some people can live relatively independently, others will have high dependency needs requiring a lifetime of specialist care. There are approximately 400,000 adults with autistic spectrum disorders in England, around half who have a learning disability.

Birmingham's Joint Strategic Needs Assessment (JSNA) suggested an autism population of between 1 to 2% of the total population. This would suggest there are between 10,000 and 20,000 people with Autism living in the city. The adult population (18 to 64 years of age) estimated to have an autistic disorder is 6,482 and is expected to increase to 6,965 by 2025. The ratio for male to female is 2:1. Table 13 shows the estimate for the city.

Table 13

Age range	Autism	General population	%
0 to 15	2,278	227,763	1%
16+	8,091	809,115	1%
Total	10,369	1,036,878	1%

Data source: JSNA

Applicable local standards

Standards of staff behaviours

The service provider must make sure that systems are in place to ensure that all staff (whether full-time, part-time or voluntary):

- Always introduce themselves to the service user;
- Always give their name to the service user;
- Treat the service user with courtesy and respect;
- Are friendly, welcoming and helpful (rather than treating the service user as a nuisance or a disruption);
- Deal with the service user quickly, rather than keeping them waiting;
- Deal with the service user's problems patiently, understandingly and sensitively;
- Do not judge the service user in any way; and
- Behave properly and professionally at all times whilst in the presence of service users (this includes not smoking, drinking, taking illegal substances or using bad language).

Service providers are expected carry out any monitoring activities that are necessary to make sure that staff and subcontractors are to comply with the standards outlined above.

6. Service Provider

<u>The following applies to all three elements of the service</u>

1. Centralised Hub
2. Community Brokerage
3. Primary Prevention services

The provider will need to:

- Deliver a service that is proactive, and responsive to the needs of the individual,
- Provide a service that is relevant and appropriate to support the individual to regain or retain their independence.
- Identify, appropriately manage and secure services for a diverse range of vulnerable people with Sickle Cell Anaemia with a range of presenting needs.
- Have proper governance and management systems in place to include policies and procedures that comply with various legislative requirements; e.g.: safeguarding policies that comply with Making Safeguarding Personal; Equal opportunities policies that comply with the Equalities Act 2010

7. Key Performance indicators

The following applies to

1. Centralised Hub and Community Brokerage

Number of adults accessing information and support

Number of cases referred to partners and other agencies

Number of organisations delivery of support and training

Number of volunteering opportunities created

Number of vocational opportunities created

Analysis of trends ,issues: service development

Evidence of positive journey throughout the citizen pathway

Number of budget holders setting up a support plan

Number of self funders setting up a support plan

The following applies to all three elements of the service

1. Centralised Hub
2. Community Brokerage
3. Primary Prevention services

Number and positive evidence of adults accessing support groups

Number of adults referred and accessing services

Evidence of positive journey throughout the citizen pathway

Evidence of plans supporting adults to maintain independence

Evidence of opportunities for employment training , volunteering and education
Numbers of adults accessing services to improve access to services social inclusion and social support

Numbers and evidence supporting transitions from childhood to adulthood

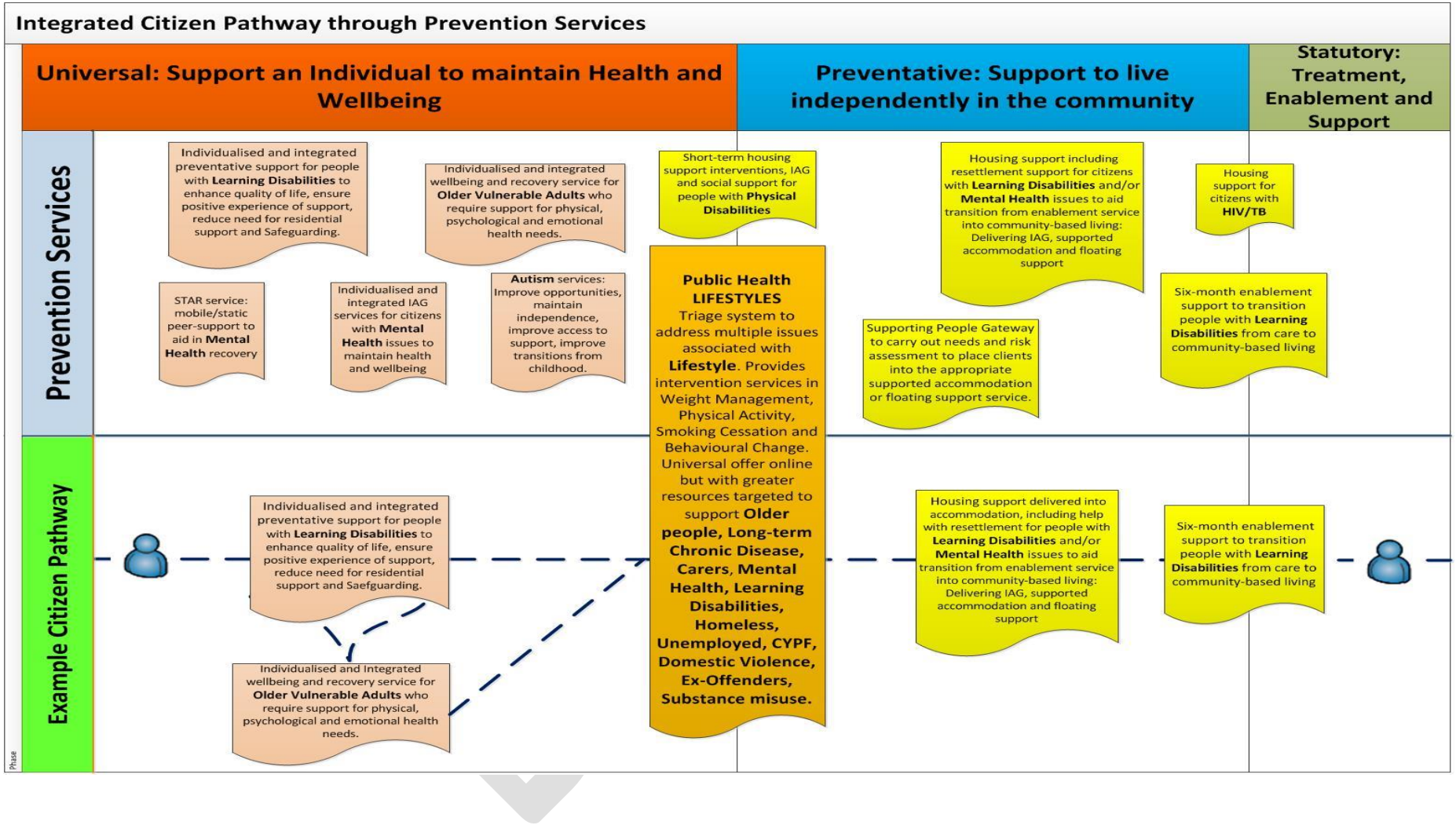
Evidence of Enhancing/improving the quality of life for people with care and support needs

Evidence of plans delaying and reducing the need for residential care and support

Evidence of people sharing positive experiences of care and support

Additional KPI will be identified with providers , this will be dependent upon the model of service delivery, and target group

Appendix A –Integrated Citizen Pathway through Prevention Services



Appendix B-ASCOF outcomes

Outcomes
ASCOF OUTCOME 1: Enhancing the quality of life for people with care and support needs: A key objective of the drive to make care and support more personalized is that services should more closely match the needs and wishes of the individual, putting users of services in control of their care and support. Therefore, asking users of care and support about the extent to which they feel in control of their daily lives is one means of measuring whether this outcome is being achieved. There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. **Measures to include the following:** • People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to meet their needs: • Carers can balance their caring roles and maintain their desired quality of life • People are able to find employment when they want, maintain a family and social life and contribute to community life and avoid loneliness or isolation
PREVENTION OUTCOME 1: Support to Self-Manage Providers must demonstrate and be able to provide evidence that the service will help citizens gain knowledge and understanding that enables them to self-care and self-manage independently thus reducing demand for high cost statutory services. Evidence of income maximisation, support to continue to work, development of coping skills and support to access other universal or mainstream services would all be relevant. **Measures to include the following**: • Individuals using the service report they are supported to actively manage their condition and support their own needs. • Users receive support to access range of financial advice and support services. • Individuals using the service feel confident that they can cope with everyday tasks and remain independent. • Individuals using the service report they feel confident to self-manage • Individuals are effectively signposted to other services • Monitoring of customer journey • Individuals are supported to access appropriate advice services of a quality sufficient to meet their requirements

PREVENTION OUTCOME 2: Reducing Social isolation

Providers must demonstrate that the service maximises community links and social interaction, and reduces social isolation resulting in less stress and anxiety and improved opportunities to engage in activities that encourage physical and mental wellbeing.

Measures to include the following:

- Individuals using the service report that they feel they have adequate social contact
- Individuals using the service report that they feel less lonely and depressed
- Individuals using the service report that their lifestyle has improved for the better
- Individuals are effectively signposted to other services
- Monitoring of citizen journey
- Individuals are supported to access appropriate advice services of a quality sufficient to meet their requirements

Examples of the type of activities and services could include :

- projects that build on and support community networks to develop services / activities that are delivered by individuals within the community; e.g. shared transport scheme; walking bus service; home visiting or floating support service
- Activities that promote/encourage the retention or regaining of skills, confidence and independence; e.g. introduction to or update use if Information Technology; intergenerational activities; peer mentoring/buddying schemes
- Activities that support inclusion in person centred care planning in developing a range of age appropriate activities that enable choice and control; e.g. peer support activities
- Activities that promote healthier and safer lifestyles; e.g. creating links and better access to Public Health lifestyles services

ASCOF OUTCOME 2: Delaying and reducing the need for residential care and support

Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care.

Measures to include the following

- Individuals had the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs
- Earlier diagnosis, intervention and rabblement means that people and their carers are less dependent on intensive services
- When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence

PREVENTION OUTCOME 3: Health and Wellbeing

Providers must demonstrate that the service contributes to the Health and Wellbeing of citizens, and supports the improvement of in health and wellbeing in communities.

Measures to include the following:

- Individuals using the service feel they are supported to manage their health condition
- Individuals report that their lifestyle has improved for the better
- Carers report that they feel that they are supported to continue providing care.
- Individuals are effectively signposted to other services
- Monitoring of citizen journey
- Individuals are supported to access appropriate advice services of a quality sufficient to meet their requirements

PREVENTION OUTCOME 4: Living Safely at Home

Providers must demonstrate how the service will ensure personal safety and security, improve mental and emotional health, resilience and wellbeing and help citizens to remain safely in their own homes. Services should be targeted at citizens who may find it hard to manage at home and improvements should prevent or delay the need for social or health care intervention.

Measures to include the following:

- Individuals using the service feel safe and confident living in their own home
- Individuals report an improvement in their living conditions
- Percentage of users who have had reduced need for health or social care services since using the prevention service

- Individuals are effectively signposted to other services
- Monitoring of citizen journey
- Individuals are supported to access appropriate advice services of a quality sufficient to meet their requirements

PREVENTION OUTCOME 5: Remaining Independent

Providers must demonstrate that the service can reduce health and social care interventions, enable citizens to live as independently as possible as full and equal citizens of Birmingham and their local communities, and ensure equal access to universal services.

Measures to include the following:

- Individuals using the service report that they feel supported to stay healthy and well
- Percentage of users have had reduced need for health or social care services since using the prevention service
- Individuals using the service feel confident that they can cope with everyday tasks and remain independent.
- Individuals are effectively signposted to other services
- Monitoring of citizen journey
- Individuals are supported to access appropriate advice services of a quality sufficient to meet their requirements

Examples of the type of activities and services could include :

- Activities that support people to move towards independent living with greater choice and control over their support and care needs;
- Activities that support people leaving hospital to return to their own home and remain independent.
- Activities that reduce isolation and support individuals to develop social interactions and become active members of their communities.
- the development of community befriending schemes with a volunteer co-ordinator who has responsibility for a group of residents and provides a regular contact service through phone calls and visits; signposting to events and activities that are being run locally; or supporting users to organise activities in their locality and neighbourhood.

ASCOF OUTCOME 4: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

A high-quality service must be one which keeps people safe from harm. The area of safeguarding is one of the core priorities of adult social care. This area remains one of the critical developmental priorities for the future of the ASCOF.

Measures to include the following:

- Everyone enjoys physical safety
- People are free from physical and emotional abuse, harassment, neglect and self-harm
- People are protected as far as possible from harm, disease and injuries
- People are supported to plan ahead and have the freedom to manage risks in the way that they wish
- Individuals are supported to access appropriate advice services of a quality sufficient to meet their requirements
- Monitoring of the citizen journey
- Volunteers and staff have basic level awareness training –(understand the forms/types of abuse and are able to recognise/respond within the principles of Making Safeguarding personal
- Individuals report that they understand the risks to themselves within their communities
- Individuals report they understand what to do if they are worried and feel empowered on how to respond
- Safeguarding policy is in place that is compliant with the WM Policies and Procedures as on the Birmingham Safeguarding Adults Board website,

Examples of the type of activities and services could include :

- Support services that meet specific or unique needs of people from diverse communities and backgrounds.
- Activities that enable people who use services and their carers to make contact with appropriate service providers when they need to.
- Activities that support people to make and resolve complaints that are well managed.
- Activities that assist people to achieve recovery and maintain abstinence from alcohol and drug misuse
- Activities that support people who are socially isolated and excluded, often in what have traditionally been perceived as hard to reach groups or as hard to reach individuals
- Activities that support people without capacity to remain independent